

# *NSW Mental Health Act (2007) no. 8* Guide Book

6TH EDITION INCORPORATING THE 2015 MENTAL HEALTH ACT AMENDMENTS



HEALTH  
EDUCATION  
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**Foreword**

The Health Education and Training Institute (HETI) is pleased to release the 2018 version of this Guide Book, funded by the Mental Health Branch, NSW Ministry of Health.

This Guide Book was produced with the expertise, knowledge and support of many stakeholders, including NSW Ministry of Health Mental Health Branch, NSW Police, NSW Ambulance, the Mental Health Review Tribunal, and staff at HETI.

The document is representative of HETI’s commitment to the production of high quality training materials and of HETI’s expertise in the field of mental health treatment.

**Rhonda Loftus**

Executive Director

HETI Mental Health Portfolio

April 2019

# Introduction

*The NSW Mental Health Act 2007* (the 'Act') establishes the legislative framework within which care and treatment can be provided for persons with a mental illness in NSW. A good understanding of the major objectives and requirements of the Act is therefore important for all of those who work within the mental health system.

The Act, which came into operation in November 2007, retained many of the central principles of the previous legislation such as the definitions of mental illness, a mentally ill person, and a mentally disordered person. The Act was amended in 2015 and again in 2018. This edition of the Guide Book incorporates those changes.

The Guide Book has been written primarily to provide mental health practitioners who apply the Act on a regular basis with a clear and practical source of information about the procedures to be followed and issues to be considered in preparing for hearings before the Mental Health Review Tribunal. However, it is also hoped that it will be useful to those who are involved in providing support and advice to consumers and carers.

## **Pamela Verrall**

Member, NSW Mental Health Review Tribunal  
Mental Health Act Guide Book author  
and reviewer

## **DISCLAIMER ON THE TERMINOLOGY USED THROUGHOUT THIS DOCUMENT**

The term 'consumer' is generally applied by key organisations that represent the interests of people who have a lived experience of mental illness or a mental disorder and have accessed mental health services. This Guide Book aims to support mental health staff in applying the *NSW Mental Health Act 2007* which makes no reference to 'consumers' and instead uses the terms 'patient' and 'person' when referring to people who have a mental illness or disorder and are assessed for a mental health illness or disorder.

In recognition of the above considerations:

- the term 'person' has been used when directly quoting the Act and/or referring to individual(s) in the general community prior to them being assessed or scheduled;
- the term 'patient' has been used when directly quoting the Act and/or referring to individual(s) treated in the mental health facilities or the mental health system; and
- the term 'consumer' has been used when broadly referring to people who are receiving mental health treatment, and their rights and recovery, etc.

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# Chapter 1

## AIMS AND OBJECTIVES OF THE MENTAL HEALTH ACT 2007

The NSW Mental Health Act 2007 (the ‘Act’) contains a range of aims and objectives that underline the central place of community based care, the importance of involving consumers wherever possible in decisions about their care and treatment, and acknowledge the important role played by carers. While these principles do not create any legally enforceable rights or entitlements they are intended to provide guidance in the daily administration of the Act (s195).

### 1.1 OBJECTS (S3)

The objects of the Act can be summarised as follows:

- to provide for the care and treatment and promote the recovery of a person who is mentally ill or mentally disordered; and
- to facilitate the care and treatment of a person who is mentally ill or mentally disordered through community facilities; and
- to facilitate the provision of inpatient care on a voluntary basis where appropriate, and on an involuntary basis in a limited number of situations; and

- to protect the civil rights of a person who is mentally ill or mentally disordered, while providing them with access to appropriate care, and, where necessary, provide treatment for their own protection or the protection of others; and
- to facilitate the involvement of a person who is mentally ill or mentally disordered and their carer(s) in decisions about their care and treatment.

### 1.2 PRINCIPLES OF CARE AND TREATMENT (S68)

The Act sets out a list of key principles for the care and treatment of people with a mental illness or mental disorder. These can be summarised as follows:

- people should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given;
- care and treatment should be timely, high quality and in line with professionally accepted standards;
- care and treatment should be designed to assist people, wherever possible, to live, work, and participate in the community;
- medication should meet the health needs of the person and be given for therapeutic or diagnostic needs and not as a punishment or for the convenience of others;
- people should be given information about their treatment that includes the effects of

- treatment and any alternatives, and should be supported to pursue their recovery;
- any restriction of liberty and interference with the rights, dignity and self-respect of a person is to be kept to the minimum necessary in the circumstances;
- each person’s particular needs should be considered, including those related to age, gender, religion, culture, language, disability or sexuality;
  1. people under the age of 18 years should receive developmentally appropriate services;
  2. Aboriginal people and Torres Strait Islanders should have their cultural and spiritual beliefs and practices considered;
- people should be involved in the development of treatment and recovery plans and should have their views considered where reasonably practicable;
  1. every reasonably practicable effort should be made to gain the person’s consent when developing their treatment and recovery plans, to monitor their capacity to consent and to support those who may lack the capacity to consent to understand these plans;
- people should be informed of their rights and entitlements under the Act, in a language and manner that they are most likely to understand;
- the role of carers and their rights to be kept informed, be involved, and have the information they provide considered, should be given effect.

# Chapter 2

## DEFINITIONS

There are two key definitions that anyone working with the Act should understand:

- a mentally ill person;
- a mentally disordered person.

These definitions provide the framework for many of the decisions made by mental health professionals and others who are authorised to exercise functions under this Act. In particular, it is these definitions that determine who can be involuntarily admitted to a declared mental health facility.

### 2.1 WHO IS A MENTALLY ILL PERSON UNDER THE ACT?

#### Definition (s14)

A mentally ill person is someone who is suffering from a mental illness and, owing to that illness there are reasonable grounds for believing that the care, treatment or control of the person is necessary:

- for the person's own protection from serious harm, or
- for the protection of others from serious harm.

In considering whether someone is a mentally ill person, their continuing condition, including any

likely deterioration in their condition and the likely effects of any such deterioration, are to be taken into account.

#### What is a mental illness for the purposes of the Act? (s4)

Mental illness for the purposes of the Act means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence of one or more of the following symptoms:

- delusions;
- hallucinations;
- serious disorder of thought form;
- severe disturbance of mood;
- sustained or repeated irrational behaviour indicating the presence of one or more of the symptoms mentioned above.

The symptoms included in this definition should be given their ordinary accepted meanings in the psychological sciences, without reference to overly clinical complexities or distinctions. For example a 'delusion' may be considered to be a false, fixed and irrational belief held in the face of evidence normally sufficient to negate that belief; and a 'hallucination' is a subjective sensory experience for which there is no apparent external source or stimulus.

The main characteristic of 'serious disorder of thought form' is a loss of coherence: one idea does not follow or link logically to the next. A 'severe disturbance of mood' refers to a sustained and profound change in mood that substantially impairs a person's level of functioning.

The term 'irrational behaviour' refers to behaviour which a member of the community to which the person belongs would consider concerning and not understandable. In deciding whether a person is 'mentally ill' the term 'irrational behaviour' includes the additional test that it can be inferred from the behaviour that the person is suffering from delusions, hallucinations, serious disorder of thought, or severe mood disturbance. In determining whether a person is 'mentally ill' the irrational behaviour must be sustained or repeated.

#### What is serious harm?

A Communique from the NSW Chief Psychiatrist was provided to Local Health Districts and Specialty Networks in 2014. It provides guidance to clinicians making involuntary treatment decisions, regarding the 'serious harm' criterion in the Act. The Communique states that, whilst serious harm is not defined in the Act, it is intended to be a broad concept that may include:

- physical harm
- emotional/psychological harm
- financial harm
- self-harm and suicide
- violence and aggression including sexual assault or abuse
- stalking or predatory intent
- harm to reputation or relationships
- neglect of self
- neglect of others (including children).

When making decisions under the Act, clinicians should undertake a comprehensive assessment of the person including a review of the person’s history of mental and physical illness, family history, psychosocial factors impacting on the presentation, and evaluation of the risk of self-harm and of harm to others. The assessment should include consideration of the harm that may arise should an illness not be treated.

**What is a continuing or deteriorating condition? (s14(2))**

This Chapter of the Act requires clinicians to not only consider a person’s symptoms at the time of an assessment, but also:

- the person’s clinical history including their degree of insight and their capacity or willingness to follow a voluntary treatment plan;
- the likely impact on the person’s prospects for improvement or recovery if there is a failure to comply with a treatment plan;
- the possible serious harm that may occur to the person or others, if the person is not able to be engaged in assessment and treatment.

**Is there a less restrictive environment for the safe and effective provision of care and treatment? (s12(1))**

A person must not be involuntarily admitted to, or detained in, or continued to be detained in, a mental health facility unless the authorised medical officer is of the opinion that:

- the person is a mentally ill (or mentally disordered) person, and
- no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available.

Thus even where an assessment leads to the view that a person is mentally ill, involuntary admission may not be necessary or appropriate. The clinician also needs to assess the person’s social resources and consider any realistic options, for example what can be expected of friends and family? What can the community mental health team provide? Is a voluntary admission possible? Is a CTO appropriate?

**Issues to be considered in deciding whether a person should be detained as a mentally ill person:**

- is there a mental illness as defined in s4, and
- is there a risk of serious harm to the person or others, and
- has the person’s continuing condition or likelihood of deterioration and its effects been considered, and;
- is there a less restrictive environment in which appropriate care, control and treatment can be safely and effectively provided?

**2.2 WHO IS A MENTALLY DISORDERED PERSON UNDER THE ACT?**

**Definition (s15)**

A mentally disordered person is someone whose behaviour is so irrational that there are reasonable grounds for deciding that the temporary care, treatment or control of the person is necessary to protect them or others from serious physical harm.

**What is irrational behaviour?**

The term ‘irrational behaviour’ refers to behaviour which a member of the community to which the person belongs would consider concerning and not understandable. In deciding whether a person is ‘mentally disordered’ the only additional test for ‘irrational behaviour’ is that temporary care, treatment or control of the person is considered necessary to prevent serious physical harm to the person or others.

**CONTINUING CONDITION**

“The phrase ‘continuing condition’ invites the clinician and the decision maker to use an involuntary treatment order to assist a person in avoiding the ‘revolving door syndrome’. This can be done by ensuring that the person is admitted when necessary, and receives involuntary treatment for long enough to lessen the risk of an early serious relapse.”

*Mental Health Review Tribunal*





**What is serious physical harm?**

It has no special legal meaning and is to be understood in its everyday usage that includes:

- risk of self-harm or suicide
- risk of violence to others.

**Is there a less restrictive environment for the provision of care and treatment? (s12(1))**

A person must not be involuntarily admitted to, or detained in a mental health facility unless the authorised medical officer is of the opinion that:

- the person is a mentally disordered person, and
- no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.

**Issues to be considered in deciding whether a person should be detained as a mentally disordered person:**

- is the behaviour so irrational that temporary care, treatment or control is necessary?
- is there a risk of serious physical harm to the person or others?
- is there a less restrictive environment in which appropriate care, control and treatment can be safely and effectively provided?

**2.3 EXCLUSION CRITERIA (S16)**

These have been included to prevent the Act’s potentially broad compulsory detention powers being used to control behaviour that is not related to mental illness or mental disorder. In themselves,

**MENTALLY DISORDERED**

This category is most commonly used where a person is actively suicidal or out of control following a personal crisis, e.g. a relationship breakup. Intoxication with drugs and alcohol and impulsivity often feature in these situations.



these criteria are neither determinative nor even indicative of either mental illness or mental disorder within the meaning of the Act.

A person is therefore not to be defined as ‘mentally ill’ or ‘mentally disordered’ merely because of any one or more of the following:

- the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief;
- the person expresses or refuses or fails to express a particular religious opinion or belief;
- the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy;
- the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or orientation;
- the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity;
- the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity;

- the person engages in or has engaged in a particular sexual activity or sexual promiscuity;
- the person engages in or has engaged in immoral conduct;
- the person engages in or has engaged in illegal conduct;
- the person has an intellectual disability or developmental disability;
- the person takes or has taken alcohol or any other drug;
- the person engages in or has engaged in anti-social behaviour;
- the person has a particular economic or social status or is a member of a particular cultural or racial group.

However, the exclusion criterion that refers to the taking of alcohol or drugs does not prevent the consideration of the serious physiological, biochemical or psychological effects resulting from the use of a substance in order to meet the definition of a mentally disordered or mentally ill person (s16(2)).

## 2.4 DIFFERENCES BETWEEN A MENTALLY ILL AND MENTALLY DISORDERED PERSON UNDER THE ACT

The Act specifies a different set of procedures and consequences for each category. These are dealt with under Involuntary Admissions ([Guide Book, Chapter 6](#)).

## 2.5 SOME OTHER IMPORTANT DEFINITIONS AND ROLES

### Accredited person

An accredited person is a suitably qualified and experienced senior mental health clinician who is not a doctor, such as a nurse, psychologist or social worker, who is authorised to write the Schedule 1 certificates and Form 1s (in certain circumstances) ([Guide Book, Chapter 6.2](#)) that underpin the process of involuntary admission. Accredited persons are appointed by the Secretary of the Ministry of Health or delegate under s136 of the Act.

### Ambulance officer

Means a member of staff of the NSW Health Service who is authorised by the Secretary to exercise functions of an ambulance officer (paramedic) under the Act.

### Assessable person

An assessable person is someone who has been detained in a declared mental health facility as a mentally ill person but has not yet been reviewed by the Mental Health Review Tribunal (the Tribunal) at a mental health inquiry (s17).

### Authorised medical officer

An authorised medical officer is either the medical superintendent of a declared mental health facility, or a doctor who has been nominated by the medical superintendent to fulfil certain responsibilities and make various decisions under the Act mainly relating to:

- Initial assessment of patients
- Ongoing assessment of patients to determine if they need to continue to be detained
- Care and treatment of people who are mentally ill or mentally disordered, including consent to surgical operations
- Decisions about whether a patient should be discharged.

In nominating a medical officer as an authorised medical officer, the medical superintendent is responsible for ensuring that the medical officer has an understanding of their responsibilities under the Act and that they have the relevant level of knowledge, skill and experience to undertake this role. The medical superintendent should also ensure that authorised medical officers have 24/7 access to appropriate consultation and support, as well as supervision and resources to help them meet their responsibilities.

The medical superintendent is required to nominate the authorised medical officer in writing, specifying the name of the medical officer, and signing and dating the written nomination.

The medical superintendent is required to maintain an up-to-date register of authorised medical officers who work in the declared mental health facility. The register is to include the following information:

- Name of the authorised medical officer
- Date of nomination as an authorised medical officer
- A copy of the written nomination
- Date the medical officer ceased to be an authorised medical officer at the declared mental health facility

The authorised medical officer should be on the register for each declared mental health facility in which they work.

### Consumer

A consumer is a person who has the experience of using mental health services, or the lived experience of a mental illness or mental health disorder.

**Declared mental health facilities**

Declared mental health facilities are premises subject to an order in force under s109. These premises are declared by the Secretary of the Ministry of Health to fulfill certain functions under the Act.

**There are three classes of facility:**

- 1 A mental health emergency assessment class that deals with short term detention for initial assessment and treatment (all declared Emergency Departments fall in this class)
- 2 A mental health assessment and inpatient treatment class that allows for the full range of inpatient functions under the Act (this class includes Psychiatric Emergency Care Centres)
- 3 A community or health care agency class to administer community treatment orders.

It is important all staff working with the Act, in particular those with the authority to take a person to a declared mental health facility against their will for the purpose of assessment (i.e. accredited persons, NSW Police, and NSW Ambulance officers (paramedics)) be familiar with their local declared mental health facilities.

A list of declared mental health facilities can be obtained by emailing the Mental Health Branch at [MOH-mentalhealthbranch@health.nsw.gov.au](mailto:MOH-mentalhealthbranch@health.nsw.gov.au). The email should indicate which of the three classes of listings is required – Emergency, Inpatient or Community.

**Designated carer**

A designated carer (who may also be a principal care provider) is someone who is entitled to certain information about a consumer's care and treatment, and is entitled to be notified of certain events (unless excluded from being given information by the consumer) ([Guide Book, Chapter 4](#)).

**Involuntary patient**

An involuntary patient is someone who is detained following a mental health inquiry.

**Medical superintendent**

The medical superintendent of a declared mental health facility is the senior medical practitioner, appointed in writing by the Secretary of the Ministry of Health, who holds a range of administrative responsibilities under the Act. The medical superintendent is also an 'authorised medical officer', and may be appointed as the medical superintendent of more than one declared mental health facility.

**Mental health inquiry**

A mental health inquiry is a hearing by the Tribunal into the circumstances of a person's involuntary admission. In most cases a mental health inquiry is conducted by a single legal member of the Tribunal.

**Principal care provider**

A principal care provider (who may also be a designated carer) is the person primarily responsible for providing support or care to a consumer (though not on a commercial basis). The principal care provider is entitled to the same information as a designated carer (unless excluded from being given information by the consumer) ([Guide Book, Chapter 4](#)).

**Schedule 1 certificate**

A Schedule 1 Certificate provides the legal foundation for the majority of involuntary admissions in NSW. It can be completed by either a medical practitioner or an accredited person, and enables a person to be taken to a declared mental health facility against their will for the purpose of an assessment. This process of involuntary admission in NSW is commonly referred to as 'scheduling'.

**Secretary**

This term refers to the Secretary of the Ministry of Health, formerly the Director General.

# Chapter 3

## CONSUMER RIGHTS UNDER THE MENTAL HEALTH ACT 2007

People with a mental illness enjoy the same rights as anyone else in the community. These include the right to self-determination and to go freely about their daily business without undue interference. At times, however, a mental illness may result in behaviour that leads to those rights being curtailed.

It is the purpose of the Act to:

- set out the circumstances in which this can happen
- provide a framework of checks and balances
- ensure that the interference with a consumer's rights, dignity and self-respect is kept to a minimum
- promote an approach to care and treatment that supports the consumer's recovery.

This Chapter sets out the rights of consumers, as well as the principles of care and responsibilities of mental health facilities that relate to consumers. It also looks at some of the agencies and individuals who have a particular role to play in ensuring that consumers have the opportunity to exercise those rights.

### 3.1 RIGHTS OF CONSUMERS DETAINED UNDER THE ACT AND RESPONSIBILITIES OF MENTAL HEALTH FACILITIES

#### Least restrictive care

A person should only be detained in a mental health facility if that is the least restrictive environment consistent with safe and effective care and treatment (and they otherwise meet the criteria for detention). Further, any detention is subject to review. These principles are expressed in a number of ways:

- the right to internal review by an authorised medical officer or medical superintendent;
- the right to external review of involuntary status by the Tribunal ([Guide Book, Chapters 7 - 9](#));
- the requirement that any restriction on the liberty or interference with the rights, dignity and self-respect of consumers be kept to the minimum necessary in the circumstances (s68(f));
- the right of people detained involuntarily (s42) as well as their designated carers and principal care providers (s43) to apply for discharge.

#### Procedural fairness

The Act requires specific procedures to be followed in:

- the process of involuntary admission ([Guide Book, Chapter 6](#))
- the processes of external review ([Guide Book, Chapters 7 - 9](#)).

#### Right to information - Statement of Rights for Persons Detained in a Mental Health Facility (Schedule 3)

This Statement of Rights sets out:

- the procedures that must be followed once a person has been detained
- a person's rights throughout the process of involuntary detention.

The Statement of Rights should be given to a person as soon as possible after they have been detained in a mental health facility (s74).

Once a person has been detained they have the right to:

- an oral explanation and written statement of their legal rights and entitlements;
- a further explanation not later than 24 hours before their mental health inquiry if they were too unwell to understand the explanation or statement when it was first given;
- an oral explanation in a language they can understand if they are unable to communicate adequately in English;
- request to be discharged by an authorised medical officer (s42);
- appeal to the Tribunal if the authorised medical officer refuses their request to be discharged, or fails to deal with the request within three working days (s44).

An involuntary patient or any person detained under the Act may apply to an authorised medical officer to be discharged at any time.

**Right to information – Statement of Rights for Voluntary Patients (Schedule 3A)**

Once a person has been admitted as a voluntary patient they should be provided with a Statement of Rights which outlines their right to information about their treatment, their right to discharge themselves, their right to nominate a designated carer and to see an official visitor. They should also be given a verbal explanation of these rights.

Where an authorised medical officer is of the opinion that the person was not capable of understanding the explanation or the statement at the time, it must be given again once the person is able to understand the explanation or statement. If the person is unable to communicate adequately in English they must also be provided with an interpreter who will explain their rights ([Guide Book, Chapter 15.3](#)).

**Right to information – Statement of Rights After a Mental Health Inquiry or Following a Mental Health Review Tribunal Hearing After Breaching a Community Treatment Order (s77)**

Section 77 of the Act requires involuntary patients be given a statement of rights when detained in a facility after a mental health inquiry, or after a breach of a community treatment order. They must be provided with this statement of rights as soon as practicable following the Tribunal’s order for their detention. The statement sets out a patient’s right to:

- Ask to be discharged from the facility
- Appeal a decision not to release them from the facility

- Ask the Supreme Court to release them from the facility
- Ask to be made a voluntary patient

The statement also provides information on applying to have a Financial Management Order removed, or appealing a Financial Management Order to the Supreme Court or the NSW Civil and Administrative Tribunal.

**Legal representation (s154)**

The Act requires that consumers be represented by a lawyer before the Tribunal when the issue of their detention is being considered at a mental health inquiry, unless they decide not to be represented ([Guide Book, Chapters 7 & 8](#)). The Act also stipulates that a consumer under 16 years of age must be represented by a lawyer, or other person approved by the Tribunal, in all matters before the Tribunal, unless the Tribunal decides that it is in their best interests to proceed without a lawyer.

This representation is offered free of charge by solicitors from the Mental Health Advocacy Service ([Guide Book, Chapter 3.3](#)). If a consumer wishes to be represented by someone other than a lawyer the Tribunal’s approval must be obtained.

The Act also allows a consumer to be represented by a lawyer in other matters that come before the Tribunal. The Mental Health Advocacy Service offers free representation in some cases ([Guide Book, Chapter 3.3](#)). If the consumer wishes to be represented by someone other than a lawyer, the Tribunal’s approval must be obtained. Where a

private solicitor appears, the consumer will need to pay for this service.

**Respect for dignity**

Respect for the individual’s dignity is mentioned in the principles for care and treatment that underlie the Act as a whole. Consumers are also given the right to wear their own clothes to any hearing before the Tribunal as a practical way of preserving their dignity. They are to be given access to shaving equipment and make-up if reasonably practicable (Mental Health Regulation clause 6).

**Right to have one’s designated carer and/or principal care provider notified**

The Act specifies a number of situations or events when a person’s carer(s) should be notified (s78). These provisions are covered in more detail in ([Guide Book, Chapter 4](#)) and include:

- notification of the person’s detention within 24 hours where practicable (s75)
- notification of a mental health inquiry (s76)
- notification of changes to or decision to revoke community treatment order (s66A)

**Right to an interpreter**

Where a consumer has a limited grasp of English, or does not speak it at all, the mental health facility must ensure an interpreter is present (this may be by telephone):

- at medical examinations for the purposes of the Act (s70)
- to explain their rights and entitlements (s74(5))
- to assist at Tribunal hearings (s158).

**Right to access medical records**

Under the Act, a consumer and/or their lawyer have the right to access the consumer’s medical records in relation to a mental health inquiry or other Tribunal hearing (s156).

If a medical practitioner warns the lawyer that it may be harmful to the consumer or any other person, to disclose certain information, the lawyer is not obliged to disclose this information to the consumer. The Tribunal can decide the matter in these cases.

Consumers also have a right to seek access to their medical records under the *Health Records and Information Privacy Act 2002* or the *Government Information (Public Access) Act 2009*.

Information about accessing medical records can be found in the NSW Health Privacy Manual for Health Information:  
<https://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx>

**Right to apply to be discharged**

Any person who has been detained in a declared mental health facility, has the right to apply to an authorised medical officer, either orally or in writing, to be discharged (s42).

The authorised medical officer has three working days to make a decision. If the application is not decided on within this time, or is refused, the person can appeal to the Tribunal (s44).

If the person indicates their wish to appeal, this must be brought to the attention of the Tribunal. A written request is useful but not essential.

**Rights in relation to medication**

Any person who has been detained in a declared mental health facility:

- does not have the right to refuse appropriately prescribed medication (although they may express their objection)
- has the right to information about their medication, including side effects and dosages (s73)
- must be prescribed with the minimum medication, consistent with proper care, to ensure that the person can adequately communicate with their legal representative (s29).

The person’s lawyer and their designated carer(s) and/or principal care provider also have the right to information about the person’s medication.

In prescribing medication the mental health facility must:

- administer drugs with due regard to relevant professional standards (s85)
- prescribe medication to meet the health needs of the person and to meet therapeutic or diagnostic needs, and not as a punishment or for the convenience of others (s68(d))
- monitor and review the prescription and use of drugs in the mental health facility (s86).

The Tribunal must:

- inquire into the medication of the person before them
- take into account the effect of the medication on the person’s ability to communicate at the hearing.

**Involvement in discharge and treatment plans**

The principles for care and treatment in the Mental Health Act state that every effort that is reasonably practicable should be made to involve people with a mental illness or disorder in the development of their treatment and recovery plans, and plans for their ongoing care (s68(h)).

This principle is reinforced by a section that states that all reasonably practicable steps must be taken to ensure that the person and their designated carer(s) and/or principal care provider are:

- consulted in relation to planning the person’s discharge and subsequent treatment
- provided with appropriate information about follow-up care (s79).

**Right to privacy and confidentiality**

While Tribunal reviews are generally open to the public, when a person is seen by the Tribunal, their name or any other detail that could identify them, is not to be broadcast or published in any way, without the consent of the Tribunal.

**Right to protection from ill-treatment**

No person employed in a mental health facility is allowed to willfully strike, wound, ill-treat or neglect a person detained under the Act (s69).

**Right to request to see an official visitor**

A person who is in a mental health facility as either a voluntary or involuntary patient, or who is under a community treatment order, or who is detained in a health facility other than a mental health facility can request to see an official visitor (s134 and s134A). The person’s designated carer(s) or principal care provider can also request to see an official visitor. The medical superintendent must inform an official visitor of any such request not later than two days after receiving notification ([Guide Book, Chapter 3.3](#)).

**Other general rights**

Consumers have other rights that are not mandated by the Mental Health Act. These may be drawn from other pieces of legislation or may generally be considered to comply with good practice.

Some of these include:

- the right to receive and send mail without interference, subject to considerations of risk
- the right to receive and make telephone calls, subject to considerations of risk
- the right to speak with friends, lawyers, relatives etc. in privacy, subject to considerations of risk
- the right to be spoken to respectfully
- the right to refuse to have students or others present while being interviewed or treated
- the right to provide feedback about a service, including making a complaint.

**3.2 RIGHTS UNDER A COMMUNITY TREATMENT ORDER**

As consumers who are being treated under a community treatment order are under fewer restrictions than those detained in a mental health inpatient facility, the Act does not set out a framework of rights in such detail ([Guide Book, Chapter 10](#)).

However, the following principles apply:

- general principles of care and treatment set out in s68, including involvement where reasonably practicable in the development of their treatment and recovery plans (s68(h))
- a treatment plan that clearly specifies reasonable times and places when treatment (including medication, therapy, counselling, management rehabilitation and other services) is to be provided (s56(1))
- procedural fairness before the Tribunal
- representation by a lawyer or other advocate before the Tribunal if such representation can be obtained
- to put their point of view to the Tribunal about the order
- an interpreter if required
- access to their medical records in accordance with the NSW Health Privacy Manual for Health Information or under s156 for matters before the Tribunal
- information about their medication

- appeal to the Tribunal against a CTO made by a Magistrate
- appeal to the Supreme Court against a CTO made by the Tribunal.

**3.3 ASSISTING CONSUMERS TO EXERCISE THEIR RIGHTS**

Although the Act makes provision for a variety of rights, it will often be difficult for a consumer to exercise these rights without assistance. It is therefore important to consider who is in the best position to provide such assistance. In some cases this may be the staff from the mental health inpatient facility or community mental health team.

However, it will often be more appropriate to involve someone outside the treating team, such as carers, the Mental Health Advocacy Service or official visitors. Where the consumer is from an Aboriginal or Torres Strait Islander background, or from a culturally or linguistically diverse (CALD) background, Aboriginal health workers and cross-cultural consultants may have a particularly important role to play ([Guide Book, Chapter 15](#)).

This Chapter looks at some of the individuals and agencies that may be involved in:

- assisting consumers to exercise their rights
- handling consumer complaints.

### Mental Health Advocacy Service

The Mental Health Advocacy Service is part of Legal Aid NSW. The solicitors from the Advocacy Service ensure that the consumer’s views are clearly presented before the Tribunal. It is their role to act on their client’s instructions, and to ensure that the procedures and rights set out in the Act are upheld.

The Service provides free telephone advice on all aspects of mental health law. The Service can be contacted on 02 9745 4277.

The Service provides free legal representation in hearings before the Tribunal in the following circumstances:

- mental health inquiries following admission to a hospital. These can result in a consumer’s detention in a mental health facility or discharge on a community treatment order
- reviews of involuntary patient orders (s37(1) (a) and (b)) during the first 12 months after a consumer becomes an involuntary patient. (These reviews must occur at the end of an initial order then at least once every three months)
- applications for an order that the management of a consumer’s finances be made under the *NSW Trustee and Guardian Act 2009*
- reviews where consumers have been detained following a breach of their community treatment order (s63)

- applications for a community treatment order for a consumer detained in a mental health facility where that person has specifically requested representation for the hearing
- applications for electroconvulsive therapy under s94
- all hearings where the consumer is under 16 years of age
- all hearings before the Tribunal concerning forensic patients.

The Service applies a merit and/or means test in the following circumstances:

- appeals against an authorised medical officer’s refusal to discharge (s44)
- appeals to the Tribunal or Supreme Court including against detention or a community treatment order
- applications for first time community treatment orders where the consumer is in the community (s51(3))
- applications for renewals of a community treatment order where the consumer is in the community
- applications to revoke a financial management order.

The Mental Health Advocacy Service does not generally represent consumers in the following matters:

- reviews of voluntary patient orders (s9)
- ongoing reviews of involuntary patient orders after the first twelve months of detention (s37(1)(c)).

The Mental Health Advocacy Service also provides representation on request to people who are the subject of applications before the Guardianship Division of the NSW Civil and Administrative Tribunal. This is conditional on the Tribunal either granting leave to represent the person or appointing a separate representative.

For further details and advice about representation contact the Mental Health Advocacy Service 02 9745 4277.

### Official visitors

Official visitors are appointed by the Minister for Health or delegate (s129) to visit mental health facilities in NSW. They are independent and come from a range of personal, professional and cultural backgrounds. Two or more official visitors visit mental health inpatient facilities, both public and private, at least once a month, and community mental health facilities at least once every six months. Two or more official visitors visit declared emergency departments once a month if an inpatient mental health facility is located at the same hospital, or once every three months in all other cases.

### **An official visitor has the following functions (s129(3)):**

- Acts as an advocate for consumers to promote the proper resolution of issues arising in the mental health treatment system, including issues raised by the consumer’s designated carer(s) or principal care provider (s129(3)(b)).



- Refers matters raising any significant public mental health issues or issues of consumer safety or care or treatment to the Principal official visitor or other appropriate body (s129(3)(a)).
- Inspects mental health facilities (s129(3)(c)).

**While inspecting mental health facilities an official visitor must (s131):**

- Inspect every part of the facility.
- Examine the registers and records of mental health facilities.
- Make inquiries into the care, treatment and control of consumers who are admitted as either voluntary or involuntary patients.
- Make inquiries into the care, treatment and control of consumers who are under community treatment orders.
- Report their impressions and findings to the Principal official visitor or the Minister.

Official visitors may visit with or without previous notice to the mental health facility.

**Contacting an official visitor:**

A consumer, whether a voluntary or involuntary patient, or a consumer who is subject to a community treatment order, or a designated carer, or a principal care provider, can ask to speak to or see an official visitor at any time. The inpatient or community mental health facility must communicate the request to the official visitor within two days (s134).

**CONTACTING AN OFFICIAL VISITOR**

Anyone with an interest in the care and treatment of a mental health consumer can contact the Official Visitors’ answering service on 1800 208 218 between 9am and 5pm Monday to Friday.



All mental health facilities promote contact with official visitors by:

- displaying a poster (available from the Official Visitors Program Office) about the role of official visitors with a telephone number on which they can be contacted
- providing a locked box in an accessible area where confidential messages can be left.

**NSW Health Care Complaints Commission**

The NSW Health Care Complaints Commission is an independent body with responsibility for dealing with complaints about health services or health providers.

The Commission has the power to investigate a wide range of matters including:

- the care and treatment delivered by a private or public health service organisation, for example hospitals, nursing homes, community health centres, clinics, medical centres and day surgeries
- the care and treatment a person has received from a health practitioner, e.g. doctor, nurse, dentist, pharmacist, psychologist, chiropractor, naturopath, dietician etc.

While complaints must be in writing, the Commission encourages people to discuss the issues with the Commission’s Inquiry Service before lodging a complaint. It also encourages

consumers and relevant others to try and resolve their complaint directly with the health care provider wherever possible. However, where there is concern about a consumer’s immediate health or safety, an Inquiry Officer should be contacted immediately.

**Health Care Complaints Inquiry Service:** 02 9219 7444 or 1800 043 159. Further information: <https://www.hccc.nsw.gov.au>

**Peer workers**

The majority of Local Health Districts employ a number of peer workers. While their roles vary, most peer workers spend part of their time providing peer support and advocacy to individual mental health consumers. For example, they may assist someone who has a hearing before the Tribunal, or someone who would like support when they go to see their case manager or psychiatrist. Peer workers also participate in relevant Local Health District committees, give talks and provide education to staff and non-government organisations.

Peer workers can be contacted either directly or via staff in mental health facilities. The contact details of some consumer workers across the state can be found on the Being (formerly known as the NSW Consumer Advisory Group) website <https://www.being.org.au> or by calling Being on 9332 0200.

# Chapter 4

## DESIGNATED CARERS AND PRINCIPAL CARE PROVIDERS

Over the past decade, the Act has sought to highlight the importance of providing carers with access to information that may assist them in providing care. The 2015 amendments to the Act have further strengthened the importance of involving carers in a consumer’s treatment and recovery.

The amendments acknowledge the role of carers:

- under the general principles for care and treatment, which state that the role of carers for people with a mental illness or mental disorder and their rights to be kept informed, to be involved, and to have information provided by them considered, should be given effect (s68(j))
- through specific provisions that set out when a carer should be informed or consulted about particular aspects of a consumer’s care and treatment, including decisions to detain and discharge.

*“Carers and families play a vital role in monitoring, treating and supporting those with a mental illness... The aim of the changes is to enable greater carer involvement in treatment decision- making and provide better dissemination of information. This includes being entitled to provide input to clinical decisions about their loved ones.”*

*Jai Rowell, Second Reading Speech, 14 October 2014*

The amendments also specify two categories of carers, the designated carer and the principal care provider.

The carer provisions apply whether a consumer is a voluntary or involuntary patient, an assessable person, or under a community treatment order.

### 4.1 WHO IS A DESIGNATED CARER? (S71)

A designated carer for the purposes of the Mental Health Act is either:

- a) someone who has been appointed as the consumer’s guardian ([Guide Book, Chapter 12](#)), or
- b) the parent(s) of a child subject to any nomination at c) below (for discussion on issues relating to children and the Act see [Guide Book, Chapter 15](#)), or
- c) if the person is over the age of 14 years and is not under guardianship, someone nominated by them as their designated carer<sup>1</sup>, or

d) if the consumer is not a person referred to in paragraph (a) or (b) or (c)<sup>1</sup> then the designated carer is determined by the following hierarchy set out in the Act:

- i. the consumer’s spouse or partner where the relationship is close and continuing (this includes de facto and same sex partners), or
- ii. someone who is primarily responsible for providing support and care (though not on a wholly or substantially commercial basis<sup>2</sup>), or
- iii. a close friend or relative<sup>3</sup> who maintains frequent personal contact and interest in the consumer’s welfare.

While the Act establishes the formal process set out above, in most cases a designated carer will be someone nominated by the consumer, who has a close and personal relationship with them, and an interest in their welfare.

<sup>1</sup> In relation to paragraph (c), paragraph (d) only applies if the person has not nominated anyone to be a designated carer.

<sup>2</sup> A person in receipt of a Carer’s Pension is not seen as providing care on a commercial basis and can therefore be considered as a designated carer.

<sup>3</sup> Where the consumer is an Aboriginal person or Torres Strait Islander, a relative includes someone who is part of their extended family or kinship system.

## 4.2 THE NOMINATION OF A DESIGNATED CARER (S72)

A person who does not have a guardian, and is over 14 years of age, can, if they wish, nominate **up to two** designated carers at any time. Where possible it is preferable for this to occur before the stressful circumstances that often surround an admission to a mental health facility. However, where this has not occurred, a designated carer should be identified as soon as possible after admission or after a community treatment order has been made.

## 4.3 FOLLOWING THE IDENTIFICATION OF A DESIGNATED CARER

Once a designated carer has been nominated or identified, the authorised medical officer must take all reasonably practical steps to contact that person to inform them of the consumer's detention or admission. Once the designated carer's role has been explained to the person and they have accepted the role, the "Nomination of Designated Carer"<sup>1</sup> form should be completed and recorded in the clinical notes. The nomination stays in force for 12 months, though it may be varied or revoked earlier by the consumer in writing.

If a nominated person does not wish to become a designated carer, the consumer should be asked to nominate another appropriate person, to ensure that there is an effective nomination in place.

Consumers may also nominate person(s) who are excluded from receiving notice or information about them (s72(2)). This may involve excluding their designated carer(s) from receiving certain information. Consumers may revoke or vary any such nominations at any time. However, a consumer over 14 years of age but less than 18 years of age may not exclude a parent from receiving information about them (s72(3)).

An authorised medical officer or the director of community treatment must give effect to the nomination (variation or revocation) unless there are reasonable grounds for believing that (s72(7)):

- the consumer, the nominated person, or any other person may be put at risk of serious harm, or
- the consumer was incapable of making the nomination, variation or revocation at the time.

A consumer may refuse or find it difficult to nominate designated carers when they are first admitted to a mental health facility. If the consumer has refused or is unable to make any nominations, a carer can be determined in accordance with the hierarchy set out in ([Guide Book, Chapter 4.1](#)) (see s71(1)(d)). However, if the person (other than a child under the age of 14 or a person under guardianship) later nominates someone else as their designated carer, that nomination should be acted upon.

## 4.4 PRINCIPAL CARE PROVIDER (S72A)

A principal care provider is the person who is primarily responsible for providing support and care to the consumer (other than on a commercial basis.) In many cases this person will also be one of the two designated carers. An authorised medical officer or director of community treatment may determine the consumer's principal care provider without requiring a specific nomination. This provision ensures that where either of a consumer's designated carers are not the person who is mainly responsible for providing support and care to the consumer, the principal care provider is still able to receive or provide relevant information about the consumer's care and treatment. In some cases this may result in three people needing to be informed: two designated carers and the principal care provider.

A person cannot be the principal care provider if they have been excluded by the consumer from being given notice or information. It should be noted, however, that there are limitations on consumers being able to exclude carers from receiving information under the Act. A designated carer or principal care provider can still receive information if the consumer is deemed to lack capacity to exclude that carer, or if the exclusion may put the consumer or any other person at risk of harm.

<sup>1</sup> NSW Health staff can order or download Mental Health Act forms from the NSW Health online catalogue, hosted by TOLL: <https://www.tollstreamdirect.com>. Forms can also be found on the Ministry's website at: <https://www.health.nsw.gov.au/mentalhealth/legislation/pages/forms.aspx>, however please note that the preferred process for NSW Health staff is to download or order the form from the online catalogue. The staff member who usually orders forms for your service or facility should be able to assist with access.

An authorised medical officer or the director of community treatment is not required to give notice or information to the principal care provider, or to appoint a person as the principal care provider if they reasonably believe that to do so may put the consumer or the principal care provider at risk of serious harm.

#### 4.5 WHEN SHOULD A DESIGNATED CARER AND/OR PRINCIPAL CARE PROVIDER BE NOTIFIED?

An authorised medical officer or director of community treatment must take all reasonably practicable steps to ensure that a consumer’s designated carer(s) and/or principal care provider, unless specifically excluded from receiving certain information, are promptly notified of the following events:

- the consumer’s detention within the first 24 hours after being detained, unless they are discharged or classified as a voluntary patient within that period (s75)
- an upcoming mental health inquiry (s76)
- an unauthorised absence from a mental health facility (s78(1)(a))
- a proposed transfer between mental health facilities (s78(1)(b))
- the consumer’s discharge (s78(1)(c))
- the consumer’s reclassification as a voluntary patient (s78(1)(d))
- the consumer’s admission as a voluntary patient

- an application for a community treatment order, or a decision to vary or revoke an existing order, or not to apply for a further order (s66A)
- an application to the Tribunal for electroconvulsive therapy (s78(1)(e))
- an urgent surgical procedure (s78(1)(f))
- a proposal to apply to the Secretary of the Ministry of Health or the Tribunal for consent to a surgical operation or special medical treatment (s78 (1)(g)) ([Guide Book, Chapter 13](#))
- the consumer has any matter before the Tribunal s78(1)(h)

#### 4.6 REQUESTS MADE BY A DESIGNATED CARER AND/OR PRINCIPAL CARE PROVIDER

A designated carer or the principal care provider can request or apply for the following:

- a consumer’s detention in a mental health facility (s26) ([Guide Book, Chapter 6](#))
- information about the types and dosages of medication being administered (s73)
- the consumer’s discharge into their care provided they give a written undertaking that the consumer will be properly taken care of, and the authorised medical officer is satisfied that there is an adequate plan in place to prevent harm to either the consumer or to others (s43)

- an appeal to the Tribunal where the authorised medical officer refuses or fails to determine a request made by the consumer or their carer for discharge (s44)
- a community treatment order (s51)
- to see an official visitor (s134).

These requests should ideally be made in writing.

#### 4.7 CONSIDERING INFORMATION PROVIDED BY A DESIGNATED CARER AND/OR PRINCIPAL CARE PROVIDER (S72B)

Where an examination is undertaken in relation to a consumer’s detention or discharge from involuntary status, the assessing clinician must consider any relevant information provided by a designated carer or the principal care provider regarding the consumer, if it is reasonably practicable to do so.

#### 4.8 INVOLVING A DESIGNATED CARER AND/OR PRINCIPAL CARE PROVIDER IN DISCHARGE PLANNING

An authorised medical officer must take all reasonably practicable steps to consult with any designated carer or the principal care provider in relation to planning the consumer’s discharge and any proposed follow-up care and treatment (s79).

Some guidance is provided in the Mental Health Regulation (clause 43) as to the sort of information that should be provided about follow-up care, including:

- support groups and community care groups in the consumer’s vicinity
- available out-patient services
- the purpose and method of obtaining community treatment orders.

#### 4.9 DESIGNATED CARERS, PRINCIPAL CARE PROVIDERS AND COMMUNITY- BASED TREATMENT

The Act specifies that a director of community treatment is to give effect to a designated carer nomination, variation or revocation (s72(6)), and may determine who is the principal care provider (s72A(2)).

All reasonably practicable steps should be taken by the director of a community mental health facility to inform any designated carers and the principal care provider about decisions relating to community treatment orders. This includes decisions to:

- apply for a community treatment order
- vary or revoke an existing order
- apply for a further order
- not to apply for a further order.

The director must also provide the consumer with information about the medication prescribed under a community treatment order (s57(4)(b)) if requested by a designated carer or principal care provider.

#### 4.10 THE IMPORTANCE OF THE CARER PROVISIONS

*“I need to know what you are trying to achieve for my son and how you are planning to do it. I need to understand the treatment that he is receiving so that I can play my part in his recovery program. What I do not need to know are the personal details of what takes place between him and the professionals concerned.”*

**Member of Rethink 2006 whose son has a serious mental illness.**

Clinicians can play an important role in reducing any fears a consumer may have about nominating a designated carer by emphasising that these provisions do not give the carer authority or decision making power over the consumer. Nor do they oblige the clinician to discuss personal aspects of the consumer’s experience with the carer. The purpose of these sections of the Act is to ensure that the carer is given information about the person’s illness and treatment that enables them to support the consumer’s welfare and recovery. It is also to ensure that carers understand that they have the right to provide information to the clinician that may assist the consumer’s treatment, including initiating contact with the clinician, if necessary.

#### 4.11 NSW FAMILY AND CARER MENTAL HEALTH PROGRAM

This Program provides a range of supports and services for families and carers of people with a mental illness, through strengthening existing partnerships between families and carers, non-government organisations, Local Health Districts and generic family and carer support services, and enhancing access to appropriate information and support in their caring journey, at the time it is needed.

The Program aims to:

- improve family/carer wellbeing
- improve outcomes for consumers
- increase family/carer knowledge and ability to manage their caring role effectively
- promote open communication between services about family/carer issues.

It is delivered by five non-government organisations across NSW that provide:

- education and training to build coping skills and resilience
- individual support, information, advocacy and infrastructure support for peer support groups.

The Program also supports awareness of, and access to, mainstream support services. Visit <https://www.health.nsw.gov.au/mentalhealth/services/carers/pages/default.aspx> for a list of the organisations running this program.

# Chapter 5

## VOLUNTARY PATIENTS

### 5.1 WHO IS A VOLUNTARY PATIENT?

A voluntary patient is a person who:

- has chosen to be admitted to a mental health facility
- is under guardianship and has been admitted at the request of, or with the consent of their guardian (s7)
- has been admitted involuntarily and has been reclassified by agreement between the person and an authorised medical officer (s40), or reclassified by the Tribunal.

### 5.2 CRITERIA FOR ADMISSION (S5)

In deciding whether someone will be admitted voluntarily, an authorised medical officer needs to be satisfied that the person is likely to benefit from inpatient care and treatment in a mental health facility.

### 5.3 RECLASSIFYING A PATIENT FROM VOLUNTARY TO INVOLUNTARY (S10)

Under s10(3) a voluntary patient can be detained for up to two hours to enable an initial assessment to be conducted by an authorised medical officer

to determine whether the patient is a mentally ill person or a mentally disordered person. The relevant form (**Detention of Voluntary Patient for Up to Two (2) Hours**) should be completed.

While the completion of a Schedule 1 certificate is not required when reclassifying a patient, the authorised medical officer should document their reasons for detaining the patient. Following this, the two (in some cases three) Form 1 examinations should be conducted ([Guide Book, Chapter 6.2](#)).

### 5.4 DISCHARGE OF A VOLUNTARY PATIENT (S7 & S8)

The following provisions apply to the discharge of a voluntary patient:

- a voluntary patient may discharge themselves at any time
- an authorised medical officer may discharge a voluntary patient if they decide that the person is unlikely to benefit from further inpatient care and treatment
- where a patient is under guardianship, notice of the discharge must be given to the person's guardian
- where a patient is under guardianship they must be discharged at the request of their guardian
- the designated carer(s) or the principal care provider should be notified of the discharge (unless they have been legitimately excluded from receiving that specific information).

### 5.5 RIGHTS OF VOLUNTARY PATIENTS (SCHEDULE 3A)

Once a person has been admitted as a voluntary patient they must be given, as soon as reasonably practicable, an oral explanation of their rights and the written [Statement of Rights](#) as set out in Schedule 3A. This document outlines:

- what a voluntary patient must be told about their treatment
- a voluntary patient's right to refuse treatment at any time
- a voluntary patient's right to leave a mental health facility once they have told a staff member
- a voluntary patient's right to nominate up to two designated carers
- a voluntary patient's right to see an official visitor
- the mental health facility's right to discharge a voluntary patient
- the mental health facility's ability to reclassify a person as an involuntary patient.

If a voluntary patient is not capable of understanding the explanation or statement when it is first given, a subsequent explanation must be given once they are capable of understanding. Where the person is not able to communicate adequately in English, an interpreter must be made available to ensure that they are made aware of their rights.

## 5.6 AVENUES OF REVIEW

### Review of decision of authorised medical officer (s11)

- A person who has been refused admission as a voluntary patient by an authorised medical officer (other than the medical superintendent) may apply to have that decision reviewed by the medical superintendent.
- A person who has been discharged by an authorised medical officer may apply to have that decision reviewed by the medical superintendent.
- The medical superintendent must review the decision as soon as practicable.

### Review of a voluntary patient by the Mental Health Review Tribunal (s9)

The Tribunal must review, at least once every 12 months, the case of every voluntary patient who has been in a mental health facility for a continuous period of more than 12 months. This applies even when the person has been detained as an involuntary patient for some of that 12-month period.

At the review, the Tribunal considers:

- the care and treatment the person is receiving
- whether the person is likely to benefit from further care and treatment as a voluntary patient
- whether appropriate care is available outside a mental health facility

- whether the person consents to remain as a voluntary patient.

At this review the Tribunal may:

- order the patient's discharge
- order the patient's discharge but defer the discharge for up to 14 days if it is in their best interest
- decide to make no order, which in effect means the person's ongoing voluntary care and treatment continues.

The medical superintendent must ensure that applications for a review of a voluntary patient are sent to the Tribunal at least five working days before the requested date for the hearing. This allows Tribunal staff to ensure that the preferred hearing time is available.

For further information about the Review of a Voluntary Patient see <https://www.mhrt.nsw.gov.au> (under Civil Patients).

# Chapter 6

## INVOLUNTARY ADMISSIONS

The Act provides a number of ways in which the process of involuntary admission can be initiated. The initial documentation required may include file notes and/or the forms required under the Act.

Between July 2016 and June 2017 20,568 people were taken to a mental health facility under a provision of the Act. Most of these (54%) were initiated by the certificate of a doctor (or accredited person), 17% by the police, and 8% were admitted at the request of a carer, relative or friend. This resulted in 18,119 admissions with 62% detained as ‘mentally ill’, 27% as ‘mentally disordered’ and 11% were admitted as voluntary patients.

### 6.1 PATHWAYS TO INVOLUNTARY ADMISSION - GETTING THE PERSON TO A DECLARED MENTAL HEALTH FACILITY

Where a person needs to be taken from the community to an inpatient unit for a mental health assessment against their will, the Act requires that they be taken to a declared mental health facility. Currently a person may be taken to a declared mental health inpatient unit, a declared emergency department or declared

### EXAMINATION BY AUDIO VISUAL LINK (S19A)

Under this section, an examination or observation of a person’s condition may be conducted by audio visual link where it is not reasonably practicable for a medical practitioner or accredited person to physically examine the person, such as in some regional and rural areas of NSW. In these circumstances, an audio visual examination can only be carried out if the clinician is satisfied that they are able to assess the person with sufficient skill and care so as to be able to form an opinion regarding the person’s mental state.



#### psychiatric emergency care centre (PECC).

A list of declared mental health facilities can be obtained by emailing the Mental Health Branch at [MOH-mentalhealthbranch@health.nsw.gov.au](mailto:MOH-mentalhealthbranch@health.nsw.gov.au). The email should indicate which of the three classes of listings are required – Emergency, Inpatient or Community.

#### Detention on certificate of a medical practitioner or accredited person (s19) (Schedule 1)

A person may be taken to and detained in a declared mental health facility on the certificate of a medical practitioner or accredited person where:

- the practitioner or accredited person has personally examined or observed the person immediately or shortly before completing the certificate, and
- the practitioner or accredited person has formed the opinion that the person is either a ‘mentally ill’ (s14), or a ‘mentally disordered’ person (s15), and
- the practitioner or accredited person is satisfied that involuntary admission and

detention is necessary (and that there is no other less restrictive care reasonably available that is safe and effective), and

- the practitioner or accredited person is not the designated carer, principal care provider, or a near relative of the person
- the practitioner or accredited person must declare any pecuniary interest either direct or indirect held by themselves, a near relative, partner or assistant in any private mental health facility.

While there are no mental health specific protocols for the use of audio visual equipment, the NSW Agency for Clinical Innovation has developed a set of ‘Guidelines for the Use of Telehealth for Clinical and Non Clinical Settings in NSW’ (<https://www.aci.health.nsw.gov.au>). These can be read in conjunction with the guidelines developed by individual Local Health Districts.

However, all care must be taken to ensure that



any interference with the dignity and privacy of the person is kept to the minimum necessary in the circumstances. The examination must be conducted on a secure network and in a designated private space. It is important to have valid consent, and to reassure them about the privacy and confidentiality of the session. Where there is doubt about the effectiveness of the examination and assessment process, a face-to-face examination should be arranged.

The certificate completed by the medical practitioner or accredited person:

- must be in the form set out in Part 1 of Schedule 1
- is valid for five days for a 'mentally ill person' and one day for a 'mentally disordered person'.

The Schedule 1 is an important legal document that authorises a person to be transported to and detained in a declared mental health facility against their will for the purpose of ensuring a further assessment.

It also:

- communicates pertinent information to other professionals involved in the person's admission
- becomes part of the person's medical record
- is scrutinised by the Tribunal at a mental health inquiry.

While the information provided on the Schedule 1 is legally sufficient to commence the process of involuntary admission, where possible it should be accompanied by additional materials such as a referral letter, history and/or outcomes of a

mental state examination. This will provide a more detailed picture of the person's condition and circumstances for subsequent examinations.

**Detention on the information of an ambulance officer (paramedic) (s20)**

A paramedic may take a person to a declared mental health facility against their will if the officer believes on reasonable grounds that the person appears to be mentally ill or mentally disturbed, and that it would be beneficial to the person's welfare to do so, and the person is unwilling to be transported voluntarily.

Where there are concerns about the person's physical health, the ambulance officer will transport the person to the nearest appropriate hospital so that the person can receive an assessment of their physical health to exclude any underlying physical causes for the presentation.

**Request for police assistance by medical practitioner, accredited person or ambulance officer (paramedic) (s21)**

A medical practitioner or accredited person who has completed a Schedule 1 under s19 may request the assistance of the police where there are serious concerns about the safety of the person or others if the person is transported without police assistance (s19(3)).

In these circumstances the medical practitioner or accredited person must complete Part 2 of Schedule 1. Part 2 must be completed by the same person who completed Part 1 (s19(3)).

A paramedic can also request police assistance

if they are of the opinion that there are serious concerns relating to the safety of the person or others in getting the person to a declared mental health facility (s20(2)).

Where the police receive a request for assistance they must, if practicable, either take or assist in taking the person to a declared mental health facility or arrange for another officer to do so (s21). In these circumstances the police may enter premises without a warrant and exercise powers under s81 in relation to searches and restraint ([Guide Book, Chapter 14](#)).

**Detention by the police (s22)**

The police may apprehend someone and take them to a declared mental health facility where the person appears to be mentally ill or mentally disturbed, and the police have reasonable grounds for believing that either:

- the person is committing or has recently committed an offence, or
- the person has recently attempted, or is at risk of, killing themselves or another person, or
- it is probable that the person will attempt to cause serious physical harm to themselves or another person, and
- it would be beneficial to the person's welfare for the person to be dealt with under the mental health legislation rather than being dealt with under criminal law.

The police do not need a warrant in these circumstances and may apprehend the person in any place.

**Detention following an order by a Magistrate for medical examination or observation (s23)**

If a Magistrate (or authorised officer\* within the meaning of *Criminal Procedure Act*) is satisfied that:

- a person may be ‘mentally ill’ or ‘mentally disordered’, and
- the person could not be personally examined due to physical inaccessibility,
- then the Magistrate may make an order authorising:
  - a medical practitioner or accredited person to visit and personally examine or observe the person
  - a police officer (or other person) to accompany and assist the medical practitioner or accredited person.

If an order is made under s23, the person authorised to visit the patient (or authorised to accompany the person conducting the examination) may enter the premises, by force if necessary, to enable the examination to take place.

Where this section is used, a medical practitioner or accredited person may complete a Schedule 1 (if the relevant criteria are met), and must notify the Magistrate of the outcome of their examination.

- In practice, s23 orders are generally made by the Registrar of the Local Court

**Detention on order of Magistrate or bail officer (s24)**

This section is used where a Magistrate is of the opinion that the person appearing before them is a mentally ill person who requires a psychiatric assessment. The person is then taken to a declared mental health facility in accordance with an order made under s33 of the Mental Health (Forensic Provisions) Act 1990.

**Detention after transfer from another health facility (s25)**

A person can be transferred from a health facility to a declared mental health facility and detained, if a medical officer of the health facility or the authorised medical officer of the mental health facility considers the person to be a mentally ill or mentally disordered person.

In these cases the person will be deemed to have been detained in the mental health facility under s19 once the person is transferred to the declared mental health facility.

While a Schedule 1 is not required, there should still be written documentation outlining the reasons for the transfer and stating why the person is considered mentally ill or mentally disordered.

**Detention on request of a designated carer, principal care provider, relative or friend (s26)**

A person may be detained on the written request of a designated carer, principal care provider, relative or friend to an authorised medical officer of a declared mental health facility. However, an authorised medical officer must not detain the

person unless he or she is satisfied that due to the distance and the urgency of the situation, it is impractical for the person to be seen by a medical practitioner or accredited person.

**6.2 AFTER THE PERSON GETS TO A DECLARED MENTAL HEALTH FACILITY - EXAMINATION REQUIREMENTS**

The different processes set out above deal with getting a person lawfully to a declared mental health facility. **Once they have arrived however, the Act requires two (and in some cases three) further examinations, for the person to continue to be detained. The results of these examinations must be written up on a Form 1 - Clinical Report as to Mental State of a Detained Person. A medical practitioner or accredited person involved in the initial ‘scheduling’ of a person must not take part in these further examinations.**

Any authorised medical officer, medical practitioner or accredited person conducting an examination may take into account their own observations and any other available evidence that they consider reliable and relevant (s28).

While the immediate circumstances leading to the person’s detention are clearly significant, it is also important to consider the person’s history and their ‘continuing condition’. This includes giving due consideration to information provided by a designated carer, principal care provider,

relative or friend. It can also include information provided by a medical practitioner or other health professional who has treated the person, or anyone who has accompanied the person to the mental health facility (s72B).

At any time throughout these examinations a person may be reclassified as a voluntary patient, where the authorised medical officer believes that it would be beneficial and the person does not object to the admission (s30).

#### First examination by an authorised medical officer (s27(a))

Where an authorised medical officer conducts the first examination, it must be done as soon as practicable (but within 12 hours). The results of this examination whether conducted in person or by audio visual link, must be recorded on a **Form 1 - Clinical Report as to Mental State of a Detained Person**.

Where the person is found to be neither a mentally ill person nor a mentally disordered person, they must be released.

Where the person is found to be either a mentally ill person or a mentally disordered person, they must have a second examination.

#### First examination by a medical practitioner or accredited person (s27A)

In limited circumstances, the first examination can be conducted:

- in person by an accredited person authorised by the medical superintendent at the mental health facility (an authorisation by the medical superintendent authorising an accredited person should be in writing); or
- by a medical practitioner at a place other than the place the person is detained using audio visual link.

An examination by an accredited person (in person) or medical practitioner (via audio visual link) can only be used for the first examination if is not reasonably practicable for an authorised medical officer at the mental health facility to conduct the examination in person.

Further, a medical practitioner must not carry out the first examination using an audio visual link unless the medical practitioner is satisfied that the examination or observation can be carried out in those circumstances with sufficient skill and care so as to form an opinion as to whether the person is a mentally ill person or mentally disordered person.

Where the first examination is conducted by a medical practitioner, or an accredited person, it must be done as soon as practicable (but within 12 hours).

Where the clinician conducting the first examination is not a psychiatrist, the advice of a psychiatrist should be obtained where it is reasonably practicable to do so, before deciding whether the person is either a mentally ill or mentally disordered person. In these situations, the psychiatrist is not required to examine or observe the person (s27A(4)).

The results of the examination must be written up on a **Form 1 - Clinical Report as to Mental State of a Detained Person**.

Where the person is found to be neither a mentally ill person nor a mentally disordered person, they must be released.

Where the person is found to be either a mentally ill person or a mentally disordered person, they must have a second examination.

#### Second examination (s27(b))

The second examination must:

- occur as soon as possible
- be conducted by a psychiatrist (unless the first examination was conducted by a psychiatrist).

Where the first examination is conducted by a psychiatrist, the second examination may be conducted by a medical practitioner or accredited person subject to the considerations set out in s27A. (See preceding paragraphs:

**First examination by a medical practitioner or accredited person (s27A)).**

The results of the examination must be written up on a **Form 1 - Clinical Report as to Mental State of a Detained Person**.

Where the person is found to be a mentally ill person at either the first or second examination, the Tribunal must be notified and the person brought before the Tribunal for a mental health inquiry as soon as possible. (This does not prevent the person being discharged or reclassified as a voluntary patient before the mental health inquiry occurs, should they no longer be mentally ill or should care of a less restrictive kind become available.)

Where both examiners agree that the person is a mentally disordered person, they can be detained for up to three days (not including weekends or public holidays).

Where the second examination finds the person neither a mentally ill person nor a mentally disordered person, a third examination must occur.

### Third examination (s27(c))

The third examination must:

- occur as soon as practicable
- be conducted by a psychiatrist.

The decision made by the third doctor determines whether the person is released or detained as a mentally disordered person or as a mentally ill person.

The third examination must take place ‘as soon as practicable’ after the relevant finding in the second examination. What is ‘as soon as practicable’ will depend on the situation and in some rural areas it may take longer to arrange the third examination.

The results of the examination must be written up on a **Form 1 - Clinical Report as to Mental State of a Detained Person**.

While awaiting the third examination, the person may be discharged (or admitted as a voluntary patient) if they are no longer either a mentally ill or mentally disordered person, or if care of a less restrictive kind becomes available.

### Interaction between examination requirements and general safeguard in section 12

Section 12 states that a person must not be involuntarily admitted to, detained in, or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that:

- a) The person is mentally ill or disordered, and
- b) No other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.

Section 12 applies at all stages while a person is detained and may require a person to be discharged. However, once the first examination has taken place under section 27 and an authorised medical officer finds that the person is a mentally ill or mentally disordered person, then the steps in section 27 (outlined above) must be completed. The exception to this is, if prior to the second examination in section 27, the first authorised medical officer changes their mind and considers that the person is no longer a mentally ill or mentally disordered person, or that less restrictive care is appropriate. In this

case section 12 could be relied upon to discharge the person without all the steps in section 27 being completed.

### Where a person requires medical attention

While the requirements of the examination procedures will generally be followed, there may be times when a person’s physical condition or illness requires urgent attention. In these cases the examination procedures may be delayed until the person’s physical condition has been stabilised (s33).

It should be noted however that if a person is medically capable of being assessed, an examination for their ongoing detention should be completed by the Authorised Medical Officer without delay. Section 33 only suspends the Authorised Medical Officer’s obligations under s27 while the patient is not medically well enough for those steps to be completed. Once the patient has recovered enough to communicate and be assessed, the examination steps should occur, even if the patient is still in a medical unit.

The person must be brought before the Tribunal for a mental health inquiry as soon as possible. The Tribunal can be flexible in the way it conducts its hearings, including the possibility of attending the patient in person in the medical unit.

### Examination procedures under s27 and s27A

Prior to undertaking a medical examination under s27 (and if relevant, s27A), it is important to ensure that the person has been detained under one of the mechanisms outlined in s18,

and that any relevant documentation relating to their detention has been completed ([Guide Book, Chapter 6.1](#)). The Tribunal has issued a Practice Direction that sets out the necessary documentation for detention (<https://www.mhrt.nsw.gov.au>).

### 6.3 BEING DETAINED AS A MENTALLY ILL OR MENTALLY DISORDERED PERSON

#### Consequences of being detained as mentally disordered (s31)

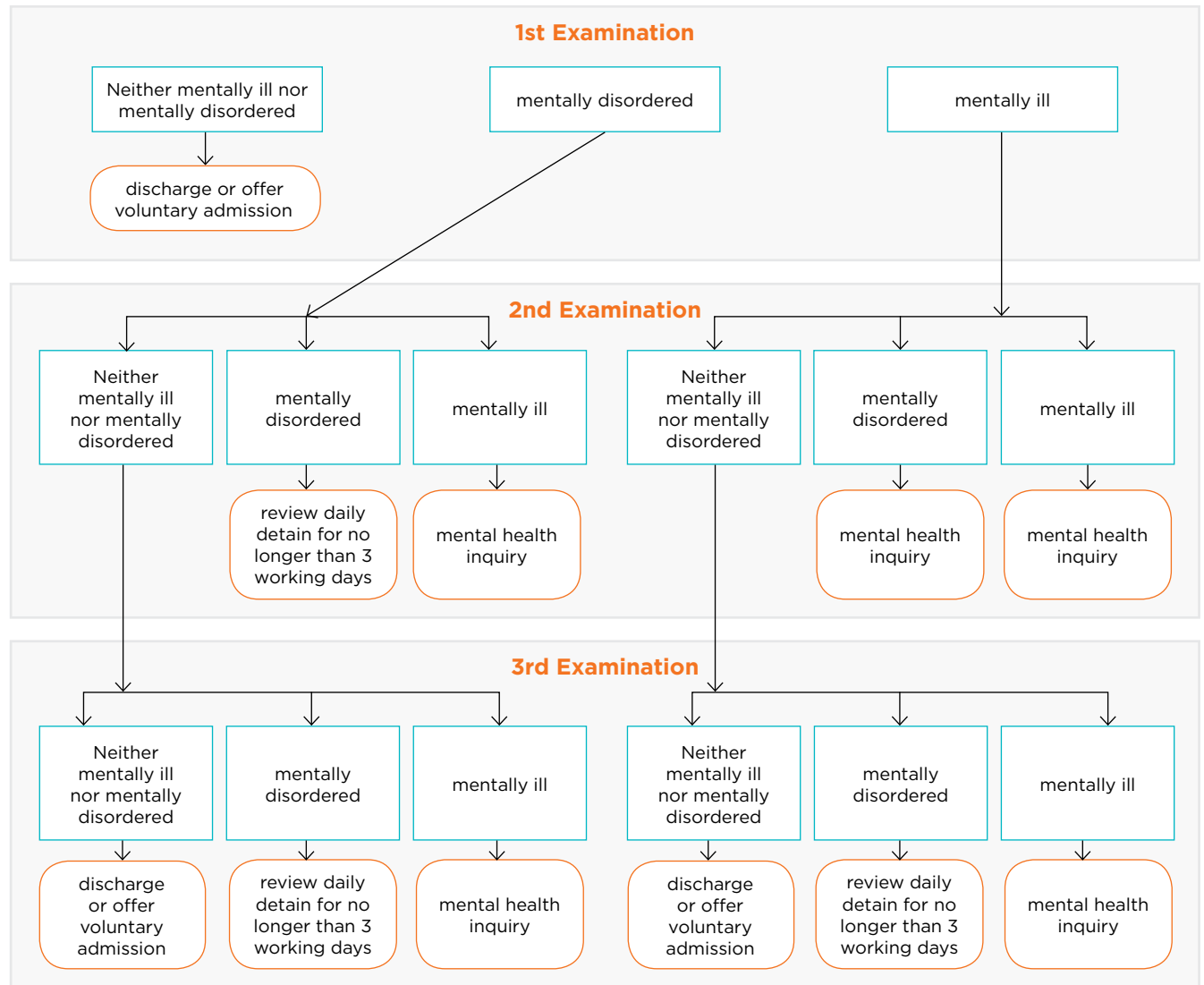
Once a person has been detained as a mentally disordered person, they can be detained for up to three continuous days, not including weekends and public holidays. The person may be detained and given treatment against their wishes.

In addition the person:

- must be examined at least every 24 hours by an authorised medical officer
- must be released if an authorised medical officer decides the person is no longer a mentally disordered person or that care of a less restrictive kind is appropriate and reasonably available
- may not be detained on the grounds of being a mentally disordered person on more than three occasions in any one calendar month
- has the right to see an official visitor, request discharge at any time, and to appeal to the Tribunal against any refusal to be discharged.

In some circumstances, an authorised medical officer may consider a person to be ‘mentally

### EXAMINATION PROCEDURES UNDER S27 AND S27A MENTAL HEALTH ACT 2007



disordered’ at the end of the initial three working day period. In these situations a paper discharge may be completed and the examination procedures required by the Act complied with again, i.e. a Schedule 1 and then a Form 1 for each assessment under s27 (and if relevant, s27A).

In some circumstances, a person who has initially been detained as a ‘mentally disordered’ person may be reassessed as a ‘mentally ill’ person. Where this occurs, a Schedule 1 must be completed and the examinations under s27 (and if relevant, s27A) must take place.

#### Consequences of being detained as mentally ill

Once a person has been detained as a mentally ill person under s27, they:

- must be reviewed by the Tribunal at a mental health inquiry as soon as practicable ([Guide Book, Chapter 7.1 & 8](#))
- can be detained, and administered medication against their wishes for the purpose of treating a psychiatric condition. However, medication must be prescribed at dosages consistent with proper care, to ensure that they can communicate with their legal representative (s29)
- may ask to see an official visitor
- may request discharge at any time and appeal to the Tribunal where the discharge is refused
- must be discharged if they are no longer considered to be mentally ill or if less restrictive care is available
- may be made a voluntary patient.

### 6.4 DETAINED PERSON’S RIGHT TO INFORMATION (S74)

Once a person has been detained at a mental health facility they must be given an oral explanation and written statement of their rights (Schedule 3).

This must occur as soon as is practicable and the oral explanation must be in a language the person understands. Where the person has not been capable of understanding the first explanation, it must be repeated no later than 24 hours before the mental health inquiry.

During this interim period the person can seek advice from the Mental Health Advocacy Service regarding their detention and may apply to be discharged ([Guide Book, Chapter 3](#)).

### 6.5 RECLASSIFYING A PATIENT FROM INVOLUNTARY TO VOLUNTARY STATUS (S40)

There are circumstances where it may be beneficial for a patient’s care and treatment for them to be reclassified from involuntary to voluntary status. A patient may be reclassified by an authorised medical officer or by the Tribunal. They must be of the opinion that the patient is likely to benefit from care or treatment as a voluntary patient and the patient must agree.

If the authorised medical officer or the Tribunal is of the opinion that reclassification from involuntary to voluntary status is beneficial, reclassification can occur in three ways:

- an authorised medical officer can reclassify a patient (s40(1))
- the Tribunal can reclassify a patient during a review (s40(1))
- the involuntary patient is discharged and readmitted as a voluntary patient (s40(3)).

Where discharge and readmission occur under s40(3) the patient must sign a ‘Personal Application for Voluntary Admission to a Mental Health Facility’ form (s5(1)).

Where a change in status has occurred an authorised medical officer must take all reasonable steps to inform any designated carer and the principal care provider (s78(1)(d)).

### 6.6 DISCHARGE OF THOSE WHO DO NOT MEET CRITERIA FOR INVOLUNTARY ADMISSION

#### General discharge procedure

In discharging a person who has been assessed and found not to satisfy the criteria for involuntary admission, consideration should be given to their welfare and their ability to return safely to the community. For mental health inpatient facilities, discharge planning is part of the continuum of care that starts with the person’s admission (s79).

The NSW Health Policy Directive Transfer of Care from Mental Health Inpatient Services establishes a detailed set of principles and procedures to guide and inform the discharge process – This policy can be accessed on the NSW Health website <https://www.health.nsw.gov.au/policies/Pages/default.aspx>

**Discharge of a person referred for assessment by court order or taken to a mental health facility by police**

Where a person has been referred to a mental health facility for assessment by a Magistrate under the *Mental Health (Forensic Provisions) Act*, the court order will specify whether or not the person is to be returned to court if they are found not to meet the criteria for involuntary admission.

If the person is ordered to be returned to court, in some cases a relevant person (being the person who brought the patient to the mental health facility) may still be present to find out the results of the examination. In such cases, the authorised medical officer must release the patient into the custody of that relevant person (s32). If the relevant person is not present, the authorised medical officer must notify the police of their decision and detain the person until the police arrive. The police must take charge of the person as soon as practicable (s32(5)).

Where the court order does not require the person to be returned, or the person was brought to the mental health facility because the police

officer believed they had committed an offence, the mental health facility must:

- release the person into the custody of any police officer who is present, or
- notify the appropriate police station of the decision not to further detain the person and ascertain whether the police intend to apprehend them.

At this stage, the mental health facility may:

- detain the person for up to two hours to enable the police to attend
- admit the person as a voluntary patient
- discharge the person, if possible, into the care of a designated carer or principal care provider
- discharge the person (s32(4)).

If the police do not wish to proceed any further with the matter, the mental health facility may:

- discharge the person into the care of a relative or friend where possible, or
- admit the person as a voluntary patient where appropriate, or
- discharge the person with consideration to their welfare.

**6.7 INTERSTATE TRANSFERS OF INVOLUNTARY PATIENTS**

NSW has developed agreements with Victoria, Queensland, Australian Capital Territory (ACT) and South Australia for the interstate transfer of civil mental health patients, including involuntary patients and assessable persons. Further information about these matters can be found at the NSW Health website at: <https://www.health.nsw.gov.au/legislation/Pages/agreements.aspx>.

**DISCHARGE**

An involuntary patient or any person detained under the Mental Health Act must not continue to be detained unless an authorised medical officer is of the opinion that the person is a mentally ill person or mentally disordered person and that no other care of a less restrictive kind, consistent with safe and effective care, is appropriate and reasonably available.



**Q: John was scheduled as a mentally disordered person on Wednesday 16th March, and held for two consecutive periods. As weekends are excluded, John was discharged on 24th March. He was readmitted as a mentally disordered person on Monday 11th April. John remains disturbed and irrational in his behaviour on 14th April. Can he be detained for a further consecutive period as a mentally disordered person?**

**A:** No. He would have to be discharged on 14th April. This is because the ‘month’ stipulated in the Mental Health Act, is a rolling calendar month. It does not start anew on the first day of the new month.



# Chapter 7

## INTRODUCTION TO THE PROCESSES OF REVIEW

The Act establishes two important external processes of review for consumers whose liberty or rights are significantly interfered with as a result of their mental illness. These are the mental health inquiry, conducted on most occasions by a single legal member of the Tribunal, and the Tribunal sitting as a three-member panel.

The Act specifies that these processes are to be conducted with as little formality and technicality as the circumstances of the case permit.

### 7.1 PROCEDURAL FAIRNESS AND A NON-ADVERSARIAL APPROACH

The concept of procedural fairness in general requires that:

- the Tribunal be fully informed of all relevant aspects of the consumer’s case
- the consumer concerned be able to hear what is being proposed, and have the opportunity to state their views either directly or through their legal representative
- the Tribunal’s decision is unbiased and based on the evidence presented.

The Act promotes procedural fairness in a number of specific ways:

- hearings are open to the public (unless the Tribunal orders the hearing to be conducted in private)
- at a mental health inquiry, the assessable person is represented by a lawyer, (or another person of their choosing with the approval of the Tribunal) unless they decide that they do not want such representation
- the consumer’s designated carer, or principal care provider is invited to participate in the hearing
- the names of those appearing before the Tribunal are not published or broadcast without the consent of the Tribunal
- the consumer’s representative is entitled to have access to the relevant medical records (and may withhold harmful information from the consumer)
- the consumer is entitled to be assisted by a competent interpreter where they are unable to communicate adequately in English
- proceedings are recorded but are not usually transcribed unless there is a specific request to do so
- the decisions of the Tribunal are recorded in the form of a legal order.

While the Act establishes some rules for the conduct of hearings, individual Tribunals have a wide discretion in determining how they will proceed.

The mental health and legal systems do not always sit easily together, and frustration on all sides is not uncommon. However, the careful preparation of reports by mental health professionals can make a significant difference to the conduct of these hearings.



# Chapter 8

## MENTAL HEALTH INQUIRY

In June 2010, the mental health inquiries that had previously been conducted by Magistrates were transferred to the Tribunal. These inquiries are generally the first time a consumer, who has been detained as a mentally ill person, has this decision reviewed by someone outside of the health system. Between July 2016 and June 2017, 6,757 inquiries were conducted with involuntary patient orders being made on 5,640 occasions.

These hearings are usually conducted by a single legal member of the Tribunal, although there is a power to refer the matter to a three-member panel. They take place on a regular basis at each mental health inpatient facility and are usually held one to two weeks after a consumer's admission. Face-to-face hearings are conducted at all major metropolitan mental health facilities, with hearings at other inpatient units held via video-conferencing.

### MENTAL HEALTH INQUIRY

The purpose of the inquiry is for the independent Tribunal to determine if the consumer is a mentally ill person. The purpose should be clearly explained to consumers and their families. It is important that they understand that it is not a criminal proceeding but an opportunity for an independent person to hear from both the treating team and the consumer, and to determine whether the consumer is a mentally ill person.

### 8.1 PREPARING FOR A MENTAL HEALTH INQUIRY

Once a consumer has been detained as an assessable person, the mental health facility must:

- notify the consumer's designated carer(s) and principal care provider of the proposed mental health inquiry (s76)
- prescribe the minimum medication, consistent with proper care, to ensure that the consumer can communicate adequately with their legal representative before the hearing (s29)
- ensure that the consumer is given an explanation of the hearing in a language they understand (s74)
- ensure that where reasonably practicable, the consumer appears in street clothes (s34) and is supplied with make-up or shaving equipment
- ensure that all the appropriate medical witnesses and relevant medical evidence are ready for the hearing (s34)
- arrange for a competent interpreter to be present where necessary (Schedule 2, s1(4))
- organise legal representation where appropriate

- facilitate the legal representative's access to the consumer's medical records before the hearing.

### 8.2 PRECISE DOCUMENTATION

The Tribunal will need to see the following documents:

- the Schedule 1 or other admitting document
- the Form 1s completed by the examining clinicians (there will be either two or three of these)
- the consumer's file and hospital notes
- a report from the psychiatric registrar and/or consultant psychiatrist
- any other information that could be relevant to the Tribunal determining whether the consumer is a mentally ill person.

### 8.3 PREPARING A REPORT

The report from the psychiatric registrar and/or consultant psychiatrist plays a crucial role in the inquiry.

The report should address the following issues:

- that the consumer is a 'mentally ill person' as defined by the Act (s14)
- that the order requested is the least restrictive alternative consistent with safe and effective treatment and care.



The report should be signed and clearly state:

- consumer’s name, address and date of birth
- author’s name and relationship to the consumer
- relevant treatment history
- consumer’s current symptoms, risk factors, and continuing condition (where relevant) ([Guide Book, Chapter 2.1](#))
- kind of order requested – involuntary patient order, community treatment order, adjournment
- proposed duration of order requested (maximum of up to three months for an involuntary patient order)
- treatment plan or options
- consumer’s attitude to treatment.

A report should:

- summarise the facts and opinions upon which the request is made
- address the relevant legislative criteria
- state whether these facts and opinions have been drawn from the author’s direct observations or from other specified parties.

Some mental health inpatient facilities routinely prepare a social work report in addition to the medical reports. These can assist by providing relevant information about the consumer’s background, social and family context. This information is often important in examining the issue of ‘the least restrictive alternative’. A social worker’s report is also generally required if the Tribunal is asked to find that a consumer is incapable of managing their financial affairs. In these cases an order for management is made under the NSW Trustee and Guardian Act ([Guide Book, Chapter 12](#)).

#### 8.4 ANSWERING QUESTIONS AT MENTAL HEALTH INQUIRY

The written report should provide the basic information that the Tribunal will need to consider in making a decision. However, the Tribunal and the legal representative will often wish to ask questions in order to:

- clarify or expand on matters contained in the report
- test matters of opinion expressed

- explore alternative treatment options
- build a clearer picture of the consumer’s individual circumstances.

There is often a difficult balance to be struck between:

- giving the consumer an opportunity to hear what the treating team considers is in their best interests, and
- conveying information that is unnecessarily distressing or humiliating.

It is therefore important to think about:

- what needs to be said
- how this can be clearly expressed in lay language (to minimise confusion for the lawyer, Tribunal, consumer, family and friends) and in a way that is respectful to the consumer.

#### 8.5 ASSISTING THE CONSUMER TO PREPARE FOR A MENTAL HEALTH INQUIRY

While an individual consumer’s ability to comprehend and participate in the proceedings will vary widely, mental health staff (along with the legal representative) can play an important role in assisting the consumer to prepare for the hearing. The involvement of interpreters, consumer workers, cross-cultural consultants and Aboriginal mental health workers should also be considered at this stage.

Before the inquiry consumers should be given:

- notice of the mental health inquiry
- a clear explanation of their rights

#### A GOOD REPORT CAN:

- minimise the need for distressing background details to be raised (or emphasised) during the hearing
- provide a basis for understanding and/or negotiation between the treating team, the consumer and the consumer’s legal representative
- focus the scope of the inquiry and therefore reduce the consumer’s confusion and/or distress.



- information relating to the possibility of the Tribunal making an order that the consumer’s estate is to be managed by the NSW Trustee (NSW Trustee and Guardian Act (s43))
- a clear explanation of the order the mental health facility is seeking
- a brief description of the hearing including:
  - where it will be held
  - who will be there
  - who will speak and in what order
  - the kinds of things the Tribunal might ask
  - the kind of decision that the Tribunal might make
- a private and appropriate place to discuss the matter with their lawyer
- an opportunity to ask questions about the process
- encouragement to think about what they might want to tell the Tribunal
- the opportunity to have someone else present at the inquiry to speak about their situation, e.g. a friend, family member or carer.

### 8.6 THE MENTAL HEALTH INQUIRY

Whilst each Tribunal will have its own approach, they will all be guided by the need to avoid unnecessary technicality. However, it is the Tribunal’s role to ensure that the requirements of Act are observed and to determine whether the consumer is a mentally ill person. It will check the documentation accompanying the admission, e.g.

the Schedule 1 and Form 1s to ensure that it has the jurisdiction to conduct the inquiry.

The Tribunal must also:

- ensure that the consumer has been given a written Statement of Rights
- ensure that the consumer and their designated carer(s) and principal care provider were notified of the inquiry
- inquire into the consumer’s medication and take into account its effect on their ability to communicate (s35(2)(c))
- take into consideration any cultural factors that may be relevant to the question of mental illness (s35(2)(d) & (e)).

Mental Health Review Tribunal hearings may be conducted in the absence of patients in specific circumstances (s37; s63 and s96). In these circumstances the authorised medical officer must provide specific information to the Tribunal prior to the hearing. The relevant form is available on the Tribunal’s website (Application for hearing to proceed in the absence of the patient or person). While the Act gives the Tribunal the authority to issue a summons and administer an oath, in practice these powers are rarely exercised.

Having heard from all the parties the Tribunal then decides, on the balance of probabilities, whether the consumer is or is not a ‘mentally ill person’. That is, the Tribunal considers whether it is more likely than not that the consumer is a ‘mentally ill person’.

### 8.7 WHAT CAN THE MENTAL HEALTH REVIEW TRIBUNAL DECIDE?

#### Finding the consumer to be a mentally ill person (s35(5))

If the Tribunal decides that the consumer is a mentally ill person it may:

- make an involuntary patient order directing that the consumer be detained for a period of up to three months
- discharge the consumer on a community treatment order of not more than 12 months
- make a community treatment order, but defer the consumer’s discharge for up to 14 days if this is in the consumer’s best interests
- discharge the consumer into the care of their designated carer or principal care provider.

Where the Tribunal makes an involuntary patient order, it must consider the consumer’s capacity to manage their financial affairs. If it is satisfied that the consumer is not capable of managing their affairs, it must make an order for financial management under the NSW Trustee and Guardian Act (s44) ([Guide Book, Chapter 12](#)).

Such an order can later be revoked if the Tribunal:

- is satisfied that the consumer can manage their own affairs, or
- decides that the revocation is in the consumer’s best interests ([Guide Book, Chapter 12](#)).

A consumer can apply to the Tribunal to have their financial management order revoked, either while they are still receiving treatment as an inpatient, or once they have been discharged (*NSW Trustee and Guardian Act (s88)*).

Once an involuntary patient order has been made, the consumer should be advised of their rights to request discharge from an authorised medical officer. If this request is refused or not considered within three working days, an appeal can be made to the Tribunal (s44).

A consumer’s designated carer(s) or principal care provider may also apply at any time for their discharge.

An authorised medical officer may discharge the consumer if:

- the carer gives a written undertaking that the consumer will be properly taken care of, and
- the officer is satisfied that adequate measures are in place to ensure the safety of the consumer and others (s43).

**Finding the consumer not to be a mentally ill person (s35(3) & s35(4))**

If the Tribunal decides that the consumer is not a mentally ill person, it:

- must discharge them, or
- defer the discharge for up to 14 days if this is in the consumer’s best interests.

**Adjourning the matter (s36)**

The Tribunal may decide to adjourn the hearing for up to 14 days if they:

- have considered all the relevant documentation, and
- are of the opinion that it is in the best interests of the consumer.

An adjournment may also be ordered where the Tribunal is not satisfied that:

- the consumer and their designated carer(s) and/or principal care provider have been given proper notice about the Inquiry
- the consumer has been informed of their legal rights.

If the matter is adjourned, the consumer continues to be detained and may be given treatment against their wishes. During this time, the consumer may request that the authorised medical officer discharges them and, if this is refused or not considered, appeal to the Tribunal (s44).

The consumer must also be discharged, or admitted as a voluntary patient, if the authorised medical officer, at any time, decides the consumer is no longer a mentally ill person or that other care of a less restrictive kind is appropriate and reasonably available.

**8.8 CONSIDERING THE OPTIONS**

Some of the difficulties that accompany a mental health inquiry may be unavoidable. However, a good understanding of the legal framework can promote a non-adversarial approach and in certain cases give the treating team more flexibility in working with detained consumers.

Requesting an adjournment may be appropriate in limited circumstances, such as where a community mental health facility is preparing a treatment

plan as a less restrictive alternative. However, as a general rule consumers should be presented to a mental health inquiry with sufficient information for the Tribunal to determine the matter.

Whatever the outcome of the inquiry, the consumer will undoubtedly need someone to talk to about the process. Consideration should be given to enabling some kind of debriefing to occur, preferably with someone outside the official framework of the mental health facility, such as the legal representative, a friend, a consumer worker, or an official visitor.

For further information, see <https://www.mhrt.nsw.gov.au> (under Mental Health Inquiries).

# Chapter 9

## OTHER FUNCTIONS OF THE MENTAL HEALTH REVIEW TRIBUNAL

The Tribunal is a specialist quasi-judicial body. It has a wide range of powers that enable it to make and review orders, as well as hear appeals about the treatment and care of consumers with a mental illness. The decisions made by the Tribunal are legally binding on the mental health facility and the individual.

The Tribunal produces an Annual Report that includes details about the numbers of people taken to and detained in mental health inpatient facilities, and the kinds of orders made. These reports provide the best source of information about involuntary treatment under the Mental Health Act in NSW. The Annual Reports are available on the Tribunal's website (<https://www.mhrt.nsw.gov.au>).

### 9.1 HOW ARE HEARINGS CONDUCTED?

The Tribunal travels to mental health inpatient facilities and community mental health facilities to conduct many of its hearings. However, those involving consumers in rural and remote communities are generally conducted by audio visual link or in some cases by telephone.

### 9.2 WHO SITS ON THE TRIBUNAL?

The Tribunal generally sits as a panel of three unless it is conducting a mental health inquiry or hearing an appeal by a consumer who has not yet had a mental health inquiry. In these cases the legal member sits alone.

Each panel comprises:

- a barrister or solicitor (who chairs the panel)
- a psychiatrist
- a suitably qualified person (a consumer, carer or person with other extensive experience in mental health).

The Mental Health Regulation sets out when the Tribunal must sit as a panel of three. These situations include:

- reviews of involuntary patients
- reviews of voluntary patients
- appeals against refusal to discharge (unless the appeal precedes a mental health inquiry in which case it will be heard by the legal member)
- applications for community treatment orders
- applications for electroconvulsive therapy (ECT), surgical operations and special medical treatment.

The Tribunal may also sit as a one-person panel when handling certain routine matters such as an uncontested variation of a community treatment order.

### 9.3 APPLYING IN A TIMELY FASHION

It is extremely important to apply to the Tribunal for a hearing wherever possible in a timely fashion. This allows Tribunal staff:

- to ensure that a time is available for the hearing
- to check that all the necessary paperwork for the hearing has been prepared.

The Tribunal generally asks that applications for a hearing be scanned and emailed to [mhrt-civil@health.nsw.gov.au](mailto:mhrt-civil@health.nsw.gov.au) at least five working days before the proposed hearing date. Where an application is urgent, it should be emailed to the Tribunal and then followed up by a phone call to a Senior Registry Officer. Applications may also be faxed to the Tribunal.

### 9.4 PREPARING FOR THE HEARING

The main clinician involved with the consumer (usually the psychiatric registrar or psychiatric case manager) should:

- organise and prepare reports and necessary documentation
- explain the hearing process to the consumer
- inform the consumer's designated carer(s), principal care provider, relatives and other key people of the hearing and encourage them to attend
- organise an interpreter where appropriate
- organise appropriate security if necessary
- arrange legal representation if necessary
- facilitate the legal representative's access to relevant reports and documents.

## 9.5 REPORTS AND DOCUMENTS

The Tribunal needs to see the following reports and documents before the hearing:

- an application form
- a copy of any existing order, e.g. involuntary patient order, previous community treatment order
- report(s) from treating psychiatrist, psychiatric registrar, case manager
- additional reports, e.g. social worker, occupational therapist etc
- a copy of the patient’s recent progress notes.

If the hearing does not occur face-to-face, these documents should be sent to the Tribunal at least three working days before the hearing.

## 9.6 PREPARING REPORTS FOR THE TRIBUNAL

Psychiatric registrars, consultant psychiatrists, social workers and case managers are often required to provide written reports to the Tribunal. In each case the report should be written in plain English and address the relevant legal criteria. For example, the Tribunal cannot grant an involuntary patient order unless:

- the consumer is still a ‘mentally ill person’ as defined by the Act, and
- the order being requested can be demonstrated to be the least restrictive alternative for providing safe and effective care and treatment.

Reports should be prepared on letterhead, dated, signed and clearly set out the following information:

- consumer’s name, address and date of birth
- author’s name, position, and relationship to the consumer
- diagnosis/current symptoms
- relevant treatment history
- kind of order requested
- proposed duration of order requested, where applicable
- treatment plan or options
- consumer’s attitude to and response to treatment
- relevant behavioural issues, if any.

## 9.7 ANSWERING QUESTIONS AT THE HEARING

While a report provides the Tribunal with important information, panel members will be interested in asking questions that:

- clarify or expand on matters contained in the report
- explore alternative treatment options where appropriate
- build a comprehensive picture of the consumer’s individual circumstances
- ensure that the legal criteria have been met.

## 9.8 ASSISTING A CONSUMER TO PREPARE FOR AND PARTICIPATE IN A HEARING

Assisting a consumer to prepare for a hearing is as important as the formal preparation of reports and documentation. Mental health staff and the consumer’s legal representative play an important role in assisting the consumer to prepare for a hearing. It is also important to consider the possible need to involve interpreters, consumer workers, cross-cultural consultants and Aboriginal mental health workers so that they can provide timely assistance to the consumer ([Guide Book, Chapter 15](#)).

Consumers should be provided with:

- a clear explanation of their rights
- a clear explanation of the nature of the hearing including:
  - where it will be held
  - who will be there
  - the kind of questions they are likely to be asked
  - the kind of matters they might like to raise
  - the kind of decisions the Tribunal can make
- an opportunity to ask questions about the process
- a private and appropriate space to discuss the matter with a friend, advocate or legal representative.

Consumers should be encouraged to:

- attend the hearing and state their point of view
- participate by telephone if they do not wish to attend the hearing in person
- have their designated carer(s), principal care provider, and/or a support person/advocate accompany them, particularly where legal representation is not available.

Consumers may also wish to complete a Client Form to write down anything they would like the Tribunal to know. The Form can be obtained before the hearing day from the mental health facility involved in the matter and it can be sent to the Tribunal before the hearing. Use of the Form is optional, but it may prompt consumers to think about anything they wish to say to the Tribunal.

### 9.9 WHAT TO DO AFTER THE HEARING

Take time to explain to the consumer and/or friends and family any aspects of the process they may have found confusing.

### 9.10 WHAT DOES THE TRIBUNAL DEAL WITH?

The Tribunal has developed a detailed Civil Hearing Kit to assist doctors, case managers and others in making an application to the Tribunal. The Kit sets out the legislative requirements of the Act and describes the paperwork needed when submitting an application. The Kit is available at <https://www.mhrt.nsw.gov.au> (under Civil Patients) and should be referred to whenever an application is being made.

The following information highlights some of the main areas covered in the Tribunal’s Kit.

#### Involuntary patient orders (s37)

If a mental health inpatient facility wishes to extend a consumer’s involuntary stay beyond the period set at the mental health inquiry, the Tribunal must review the consumer before the initial order expires. Applications to review a consumer’s detention and involuntary treatment should be sent to the Tribunal at least five working days before the requested date for the hearing.

The Tribunal then decides whether or not the consumer is a mentally ill person for whom no other safe and effective care of a less restrictive kind is appropriate and reasonably available ([Guide Book, Chapter 2.1](#)).

Where a further order is made, it must be reviewed:

- at least every three months during the first 12 months
- at least every six months thereafter.

It is the responsibility of the authorised medical officer to bring an involuntary patient back before the Tribunal for these further reviews if it is considered appropriate that the patient’s detention needs to be extended.

In most cases the patient will be expected to attend the hearing. However, where the patient either refuses or is too unwell to attend, the authorised medical officer may apply to the Tribunal to have the review proceed in the patient’s absence (s37(3A)).

In these circumstances the authorised medical officer must submit a form to the Tribunal prior to the hearing, setting out the following information:

- the reasons for the patient’s non attendance (s37(3A(a))
- why it is desirable for the patient’s safety or welfare that the hearing proceed (s37(3A(e))
- the steps that have been taken to inform the Mental Health Advocacy Service (or other representative) of the hearing (s37(3A(c))
- the steps that have been taken to inform the patient’s designated carer(s) and/or principal care provider of the hearing and to obtain their views on the proposed treatment (s37(3A(d))

This form is available on the Tribunal’s website (Application for hearing to proceed in the absence of the patient or person).

The Tribunal may review a patient on an involuntary patient order more frequently than the three and six monthly periods stipulated in the Act.

The Act also allows for the possibility that a consumer on an involuntary patient order be reviewed at intervals of up to 12 months where they have been detained for over a year (s37(4)). However, this is only likely to be applied in limited circumstances, such as where the consumer has a chronic illness, finds the Tribunal process stressful, and there is little prospect of significant improvement.

Where the Tribunal finds that the patient remains a mentally ill person, a time will be set for further review. In most cases, where the person has been detained for less than 12 months, it sets a three month review period. If there are specific reasons why the treating team wishes to apply for an earlier review date, for example where an application for a community treatment order is being prepared these reasons should be outlined at the hearing.

In some cases treating teams apply for orders of a specific duration, for example six weeks. If the Tribunal then sets a three month review period, this can lead to patient confusion and distress. It is therefore important for the team to explain prior to the hearing that the Tribunal's order only establishes the maximum period in which a patient must be reviewed again by the Tribunal. It does not prevent the consumer being discharged when the treating team considers this appropriate.

Where a date for a subsequent review has been stipulated, and the treating team believes the patient requires further hospital treatment, the authorised medical officer must arrange a further hearing before that review date. A patient cannot be detained beyond the specified review period without a further order from the Tribunal.

In some cases the Tribunal may decide that although the consumer remains a mentally ill person, there is a less restrictive, but safe and effective form of care available. It must then discharge the consumer (this may include discharging them into the care of a designated carer or principal care provider).

Where the Tribunal decides that the consumer is no longer a mentally ill person it:

- must discharge the consumer
- may defer the discharge for up to 14 days if it is in the consumer's best interests
- may make a community treatment order, and
- may defer the consumer's discharge on the making of the community treatment order for up to 14 days.

**Appeals against refusal to discharge (s44)**

Any consumer who has been detained as either a mentally ill person or a mentally disordered person can apply to an authorised medical officer to be discharged.

This includes a consumer who is:

- on an involuntary patient order
- on a mental health inquiry adjournment
- detained, but has not yet been reviewed at a mental health inquiry
- detained following a breach of a community treatment order.

A consumer's designated carer or principal care provider can also apply for discharge.

An application for discharge can be either verbal or in writing. Once the request has been made, the authorised medical officer has three working days to respond.

If the application is refused or no decision is made within three working days, an appeal can be lodged by the consumer or the carer. While the appeal can be made either verbally (by

declaring to the authorised medical officer that the consumer wishes to appeal to the Tribunal) or in writing, consumers are encouraged to complete an appeal form.

At the appeal hearing, the Tribunal considers whether the consumer continues to be either a mentally ill person or mentally disordered person and may decide to:

- discharge the consumer
- defer the discharge for up to 14 days if the Tribunal decides it is in the best interests of the consumer to do so
- make a community treatment order
- dismiss the appeal
- reclassify the consumer as a voluntary patient
- adjourn the hearing.

The Tribunal may also decide that no further right of appeal may be exercised until the consumer's involuntary status is next reviewed by the Tribunal (s44 (5)).

**Voluntary Patient Reviews**  
([Guide Book, Chapter 5](#))

**Community Treatment Orders**  
([Guide Book, Chapter 10](#))

**Consent to Electroconvulsive Therapy**  
([Guide Book, Chapter 11](#))

**Financial Management Orders**  
([Guide Book, Chapter 12](#))

**Consent to Surgical Operations or Special Medical Treatment**  
([Guide Book, Chapter 13](#))



## 9.11 OTHER PROCESSES OF REVIEW

### Supreme Court

Decisions of the Tribunal can be appealed to the Supreme Court. The Court may also require the medical superintendent of a mental health facility to bring a consumer before it for examination. The consumer may be discharged if the Court decides the consumer is not a mentally ill person. Due to the costs involved, very few consumers appeal to the Supreme Court. Where a consumer is considering an appeal, they should contact the Mental Health Advocacy Service to see whether legal aid is available.

### Other Bodies

The following entities can also play a role in scrutinising the treatment of consumers under the Act, and in supporting them to exercise their rights ([Guide Book, Chapter 3.3](#)):

- Official visitors
- Mental Health Advocacy Service
- NSW Health Care Complaints Commission
- Consumer workers.

# Chapter 10

## COMMUNITY TREATMENT ORDERS

Community treatment orders (CTOs) provide a community-based alternative to involuntary inpatient treatment. They are intended to allow consumers, who might otherwise be detained in a mental health facility, to live in the community while receiving the treatment, care and support they need.

### 10.1 WHAT IS A CTO? (S51)

A CTO is a legal order made by the Tribunal (or in limited circumstances by a Magistrate under the *Mental Health (Forensic Provisions) Act 1990*. It sets out the terms under which a consumer must accept medication, therapy, counselling, management, rehabilitation and other services while living in the community. It is implemented by a community mental health service that has developed an appropriate and individual treatment plan for the consumer.

A CTO authorises the compulsory care and treatment of a consumer living in the community. If the consumer does not comply with the order, in certain circumstances they can be taken to a declared mental health facility to be given appropriate treatment, including medication.

### 10.2 WHO CAN APPLY FOR A CTO? (S51(2))

The following people can apply for a CTO:

- an authorised medical officer of a mental health facility in which a consumer is detained
- a medical practitioner who is familiar with a consumer’s clinical history<sup>1</sup>
- a consumer’s designated carer or principal care provider<sup>1</sup>
- a director of community treatment who is familiar with a consumer’s clinical history.

### 10.3 APPLYING FOR A CTO

Where a consumer is detained in a mental health inpatient facility and a CTO is sought at a mental health inquiry or as part of an appeal or involuntary patient review, a treatment plan must be prepared by the appropriate community mental health facility. The consumer must be provided with a copy of the application and the proposed plan.

Where the consumer is on an involuntary patient order, or is in the community, and a CTO is sought, the standard application form should be used ([Appendix 3](#)).

The application should be sent to the Tribunal so that a hearing time can be allocated and the necessary information sent to the consumer to inform them of the hearing.

### Making an application for a further CTO

It is important for community mental health staff to know when a consumer’s CTO is due to expire. The Tribunal prefers applications for second or subsequent CTOs to be sent to the Tribunal at least three weeks before the requested hearing date.

This allows sufficient time for notice of the hearing to be given and for the Tribunal to write to the consumer with the details of the hearing. It also gives the community team time to ensure that:

- the consumer is reviewed by a psychiatrist
- the new treatment plan is discussed with the consumer
- a report into the efficacy of the previous CTO is prepared.

### Making an application from the community

An application for a CTO can be made from the community in a number of circumstances including where:

- a consumer’s CTO has expired or is about to expire
- a consumer has had a previous admission as an involuntary patient but has been discharged without a CTO
- a consumer has never been admitted as an involuntary patient.

<sup>1</sup> While the Act enables a medical practitioner or carer to apply for a CTO, these applications should occur in collaboration with the community mental health service that is responsible for drawing up and administering the treatment plan.

When such an application is made, it is important to ensure that a clear picture of the consumer’s circumstances can be presented to the Tribunal. This includes:

- discharge summary (where relevant)
- psychiatric report
- doctor’s report (e.g. if the consumer has been managed by a GP)
- psychiatric history (gathered from the consumer and/or family members).

#### 10.4 PROVIDING NOTICE TO THE CONSUMER OF A CTO APPLICATION (S52)

The applicant for a CTO must:

- notify the consumer of the application in writing
- include a copy of the proposed treatment plan with the application
- provide 14 days’ notice of the application where the consumer is in the community.

The 14-day notice period does not apply, however:

- where the consumer is already on a CTO that has not expired and the notice of the application is served on the consumer while the existing CTO is still in operation
- where the Tribunal decides it is in the consumer’s best interests to hear the application earlier than the 14-day notice period
- where the consumer is in a mental health inpatient facility.

Where the 14-day notice provision does not apply, the consumer should be given a copy of the proposed treatment plan in sufficient time to allow them to prepare for the hearing and to seek legal or other assistance if they so wish. It is important that the consumer has the opportunity to discuss the purpose of the CTO and the specifics of the treatment plan with their case manager and/or legal representative, where possible.

Notice can only be given in the following ways (s192):

- in person
- sending it by post
- by fax.

#### THE NOTICE REQUIREMENTS ARE NOT MET BY:

- putting the application under the consumer’s door, or
- leaving the application in the consumer’s mailbox.



#### 10.5 WHEN CAN A CTO BE MADE?

The Tribunal can make a CTO at a mental health inquiry, where:

- the consumer is found to be a mentally ill person, and
- the order is seen as the least restrictive alternative consistent with safe and effective care.

The Tribunal as a three-person panel can make a CTO:

- where a consumer is on an involuntary patient order
- where the consumer is appealing against the authorised medical officer’s refusal to discharge<sup>1</sup>
- where the consumer is on a CTO that is about to expire
- where there is an application from the community by a person who is legally authorised to do so.

#### What is considered before making a CTO? (s53)

The Tribunal considers the following issues in reaching its decision:

- Has an appropriate treatment plan been drawn up by the community mental health facility?
- Will the consumer benefit from a CTO as the least restrictive alternative that is consistent with safe and effective care?
- Does the community mental health facility have the capacity to implement the plan?
- Does the consumer have a prior diagnosis of a mental illness, and if so, is there a previous history of refusing to accept treatment?

However, a consumer’s history of refusing to accept appropriate treatment is not relevant where they have been a forensic patient or subject to a CTO in the previous 12 months. In these cases the Tribunal considers whether the consumer is likely to relapse into an active phase of mental illness if the order is not granted.

<sup>1</sup> Where a consumer lodges an appeal before they have been seen at a mental health inquiry, the appeal and mental health inquiry may be heard at the same time, before a single legal member of the Tribunal.

In all other cases, the consumer must have a history of refusing to accept appropriate treatment. This means that (s53(5)):

- appropriate treatment has been refused
- this refusal has led to a relapse into an active phase of mental illness
- the relapse has been followed by mental or physical deterioration justifying involuntary admission (whether or not an admission occurred)
- care or treatment following involuntary admission resulted, (or could have resulted) in an amelioration of, or recovery from, the debilitating symptoms of a mental illness or the short-term prevention of deterioration in the mental or physical condition of the consumer.

If a consumer has a prior diagnosis of mental illness but no history of refusing proper treatment, then a CTO cannot be made.

Where a consumer has been subject to a previous CTO, the Tribunal also considers a report from the psychiatric case manager outlining the efficacy of the previous order.

### 10.6 THE TREATMENT PLAN

This sets out how a consumer is to be managed while on a CTO and:

- is usually prepared by the consumer’s psychiatric case manager
- must be presented to the Tribunal for approval.

### MEDICATIONS LISTED ON A TREATMENT PLAN



Generally only medications that directly relate to the management of a consumer’s mental illness appear on a treatment plan. However, where a consumer’s mental wellbeing is significantly and adversely affected by their failure to take other medication on a regular basis, these can be included in the treatment plan.

#### What should be in a treatment plan? (s54)

Treatment plans should contain:

- in general terms, an outline of the proposed treatment, counselling, management, rehabilitation and other services to be provided
- in specific terms, the method by which, the frequency with which, and the place at which, the services will be provided.

The Tribunal has prepared guidelines and a template to assist in the development of treatment plans. It sets out the following requirements:

- the consumer’s recovery goals
- the consumer’s obligation to make contact with the treating team: including time, place and frequency of contact with the case manager and treating doctor
- the consumer’s obligation to accept treatment, including a list of current medication(s)
- the consumer’s obligation to accept rehabilitation and/or other services (where relevant)
- any additional clauses that outline when a consumer may be required (or encouraged) to comply with blood tests, urine drug screens, drug or alcohol counselling.

The Template is available at

<https://www.mhrt.nsw.gov.au> (under Documents).

All treatment plans should be:

- specifically tailored to the needs of the individual consumer
- written in plain English (i.e. no Latin terms such as mane and nocte)
- discussed with the consumer prior to the hearing.

### 10.7 THE LENGTH OF A CTO

While the Tribunal can make a CTO for up to 12 months, the Act also provides for an automatic right of appeal where an order is made for longer than six months, or no duration is specified (s67). Therefore most orders are made for six months.

In deciding the duration of a CTO, the Tribunal must take into the account the estimated time required to:

- stabilise the consumer’s condition, and
- establish, or re-establish a therapeutic relationship between the consumer and their case manager (s53(7)).

Where a longer order is requested the applicant will need to explain their reasons to the Tribunal and give a clear indication of what they hope to achieve by being granted a longer CTO period.

Some of the factors that may be considered in granting a longer CTO include:

- where the consumer has a lengthy history of mental illness with repeated admissions to mental health inpatient services
- where the consumer’s condition and treatment have not changed for a long time
- where the consumer requests a longer order
- where the consumer is agreeable to a longer order and is involved in the hearing
- where the consumer has recently been diagnosed with a mental illness, and their age and/or the severity of the illness, make it important that they have an initial extended and consistent period of treatment
- where there appears to be little chance of improvement in the next 12 months.

### NEGOTIATION

Resentment and resistance to CTOs can be minimised by consulting and negotiating with consumers and, where possible, working towards the consumer’s recovery goals.



It is unlikely that a longer order would be granted where:

- the consumer has not been consulted about the length of the order
- the consumer’s treatment is in a state of flux
- the consumer is opposed to a longer order
- the consumer is absent from the hearing.

### 10.8 PREPARING FOR AND ATTENDING CTO HEARINGS

#### What should be in the applicant’s report?

A dated and signed report should be prepared on letterhead outlining:

- the name and date of birth of the consumer
- the name of the psychiatric case manager
- the declared name of the community mental health facility
- the type of order previously made
- when that order was made
- the duration of that order.

It should also contain:

- a summary of the previous treatment plan and whether any changes have occurred or are proposed
- how that plan was implemented and any difficulties encountered or gains made during the last order
- why a further order is sought.

It is the role of the Tribunal to ensure that the provisions of the Act have been complied with. They will therefore ask questions that

relate to the legal criteria for CTO’s particularly where these issues are not apparent in the accompanying reports.

It is therefore important for the person requesting the CTO to have a good understanding of the consumer and their situation.

The authorised medical officer or case manager should be prepared to answer questions about:

- the consumer’s attitude toward the previous or proposed treatment plan
- the consumer’s history of compliance with aspects of the plan (including the consequences of compliance/non-compliance)
- any rehabilitation, training, or social activities that the consumer has been involved in or is working towards
- the consumer’s interactions with family, friends, and others
- relevant accommodation, employment, legal and mobility issues.

Where an application for a CTO is being heard in relation to a consumer who is in a mental health inpatient facility it is important for the nominated case manager to meet with the consumer prior to developing the proposed treatment plan and then to participate in the hearing so that they can answer questions about the proposed treatment plan. If the case manager is unable to attend in person, their participation by phone should be arranged.

### 10.9 ADJOURNING A CTO APPLICATION

While the Tribunal has a general power to adjourn hearings, an adjournment cannot be used to extend the operation of a CTO. To ensure the continuity of a consumer's care it is therefore important to comply with all of the requirements of a CTO application, so that a scheduled Tribunal hearing can proceed. Where this does not occur, a consumer's order may expire and a new application may need to be made.

### 10.10 VARYING OR REVOKING A CTO (S65 AND S66)

Where there has been a significant change in a consumer's circumstances surrounding the making of a CTO, or where relevant information not previously available becomes available, an existing CTO can be varied.

This most commonly occurs when:

- the consumer moves to a different area
- there is a significant change in the consumer's treatment (such as where the consumer's medication is changed to clozapine which requires regular blood tests).

In most cases an application for a variation is made to the Tribunal by the consumer's case manager, though it can also be made by any of those who can apply for a CTO ([Guide Book, Chapter 10.2](#)) or by the consumer. These matters are usually managed via printed documentation and do not require a formal hearing.

The Tribunal can also revoke a CTO where there has been a significant change in the consumer's circumstances, or where relevant information that was not available when the order was made becomes available. In these cases, a hearing is required.

A CTO can also be revoked by the director of the community mental health facility that is providing case management for the consumer, where they believe the consumer is not likely to benefit from the continuation of the order. However, before revoking a CTO, the director must consult the consumer to whom the order applies, and where practicable also consult the consumer's designated carer(s) and principal care provider. The director must also notify the Tribunal and the carers in writing of the revocation.

In cases where a community mental health facility decides to make no further application for a CTO, the director must both inform the Tribunal in writing and take all reasonably practicable steps to notify the consumer and their designated carer(s) and principal care provider.

### 10.11 APPEALING AGAINST A CTO (S67)

There is a right of appeal to the Tribunal where a CTO has been made by a Magistrate under the *Mental Health (Forensic Provisions) Act 1990*. A consumer may appeal:

- against the length of the order where it is more than six months, or no duration has been specified, or
- on any question of law or fact arising from the order or its making.

However, in practice very few CTOs are made by Magistrates.

Where the CTO is made by the Tribunal, an appeal may be made to the Supreme Court. The same grounds of appeal apply as when appealing against a CTO made by a Magistrate. Anyone wishing to appeal should contact the Mental Health Advocacy Service ([Guide Book, Chapter 3.3](#))

### 10.12 BREACH OF A CTO (S58)

This may happen when a consumer refuses or fails to comply with a CTO. However, before a breach can be said to have occurred, a clinical decision must be made. A consumer’s failure to comply with the terms of the order does not, of itself, automatically trigger breach proceedings.

The director of the community mental health service must:

- consider whether the service has taken all reasonable steps to implement the order, and
- assess whether there is a significant risk of deterioration in the mental or physical condition of the consumer, and
- document their clinical opinion, the facts upon which it is based, and the reasons for forming it.

#### BREACH PROCESS

The breach process commences and continues at the discretion of the director of community treatment from the mental health facility supervising the CTO.



#### The first warning - verbal

If the director decides that all reasonable steps have been taken by the service and that there is a significant risk of deterioration, the case manager may give the consumer a warning that continued non-compliance with their CTO may result in them being taken to a mental health service and treated in accordance with their treatment plan. The director must document these reasons and actions in writing.

#### The second warning – issuing a breach notice

If the consumer still fails to comply the director may give them a written breach notice ([Appendix 2](#)):

- requiring the consumer to accompany a member of staff to the community mental health service or mental health inpatient service for treatment in accordance with their CTO, and
- warning them that police assistance may be obtained to ensure compliance.

The written breach notice must be handed directly to the consumer or, if not reasonably practicable, posted to their last known address.

#### Where the consumer agrees

If the consumer agrees to come to the mental health service they may be:

- given treatment in accordance with the CTO, and
- assessed for voluntary or involuntary admission if appropriate.

If the treatment is accepted and admission is not required, the consumer may then return home.

#### Where the consumer refuses – issuing a breach order

Where the consumer refuses to comply with a breach notice, the director of community treatment may issue a breach order authorising the consumer to be taken to a specified mental health facility (either community or inpatient) against their will.

Once at the specified facility, the consumer can be given treatment in accordance with the CTO, and, where appropriate, assessed for admission.

#### Involving the police (s59)

If a mental health worker cannot implement a breach order, the assistance of the police may be obtained.

The police:

- must if practicable, apprehend and take, or assist in taking, the consumer to the appropriate mental health facility
- may use reasonable force to enter premises, apprehend the consumer, and transport them to the appropriate mental health facility ([Guide Book, Chapter 14](#)).

#### Detention in a mental health inpatient facility following a breach order (s61)

Where a consumer refuses treatment at a community mental health service, they will generally be taken to a mental health inpatient facility. If treatment is accepted at this stage, they may return home if this is deemed appropriate by the authorised medical officer.

If treatment continues to be refused, the authorised medical officer can direct that the person be given treatment in accordance with the CTO. They must also review the consumer within 12 hours to determine whether they are a mentally ill or a mentally disordered person, for whom no other care of a less restrictive kind that is consistent with safe and effective care, is appropriate or reasonably available.

If the consumer is found to be either a ‘mentally ill person’ or a ‘mentally disordered person’, they can then be detained for further observation and/or treatment. Once a consumer is detained following a CTO breach, they must be given an Involuntary Patient Statement of Rights (Schedule 3) as soon as possible.

Where the consumer is assessed as a mentally disordered person, they can only be detained for the maximum period allowed under s31 or until the expiry of the CTO (whichever occurs first) ([Guide Book, Chapter 6.4](#)). However, a consumer who is assessed as a mentally ill person can be detained for the remainder of their CTO, although they must be reviewed by the Tribunal at least every three months. In most cases the patient will be expected to attend the hearing. However, where the patient either refuses or is too unwell to attend, the authorised medical officer may apply to the Tribunal to have the review proceed in the patient’s absence (s63(2A)).

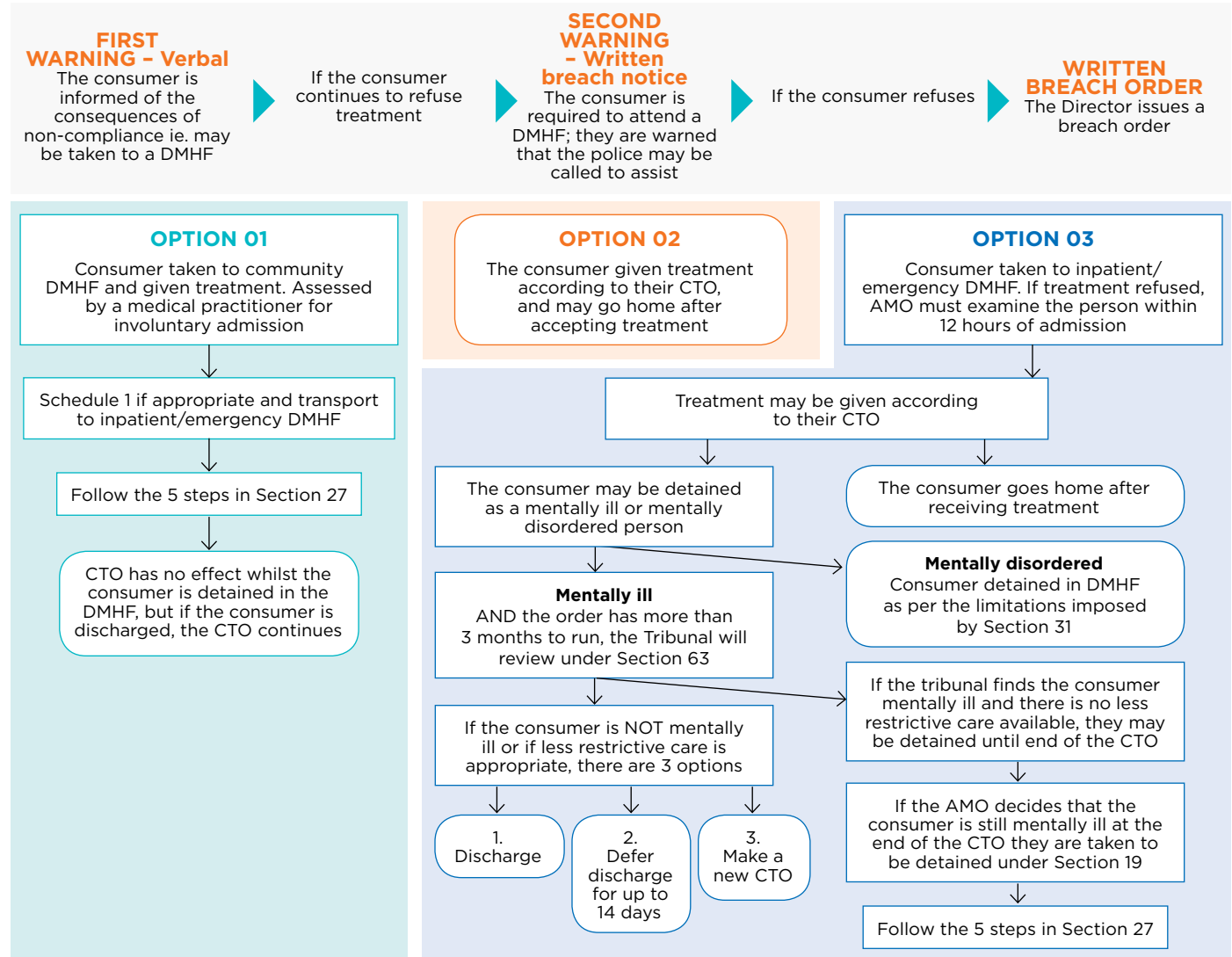
In these circumstances the authorised medical officer must provide specific information to the Tribunal prior to the hearing. The relevant form is available on the Tribunal’s website (Application for hearing to proceed in the absence of the patient or person).

If the Tribunal finds at the review that the person is still mentally ill, it may continue their detention:

- until the end of the CTO, or
- as an involuntary patient under an involuntary patient order.

### BREACH OF COMMUNITY TREATMENT ORDER (S58)

Breach action may be instigated when a consumer fails or refuses to comply with the CTO AND the Director of Community Treatment believes that there is a significant risk of deterioration, AND the Declared Mental Health Facility (DMHF) has taken all reasonable steps to implement the order. The Director must document all of the above.





Where the Tribunal decides to continue a consumer’s detention following the breach of a CTO, the authorised medical officer must give the consumer a statement of their appeal rights.

If the Tribunal finds that the consumer is no longer mentally ill, or that they can be cared for in a less restrictive environment, it may:

- discharge the consumer
- discharge the consumer on the same or a varied CTO
- defer the consumer’s discharge for up to 14 days if in the consumer’s best interests.

The consumer must be discharged at any time the authorised medical officer decides they are no longer a mentally ill or mentally disordered person, or that care of a less restrictive kind that is consistent with safe and effective care is reasonably available to the person.

Where discharge occurs before the original CTO has expired, the CTO continues.

### 10.13 EFFECTIVENESS OF COMMUNITY ORDERS

Compulsory community treatment is now a major tool for the treatment of mental illness, and the making and review of these orders provides the Tribunal with a significant proportion of its workload. Research suggests that these orders have reduced readmission rates and increased compliance with medication. However,

### EFFECT OF SCHEDULING A CONSUMER ON A CTO



As with a consumer detained on a breach, a CTO is suspended during a period of detention but continues once the consumer is discharged. For example, Mary is on a CTO that expires on September 14th. Although compliant with her CTO, she has become very unwell due to the death of a good friend. She was scheduled in June and subsequently placed on a six week involuntary patient order. By mid-July she is well enough to be discharged and returns home.

While Mary’s CTO does not apply while she is in the mental health inpatient facility, her CTO continues to run until September 14th and has effect after her discharge. This means that Mary, her case manager and community psychiatrist have the time to assess whether a further CTO is necessary and make the necessary application if appropriate.

less is known about the impact of compulsory community treatment on the consumer’s psychosocial functioning, quality of life, perceived distress and rehabilitation outcomes.

Studies into the use of coercive community orders suggest that the consumer’s perceptions of the following factors play an important part in determining their effectiveness:

- **motivation** – did the consumer see concern for their particular situation as the motivation behind the treatment order?
- **respect** – how respected did the consumer feel during the process?
- **being heard** – did the consumer feel that they had an opportunity to express their opinion?
- **validation** – did the consumer believe they were taken seriously?
- **fairness** – did the consumer believe they were treated fairly or that decisions were taken behind their back?

- **persuasion or threats** – what sort of pressure did consumers feel was applied in their case?

Many CTO renewals occur without the consumer’s participation, representation or advocacy. Wherever possible, the consumer’s participation at these hearings should be encouraged.

### 10.14 INTERSTATE CTOS

The Act makes some provision for implementing and recognising interstate community treatment orders.

Where NSW has made an interstate agreement with another jurisdiction, the following provisions apply:

- A CTO cannot be transferred interstate
- However, a CTO can be recognised interstate, such that:
  - a NSW CTO may be made for a consumer who does not reside in NSW if the mental health service implementing the order is located in NSW (s181)
  - a consumer who is subject to a NSW CTO may have that order implemented by a mental health service in another state (s182), however NSW will retain ultimate responsibility for administering the order and monitoring the patient
  - a NSW mental health service may implement a CTO or equivalent order made in another state providing it is permitted to do so by that state’s legislation (s183), however the other state will retain ultimate responsibility for administering the order and monitoring the patient

NSW has entered into agreements relating to the treatment, care and transfer of civil mental health patients with Victoria, Queensland, South Australia and the Australian Capital Territory (ACT). There are also interstate agreements with Victoria and Queensland concerning the apprehension and return of forensic patients. These agreements are available via the NSW Health website at:

<https://www.health.nsw.gov.au/legislation/Pages/agreements.aspx>

For further information about Community Treatment Orders see: <https://www.mhrt.nsw.gov.au> (under Civil Patients)

# Chapter 11

## CONSENT TO ELECTROCONVULSIVE THERAPY

Electroconvulsive Therapy (ECT) is a safe and effective treatment for people with severe major depressive disorder and some other mental illnesses. Advances in the delivery of ECT, including anaesthesia and muscle relaxation during the brief treatment procedure, and carefully adjusted dosing schedules, ensure that treatment is well tolerated. (See Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW. This policy can be accessed on the NSW Health website <https://www.health.nsw.gov.au/policies/Pages/default.aspx>). It is most commonly used where medication is not an appropriate option or has not been effective. ECT can only be administered in a declared mental health facility or a place that has been approved by the Secretary of the Ministry of Health. The Act establishes a strict regulatory framework for its use in all cases.

### 11.1 WHO CAN ADMINISTER ECT? (S88)

At least two doctors must be present:

- one experienced in administering ECT, and
- the other experienced in administering anaesthesia.

### 11.2 VOLUNTARY PATIENTS

ECT may be given to a person who is a voluntary patient, providing their informed and freely given written consent has been obtained. The exception to this is where the patient is under 16 years of age. In such cases, consent must be sought from the Tribunal even where the patient has provided informed consent ([Guide Book, Chapter 11.4](#)).

The Act sets out a number of conditions that must be met for informed consent to be obtained (s91). The following provides a summary of the requirements:

- a clear explanation of the procedure
- a full description of the possible discomforts and risks, including possible loss of memory
- a full description of the expected benefits
- information about alternative treatments
- a reply to the person's questions about the procedure in terms they appear to understand
- a full disclosure of any financial relationship between the person proposing the treatment and those administering the treatment
- a notice of their right to obtain legal and medical advice and to be represented before giving consent
- a notice of their right to withdraw consent and discontinue the treatment at any time.

A person will be presumed to be incapable of giving informed consent if their ability to consent is significantly impaired by medication (s92).

As well as a person's informed consent, ECT also requires two doctors (one of whom must be a psychiatrist) to confirm in writing that they have considered the person's clinical condition, their history of treatment and any appropriate alternative treatments and formed the opinion that:

- ECT is a reasonable and proper treatment in the circumstances, and
- ECT is necessary or desirable for the person's safety or welfare (s93).

It is only where an authorised medical officer is unsure whether a voluntary patient is capable of giving informed consent that they need apply to the Tribunal (with exception of patients who are under 16 years of age, [Guide Book Chapter 11.4](#)). Where such an application is made, reasonably practicable steps must be taken to inform the person's designated carer(s) and principal care provider.

In relation to voluntary patients aged 16 years and over, the Tribunal's only role is to decide whether or not the person is capable of giving informed consent, and whether or not they have actually given that consent (s96(1)).

Where the Tribunal decides that the person lacks capacity, or has refused treatment, ECT may not be administered while they remain a voluntary patient.

## ECT AND VOLUNTARY PATIENTS



Voluntary patients cannot be given ECT without their informed consent. If they lack the capacity to consent, no other person may consent on their behalf. For example, parents cannot consent on behalf of a child who lacks the capacity to consent, or who refuses to give their informed consent. Similarly a guardian is not able to consent to ECT.

### 11.3 INVOLUNTARY PATIENTS AND ASSESSABLE PERSONS

Where two doctors (one of whom must be a psychiatrist) confirm in writing that:

- the treatment is reasonable and proper in all the circumstances, and
- it is necessary or desirable for the person's safety or welfare (s94)

then an authorised medical officer may apply to the Tribunal for permission to administer ECT.

An application for ECT can be made where:

- a person has been detained in a declared mental health facility as an assessable person (the initial detention documentation and two Form 1s are required), or
- a person is subject to an adjournment made at a mental health inquiry, or
- a person is subject to an involuntary patient order made by the Tribunal.

## ECT APPLICATION WHERE THE PERSON IS IN A GENERAL HEALTH FACILITY



On occasions, a person for whom an application for ECT has been made may require and/or may be receiving care in a general health facility. In this instance, where the person has not been reviewed at a mental health inquiry, the application for ECT should be accompanied by the initial detention documentation, two Form 1s and the relevant transfer document under s80.

Where an application for ECT is proposed, the authorised medical officer must take all reasonably practicable steps to notify the person's designated carer(s) and principal care provider (s78).

### 11.4 ECT FOR A PERSON UNDER 16 YEARS

In some circumstances ECT may be an appropriate treatment option for a person under 16 years. Where ECT is being considered for a person under 16 years, at least one of the two medical certificates supporting the application, must be given by a psychiatrist with expertise in the treatment of children and adolescents (s94(2A)).

The views of the designated carer(s), principal care provider, or parent should be considered, along with the young person's views and their capacity to give informed consent.

The approval of the Tribunal must be sought before treatment can commence. This applies regardless of whether the person under 16 years is a voluntary or involuntary patient. The young person must also be represented at the hearing by a legal practitioner or, with the approval of the Tribunal, by another person of their choice. However, the Tribunal may proceed in the absence of such representation where it decides it is in the best interests of the young person to do so (s154(4)).

#### ECT and voluntary patients under 16 years

ECT can be administered to a voluntary patient under 16 years where the Tribunal is satisfied that:

- the person is capable of giving informed consent and has given their consent, and
- ECT is a reasonable and proper treatment in the circumstances, and
- it is necessary or desirable for the safety or welfare of the person.

#### ECT and involuntary patients under 16 years

ECT can be administered to an involuntary patient under 16 years where the Tribunal is satisfied that:

- either the person is capable of giving informed consent and has given that consent (s96(3A)(a)(1)), or the person is incapable of giving informed consent, or is capable of giving consent but has refused, or has neither consented or refused (s96(3A)(b)(1)), and
- ECT is a reasonable and proper treatment in the circumstances, and
- it is necessary or desirable for the safety or welfare of the person (s96(3A)(a)(2)).

### 11.5 THE MENTAL HEALTH REVIEW TRIBUNAL'S ROLE

The Tribunal must:

- hold an inquiry into whether ECT should be granted as soon as practicable (s95)
- check if the authorised medical officer has provided notice of the Tribunal hearing to their designated carer(s) and principal care provider
- inform the person about the purpose and possible outcome of the hearing
- ask about the person's medication and take into account its effect on their ability to communicate
- consider the views of the person as well as the medical evidence
- consider the views of any designated carer, principal care provider or parent where the person is under 16 years of age (s96(6)).

While in most cases the patient will be expected to attend the hearing, where the patient either refuses or is too unwell to attend, the authorised medical officer may apply to the Tribunal to have the ECT inquiry proceed in the patient's absence (s96(5A)). In these circumstances the authorised medical officer must provide specific information to the Tribunal prior to the hearing. The relevant form is available on the Tribunal's website

(Application for hearing to proceed in the absence of the patient or person).

ECT can be administered to an involuntary patient where the Tribunal decides:

- the person is capable of giving informed consent and has given their consent, or
- there is no informed consent, but the treatment is reasonable and proper, and is necessary or desirable for the safety or welfare of the person (s96(3)).

The Tribunal's role in relation to voluntary patients and ECT is outlined in the [Guide Book, Chapter 11.2](#).

#### Maximum number of treatments

When the Tribunal makes an order for ECT, it must specify a maximum number of treatments. In most cases this number will not exceed 12 (s96(4) & (5)). However, in special circumstances, including the success of previous ECT, the Tribunal may approve a greater number of ECT treatments.

Where additional treatments are sought, the doctor presenting the case would need to clearly outline the reasons for that request. Once the 12 treatments have been given, a new application would need to be made to the Tribunal for further treatments.

#### Duration of an order for ECT

An order for ECT made by the Tribunal has effect for six months from the date of the hearing unless a shorter period is specified or until the person ceases to be an involuntary patient.

### 11.6 MAINTENANCE ECT

*"Some patients may require treatment with continuation or maintenance ECT because other treatments have not been effective in preventing illness relapse. Continuation/maintenance ECT consists of further treatments given after the end of the acute treatment course, to prevent relapse. It typically ranges from an ECT treatment given every week to every few weeks".*

**Royal Australian and New Zealand College of Psychiatrists Position Statement 74**

For many of those receiving maintenance ECT, the treatment may enable them to live in the community and return to the mental health facility only for each specific ECT treatment. Some of these people may be able to be treated as voluntary patients who are able to give informed consent to this continuing form of treatment.

### ECT AND INVOLUNTARY PATIENTS AND ASSESSABLE PERSONS

All ECT for consumers who are involuntary patients, assessable persons or who are under the age of 16 requires prior authorisation by the Tribunal.



In other cases, the severity of the person's illness, their continuing condition and the likelihood of deterioration without maintenance ECT, means that their involuntary patient status may need to be extended throughout the course of treatment. However, as involuntary patients, the authorised medical officer should consider whether periods of leave can be granted (s47).

Where those receiving maintenance ECT are classified as involuntary patients, the approval of the Tribunal must be sought for this treatment (usually a course of 12 treatments at a time) and ongoing reviews of their involuntary patient status must be conducted.

### 11.7 ECT REGISTER

Each mental health facility, whether public or private, must keep a register that documents each administration of ECT treatment (s97). The information to be recorded is set out in the Mental Health Regulation.

It includes:

- date of treatment
- patient details
- names of medical personnel in attendance
- duration of the treatment, etc.

ECT Registers can be obtained from the NSW Health website <https://www.health.nsw.gov.au/mentalhealth/legislation/pages/forms.aspx>.

For further information on Electroconvulsive Therapy see <https://www.mhrt.nsw.gov.au> (under Civil Patients).

# Chapter 12

## GUARDIANSHIP, FINANCIAL MANAGEMENT AND THE MENTAL HEALTH ACT

There are circumstances in which mental health workers will need to take into account the *NSW Mental Health Act 2007*, the *Guardianship Act 1987* and the *NSW Trustee and Guardian Act 2009*. These pieces of legislation have been designed to be complementary and a guardianship order made under the Guardianship Act can coexist with an order made under the Mental Health Act. However, the Mental Health Act takes precedence where there is an inconsistency between the two orders.

Decisions about involuntary patients are made under the Mental Health Act. However, where an involuntary patient is already under a guardianship order, a copy of the guardianship order should be obtained from the person’s guardian. This will make it easier to keep the guardian appropriately informed about the patient’s care and treatment, and enable them to work with mental health staff in organising support services and accommodation in readiness for discharge. Where a guardian has been appointed, they are also a designated carer under

the Mental Health Act ([Guide Book, Chapter 4](#)).

Where a voluntary patient is admitted and already has a guardian, then the guardian can give consent to medical treatment during the admission, if the order gives them a medical consent function. However, the guardian can only consent if the patient is unable to consent to the particular treatment and consent is given in accordance with the Guardianship Act.

A person can also appoint their own guardian, called an enduring guardian. An enduring guardian only takes effect when the person lacks capacity. A copy of the appointment should be obtained from the enduring guardian. The enduring guardian should be consulted and informed about the patient’s care and treatment. Where an enduring guardian has been appointed, they are also a designated carer under the Mental Health Act.

### 12.1 WHAT DOES THE GUARDIANSHIP DIVISION OF THE NSW CIVIL AND ADMINISTRATIVE TRIBUNAL (NCAT) DO?

The Guardianship Division of the NSW Civil and Administrative Tribunal (NCAT), appoints guardians and financial managers for persons 16 years and over, who are incapable by reason of their disability (which may include mental illness as defined by the Mental Health Act), of making their own personal and financial decisions. It can also provide substitute consent to medical and dental treatment in situations where people are unable to consent for themselves (although in

practice, this only occurs in limited situations).

Whereas the Mental Health Act requires consideration to be given to the risk both to an individual and to the community if care and treatment is not given, the focus of the Guardianship Act is exclusively on the welfare and interests of the person with the disability.

The Guardianship Division of NCAT can only make a guardianship order if it is satisfied that the person to whom the order will apply has a disability that makes them incapable of making their own decisions, and there is a need to appoint a guardian to make these decisions. The guardian may be a private person or the Public Guardian.

The Guardianship Division usually gives the guardian one or more powers (called ‘functions’) to make decisions in specified areas of a person’s life, such as accommodation services or health care.

Before making a guardianship order, the Guardianship Division considers whether there are suitable informal arrangements that support the person with a disability. If so, there may be no need to make a guardianship order. (Further information about the Guardianship Division of NCAT: <https://www.ncat.nsw.gov.au>)

## 12.2 ADMISSION AND DISCHARGE OF A PERSON UNDER GUARDIANSHIP TO A MENTAL HEALTH FACILITY

### Involuntary admission

A person can only be involuntarily admitted to a declared mental health facility if the criteria for involuntary admission under the Mental Health Act are met. However, where a person is under guardianship or has an enduring guardian, a copy of the guardian's appointment or guardianship order should also be obtained.

Where a person is under guardianship, their guardian (including enduring guardian when the enduring guardianship is in effect) is a designated carer under the Mental Health Act, and must therefore be notified of all relevant aspects of the person's care and treatment ([Guide Book, Chapter 4](#)).

### Voluntary admission

A person under guardianship may be admitted under s7(1) of the Mental Health Act to a mental health facility as a voluntary patient at the request of their guardian (including their enduring guardian, when their enduring guardianship is in effect).

The mental health facility should obtain a copy of the enduring guardianship appointment or of the guardianship order, either from the guardian or the Guardianship Division of NCAT, so that they are aware of the scope of the guardian's authority. It should be noted that, despite having a guardian, if the patient is capable of consenting, you will

need to obtain the patient's consent for any treatment given. If the patient lacks capacity to consent, consent for treatment from the guardian should be obtained.

### Voluntary discharge

- A voluntary patient, whether under guardianship or not, may discharge themselves at any time (s8(2)).
- Notice of the discharge of a voluntary patient under guardianship must be given to the guardian (s8(3)).
- An authorised medical officer must discharge a person under guardianship who has been admitted as a voluntary patient if the person's guardian requests the discharge (s7(3)).
- Where it is considered that the person seeking discharge is either a 'mentally ill person' or a 'mentally disordered person', an authorised medical officer may detain the person ([Guide Book, Chapter 5.3](#)).

If a patient under guardianship has been voluntarily admitted on request of a guardian and seeks to be discharged without the agreement of the guardian, this is likely to raise a range of issues relating to the care and treatment of the patient and the interaction with the Guardianship Act. The mental health facility should discuss these matters with the patient's guardian and the Legal Branch at the Ministry of Health to ensure appropriate care and treatment.

## 12.3 USING GUARDIANSHIP IN THE AREA OF MENTAL HEALTH

Some people who fall outside the definitions of 'mentally ill' or 'mentally disordered' as defined by the Mental Health Act may nonetheless require care and treatment in a mental health facility. A person who does not meet these definitions, but who lacks the capacity to consent, can still be admitted as a voluntary patient on the request of their guardian. If the person does not have a guardian, or the guardian does not have the appropriate authority or function to request voluntary admission, then making an application to the Guardianship Division of NCAT to appoint a guardian may become particularly important. However, the patient's 'person responsible' may be able to consent to treatment, provided the patient does not object.

The Guardianship Division of NCAT can make a guardianship order where a person has a disability and due to that disability the person is incapable of managing their affairs. A disability under the NSW Guardianship Act can include:

- a mental illness within the meaning of the Mental Health Act, or
- an intellectual, physical, psychological or sensory disability.

In these instances, an application to the Guardianship Division of NCAT is usually made by the person's treating doctor or a family member, but may be made by anyone whom the Guardianship Division is satisfied has a genuine concern for the welfare of the person.



Where the matter is urgent, a hearing of the Guardianship Division may be arranged within a matter of days, but there must be sufficient time to allow for a proper investigation of the issues before the hearing takes place.

(For further information about making a guardianship application to the Guardianship Division of NCAT see: <https://www.ncat.nsw.gov.au>).

## 12.4 CONSENT TO MEDICAL TREATMENT

### Involuntary patients and detained persons

While a person is detained as a ‘mentally ill person’ or a ‘mentally disordered person’, an authorised medical officer can in most cases consent to any non-surgical treatment (including any medication) the person needs, even if they object to it (s84). Treatments such as ECT ([Guide Book, Chapter 11](#)) however, require the consent of the Tribunal ([Guide Book, Chapter 13](#) for further information on consent to surgery and special medical treatment). However, in all cases, the authorised medical officer should make all reasonable attempts to try and obtain the patient’s consent to treatment.

### Voluntary patients

Under the Act, consent must be obtained before providing any treatment to a voluntary patient. In addition, if special medical treatment within the meaning of the Act is proposed, the consent of the Tribunal is also required.

However, where a voluntary patient is not capable of consenting to their own treatment, the provisions of the Guardianship Act apply. The Guardianship Act has different rules as to who can consent to medical (or dental treatment) on behalf of a person who is over the age of 16. These rules are different depending on whether the treatment is considered non-urgent or an emergency and on the category of treatment.

### Non-urgent treatment for voluntary patients who lack capacity

In the case of non-urgent treatment for voluntary patients over the age of 16 who are incapable of consenting:

- in respect of ‘minor’ or ‘major’ medical or dental treatment, within the meaning of the Guardianship Act, the patient’s ‘person responsible’<sup>1</sup> or the Guardianship Division of NCAT can consent to treatment

- if the treatment is ‘minor’ and no ‘person responsible’ can be located, the doctor may treat the person without their consent, provided the doctor (or dentist) certifies in writing on the patient’s record that the treatment is necessary and will improve the patient’s health and wellbeing, and that the patient does not object
- special medical treatment within the meaning of Mental Health Act requires the consent of the Tribunal. For other forms of special treatment (within the meaning of the Guardianship Act), the consent of the Guardianship Division of NCAT is required.

If the person who is incapable of giving consent objects, then only the Guardianship Division of NCAT or a guardian with special authority can consent to treatment overriding those objections.

## CASE STUDY

Janine is a 56-year-old woman suffering from alcohol related brain damage who has had a stroke. She usually lives at home but has periods when she needs the care and supervision offered by the local mental health facility, although she does not have a mental illness. Her daughter applies to the Guardianship Division of NCAT to be appointed as her guardian. The Guardianship Division appoints Janine’s daughter as her guardian with an accommodation and medical and dental consent functions. Janine’s daughter requests the voluntary admission of her mother to the local mental health facility where she receives treatment and care on a short-term basis.

After a few days, Janine wants to leave the mental health facility although both the treating team and Janine’s guardian believe it would be beneficial for her to stay. The treating team should discuss Janine’s on-going care and treatment with Janine, her guardian and the Legal Branch at the Ministry of Health to ensure appropriate on-going care and treatment for Janine.

<sup>1</sup> Further information about ‘person responsible’ and the different categories of urgent, minor, major, special medical treatment see Guardianship Division Fact Sheets: [https://www.ncat.nsw.gov.au/Documents/gd\\_factsheet\\_consent\\_to\\_medical\\_or\\_dental\\_treatment.pdf](https://www.ncat.nsw.gov.au/Documents/gd_factsheet_consent_to_medical_or_dental_treatment.pdf).

The Guardianship Act sets out stringent requirements in relation to the information that must be provided to the patient’s ‘person responsible’<sup>1</sup> or the Guardianship Division of NCAT. These requirements must be complied with.

For voluntary patients under 16 who lack the capacity to consent, consent can be obtained from the child’s parents (except in the case of special medical treatment within the meaning of the Children and Young Persons (Care and Protection) Act).

**Emergency treatment**

Where a patient over 16 lacks capacity, in an emergency, medical treatment can be carried out without consent if the doctor (or dentist) considers the treatment necessary, as a matter of urgency:

- to save the patient’s life
- to prevent serious damage to the patient’s health
- except in the case of ‘special medical treatment’; to prevent the patient from suffering or continuing to suffer significant pain or distress.

A medical or dental practitioner can carry out medical or dental treatment on a person under 18 if the treatment is necessary, as a matter of urgency, to save the child or young person’s life or prevent serious damage to their health.

**Identifying a ‘person responsible’**

A ‘person responsible’ is either:

- a person with parental responsibility for a child (over the age of 16)
- a guardian (including enduring guardian) who has been given the function of consenting to medical and dental treatments, or, if there is no guardian
- a spouse or de facto spouse (including same sex partners) with whom the person has a close, continuing relationship, or, if there is no spouse or de facto spouse
- an unpaid carer who was providing support to the person before their admission, or, if there is no carer
- a close relative or friend of the person.

**12.5 FINANCIAL MANAGEMENT AND THE NSW TRUSTEE AND GUARDIANSHIP ACT 2009**

The area of financial management can be difficult for people with a mental illness. Under the *NSW Trustee and Guardian Act 2009*, a number of bodies can make orders for financial management including Magistrates, the Supreme Court, and the Tribunal. The Guardianship Division of NCAT can also make financial management orders under the *NSW Guardianship Act 1987*.

Under the NSW Guardianship Act, the Guardianship Division of NCAT can:

- appoint a private person or the NSW Trustee as the financial manager
- make orders subject to a specified review period
- exclude part of the person’s estate from management
- review its own order and replace a manager
- review its own order and revoke it if the person has regained capacity, or it is considered to be in the person’s best interests.

This flexibility means that where financial management is an issue for a person with a mental illness, it may be better dealt with by the Guardianship Division of NCAT rather than by the Tribunal (as the Tribunal has less flexible options).

However, where an order has already been made by one of the other bodies, the Guardianship Division of NCAT cannot hear an application while that order is still in effect. However, once an order made by another body has expired or has been revoked, an application can be made to the Guardianship Division of NCAT.

## 12.6 FINANCIAL MANAGEMENT AND THE MENTAL HEALTH ACT

The Tribunal can also make financial management orders under the NSW Trustee and Guardian Act. Such orders can only be made where a person is a patient in a mental health facility.

The general principles to be considered when applying this Act include (s39):

- giving paramount consideration to the welfare and interests of the person
- restricting the freedom of decision and action of the individual as little as possible
- encouraging the person to live a normal life in the community as far as possible
- considering the views of the person
- recognising the importance of preserving the person’s family relationships and cultural and linguistic environment
- encouraging the person to be self-reliant regarding their personal, domestic and financial affairs as far as possible, and
- ensuring that the person is protected from abuse, neglect and exploitation.

At a mental health inquiry, the Tribunal must make a financial management order in relation to an involuntary patient where they decide that the person is not capable of managing their affairs (NSW Trustee and Guardianship Act s44).

The Tribunal may also consider the issue of a patient’s capacity to manage their affairs when an application is made by a person who has in the opinion of the Tribunal a sufficient interest in the matter (NSW Trustee and Guardianship Act s46).

### CASE STUDY

John has a diagnosis of schizophrenia, and has been on a community treatment order for the last 18 months. While John has been taking his medication regularly, for the last six months he has been spending his pension on the same day he receives it. This has made it very difficult for him to retain stable accommodation, which has in turn led to a marked deterioration in his condition. John’s parents approached the Guardianship Division of NCAT for orders in relation to guardianship and financial management.

The Guardianship Division did not believe that a guardianship order was necessary. However, they did make a financial management order that enables the NSW Trustee and Guardian to manage John’s finances and pay his regular bills, such as rent and electricity. This order will be reviewed in two years by the Guardianship Division to see if John still requires this assistance.

The Tribunal may make a Financial Management Order in relation to:

- a voluntary patient
- a person on an involuntary patient order
- an assessable person.

#### Who can apply for a financial management order?

Any person with a sufficient interest, such as staff of mental health facilities, case managers, family members, or any person who might be affected by the decision, can apply to the Tribunal asking them to consider the person’s ability to manage their finances. In most cases, the applicant will be an authorised medical officer at the mental health facility where the person is a patient.

#### What does the Tribunal consider?

The Tribunal must decide whether the person is capable of managing their own financial affairs. If they decide that the person is not capable of

managing their own affairs, then an order will be made appointing the NSW Trustee as the person’s financial manager. An order for financial management can be in relation to the whole or only part of the person’s estate.

#### How long do these orders last?

The Tribunal may make either:

- an order without a time limit that remains in place until it is formally revoked, or
- an interim order.

An interim order is made for a specific period of up to six months. It is made to allow further evidence to be gathered so that the Tribunal can determine the patient’s capability to manage their affairs. If the interim order is not reviewed, or the review is not commenced prior to the expiry date, it is automatically revoked.



**Preparing for the hearing**

When notifying a person about an upcoming mental health inquiry, an authorised medical officer is required to give the person information about the Tribunal’s role in determining their capacity to manage their affairs.

The person must be informed of:

- their right to be represented by a barrister or solicitor
- their right to appeal to the Supreme Court or the NSW Civil and Administrative Tribunal if the decides that their affairs should be managed by the NSW Trustee and Guardian
- their right to ask the medical superintendent to arrange for the NSW Trustee and Guardian to manage their affairs if they so wish (Schedule 1 NSW Trustee and Guardian Regulations).

As there are significant implications for a person once a financial management order is made, it is important to have accurate and clearly documented evidence of the person’s financial position.

Supporting documentation should be provided including:

- details of the person’s assets and liabilities
- copies of outstanding accounts
- bank statements
- letters from creditors
- other financial papers.

All the reports in relation to applications for financial management orders must address the question as to whether or not the person is capable of managing their own financial affairs.

**Appeals against a financial management order**

Appeals can be made to either the Supreme Court or the NSW Civil and Administrative Tribunal. Where a person wishes to appeal, they should be referred to the Mental Health Advocacy Service for advice on how to lodge an appeal ([Guide Book, Chapter 3.3](#)).

**Revoking a financial management order**

The Tribunal can only revoke an order that it has made. The Tribunal can only revoke an order if it is satisfied that:

- the protected person is capable of managing their own affairs, or
- the revocation is in the best interests of the protected person.

Only the person subject to the financial management order can apply to have it revoked. They may apply either while they are still a patient in a mental health facility or when they have been discharged.

**INTERIM FINANCIAL MANAGEMENT ORDERS**

An interim order may be appropriate when there is an urgent need to protect a patient’s estate from being dissipated, or there is a risk of financial exploitation. These orders are generally made to enable the relevant evidence relating to the person’s capability to manage their financial affairs to be gathered. Where an interim order is made, the Tribunal will set down a date at which the matter can be considered and a decision made. This subsequent hearing can, of course, only proceed if the person is still a patient (either voluntary or involuntary).



Some of the factors the Tribunal takes into account when deciding whether or not to revoke a financial management order may include:

- the size and nature of the person’s estate
- any outstanding debts
- how the person’s estate will be managed if the order is revoked
- whether the person has developed skills in managing some of their estate and/or whether they could be supported to do so by informal means
- the person’s financial goals or objectives
- the person’s willingness to seek advice, support or information from a financial counsellor or accountant where appropriate
- the person’s current mental state
- whether the financial management order is having a negative impact on the person’s social, psychological, or physical wellbeing
- the NSW Trustee and Guardian’s view as to whether the revocation is appropriate
- the likely impact of the revocation on the person’s recovery
- whether the revocation might encourage the person’s independence or self-reliance in their financial, personal and domestic arrangements.

Where the Tribunal has revoked a financial management order, an application can be made to the Guardianship Division of NCAT to seek the appointment of a family member or friend as the person’s financial manager where this is considered to be appropriate.

For further information on Financial Management Orders see <https://www.mhrt.nsw.gov.au> (under Civil Patients)

### CASE STUDY



When Joan was in hospital in 2012, a financial management order was made by the Tribunal, and the management of her affairs was taken over by the NSW Trustee and Guardian. While Joan is no longer a patient, her illness remains chronic and she requires a high level of care and support which is provided by her family.

Joan’s family are unhappy about the quality of financial management being provided by the NSW Trustee and would like to manage Joan’s financial affairs themselves. Joan makes an application to the Tribunal for a revocation of the order. While Joan cannot demonstrate her capacity to manage her own affairs, her family are able to show that there are informal systems in place to assist Joan in the management of her affairs and that it is in Joan’s best interests for the order to be revoked.

# Chapter 13

## CONSENT TO SURGERY OR SPECIAL MEDICAL TREATMENT

### 13.1 WHAT IS SURGERY UNDER THE MENTAL HEALTH ACT?

A surgical operation is defined as a surgical procedure, a series of related surgical operations or surgical procedures, and the administration of an anaesthetic for the purpose of medical investigation (s98).

Examples of surgical operations include cholecystectomy, repair of inguinal hernia, and procedures requiring a general or local anaesthetic. Surgical termination of pregnancy is also considered to be a surgical operation under the Mental Health Act, 2007. However, where the Guardianship Act 1987 applies, surgical termination of pregnancy is considered to be special treatment within the meaning of the Guardianship Act.

The definition of 'surgical operation' in the Mental Health Act does not, however, include 'special medical treatment', which includes procedures that are designed to or are reasonably likely to cause a person to become permanently infertile ([Guide Book, Chapter 13.4](#)).

The surgical provisions in the Mental Health Act only apply to involuntary patients. They do not apply to assessable persons or voluntary patients ([Guide Book, Chapter 2.5](#)). If a voluntary patient or assessable person who lacks capacity requires surgery, the provisions of the Guardianship Act apply. However, the provisions relating to special medical treatment, within the meaning of the Mental Health Act, apply to all patients.

### 13.2 CONSENT TO EMERGENCY SURGERY FOR INVOLUNTARY PATIENTS (S99)

An authorised medical officer or the Secretary of the NSW Ministry of Health may consent, in writing, to emergency surgery on an involuntary patient where:

- informed consent cannot be obtained from the person (due to incapacity or unwillingness to give consent), and
- the surgery is necessary, as a matter of urgency, to save the person's life or prevent serious damage to their health, or prevent ongoing pain or distress.

The authorised medical officer of the mental health facility must inform the designated carer(s), principal care provider and the Tribunal of the performance of the operation as soon as practicable. A decision to proceed with emergency surgery should be clearly documented in the person's hospital records along with the reasons for this decision.

### 13.3 CONSENT TO NON-EMERGENCY SURGERY FOR INVOLUNTARY PATIENTS (S100)

If the surgery is not an emergency, an authorised medical officer can apply to the Secretary or to the Tribunal for consent to the performance of a surgical operation on an involuntary patient, depending on the agreement or not of a designated carer.

The following procedures apply:

- inform the designated carer(s) in writing
- wait for 14 days for a response from the designated carer(s) (or such lesser period as set out below).

Where the designated carer agrees in writing, then an application is made to the Secretary for consent to the surgery.

The Secretary may consent if they are of the opinion that:

- the patient is not capable of consenting, and
- the surgery is desirable, having regard to the interests of the person.

An application may, however, be made to the Secretary for consent before the 14-day period has elapsed, where:

- the authorised medical officer is of the opinion that the urgency of the circumstances require an earlier determination, or
- the designated carer notifies that they do not object to the surgery.

**THE SECRETARY HAS DELEGATED THESE CONSENT FUNCTIONS TO SENIOR OFFICERS WITHIN THE NSW MINISTRY OF HEALTH**

To obtain consent from the delegate, contact the Mental Health Branch by phone 02 9461 7243.



Where neither of the designated carers (if more than one has been nominated) agree in writing to the proposed surgery within 14 days (or a designated carer cannot be identified), or the involuntary patient has capacity but is refusing to consent, an authorised medical officer can apply to the Tribunal for consent.

The Tribunal may consent where it is of the opinion that:

- the person is incapable of consenting, or is capable but refuses to give to consent, and
- the surgery is desirable, having regard to the interests of the person.

As with the Secretary, an application for consent may be made to the Tribunal before the 14-day period has elapsed where:

- the authorised medical officer is of the opinion that the matter is urgent, or
- the designated carer notifies that they do not object to the surgery.

**13.4 CONSENT TO SPECIAL MEDICAL TREATMENT FOR INVOLUNTARY PATIENTS (S102 & S103)**

While the Mental Health Act allows other treatments to come under this category, at present for persons 16 years of age and over, special medical treatment only refers to sterilisation procedures, or any treatment or procedures that are reasonably likely to result in a person becoming permanently infertile. For persons under 16, there are different requirements and a broader definition of special medical treatment. These requirements are detailed under the Children and Young Persons (Care and Protection) Act 1998 [https://www.austlii.edu.au/cgi-bin/viewdb/au/legis/nsw/consol\\_act/caypapa1998442/](https://www.austlii.edu.au/cgi-bin/viewdb/au/legis/nsw/consol_act/caypapa1998442/).

It is an offence to carry out special medical treatment in respect of a person 16 years of age or over, unless:

- a medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment to save the person's life or prevent serious damage to their health, or
- the Tribunal consents.

It is an offence to carry out special medical treatment on a child under 16 years of age, unless it is carried out in accordance with the Children and Young Persons (Care and Protection) Act (s175).

NSW Health Policy Directive PD2005\_406 - Consent to Medical Treatment - Patient Information, also includes details on special medical treatment in relation to children - This policy can be accessed on the NSW Health website <https://www.health.nsw.gov.au/policies/Pages/default.aspx>

The Tribunal may consent to this treatment being given to a patient where it is satisfied that:

- it is necessary to prevent serious damage to the person's health
- the person is 16 years of age or over.

The authorised medical officer must notify the person's designated carer(s) of the intention to seek consent for special medical treatment.

At least 14 days must elapse after the notice is given to the designated carer(s) before an application is made to the Tribunal unless:

- a designated carer notifies that they do not object to the special medical treatment, or
- the authorised medical officer is of the opinion that the urgency of the circumstances requires an earlier determination.

### 13.5 CONSENT TO SURGICAL TREATMENT FOR VOLUNTARY PATIENTS AND ASSESSABLE PERSONS

In general, a voluntary patient must consent to their own treatment, including consent to surgical treatment ([Guide Book, Chapter 5](#)). However, if special medical treatment within the meaning of the Mental Health Act is proposed, the consent of the Tribunal is also required (unless it is an emergency).

In respect of assessable persons, where the assessable person has capacity, consent to surgical treatment must be obtained from the assessable person. However, if special medical treatment within the meaning of the Act is proposed, the consent of the Tribunal is also required (unless it is an emergency).

Where surgical treatment is sought in relation to a voluntary patient or assessable person who lacks the capacity to consent, the provisions of the Guardianship Act apply. Consent can be obtained from a 'person responsible' or an application can be made to the Guardianship Division of the NCAT. If special medical treatment within the meaning of the Mental Health Act is proposed, the consent of the Tribunal is required (unless it is an emergency).

Where a voluntary patient has capacity to consent, they are free to consent or refuse to consent to treatment.

For further information see: <https://www.mhrt.nsw.gov.au> (under Civil Patients)



# Chapter 14

## TRANSPORT BY HEALTH SERVICE STAFF, POLICE, AMBULANCE OFFICERS (PARAMEDICS)

The transport and management of a person with a mental illness or mental disorder at times requires a coordinated response by mental health staff, ambulance and police to ensure that:

- the person receives appropriate care, and
- the safety of the person, staff, and the community is protected.

While the Act provides the legislative framework for the allocation of responsibility, it is the Memorandum of Understanding between the Ministry of Health (including NSW Ambulance) and the NSW Police Force that “guides how these agencies will work together when delivering services to people with mental health problems.” (NSW Health – NSW Police Force Memorandum of Understanding 2018)

Staff across these agencies are expected to work collaboratively in implementing the following principles which underpin the operation of the MOU:

- A commitment to ensure that people are treated with dignity and respect and that services are provided in a confidential environment

- A commitment to respond to incidents and to provide services in a manner that is least restrictive, consistent with the person’s clinical and safety needs and the circumstances at the time
- A commitment to work together to ensure that people with mental illness have timely access to appropriate care and treatment in a safe environment
- Every effort will be made to involve people with a mental illness or mental disorder and their carers where relevant, in the development of treatment and recovery plans and to consider their views and expressed wishes in that development. This includes obtaining the person’s informed consent when collaboratively developing treatment and recovery plans, monitoring their capacity to consent and supporting those who lack capacity to understand their plans.
- A commitment to respond to people in a mental health emergency with the same urgency as a physical health emergency
- Age, gender, religious, cultural, language and other significant factors would be recognised and accommodated if possible in the circumstances
- Wherever possible the care and treatment of people with a mental illness should aim to support the person to live, work and participate in the community
- All interventions will be in keeping with the Mental Health Act

- Local MOU Committees will support the operational effectiveness of the MOU and timely issue resolution.

MOU: <https://www.health.nsw.gov.au/legislation/Pages/agreements.aspx>

FAQ: <http://internal.health.nsw.gov.au/communications/police/mou-faqs.html>

The following, however, sets out the legislative provisions that relate to the safe transport of a mentally ill or mentally disordered person.

### 14.1 INVOLUNTARY ADMISSIONS

Both ambulance officers (paramedics) (s20) and police officers (s22) have independent powers to take a person to a declared mental health facility against their will for the purpose of a mental health assessment ([Guide Book, Chapter 6.1](#)).

### 14.2 TRANSPORT PROVISIONS

#### General transport provisions (s81)

The 2007 Act introduced specific provisions relating to transport, sedation, and searches (s81). A person may be taken to or from a mental health facility or transported between appropriate health facilities by:

- a member of staff of the NSW Health Service (including an accredited person appointed to a public health organisation)
- an ambulance officer (paramedic)
- a police officer
- a person prescribed by the regulations

(includes a person who provides a transport service approved by the Secretary for the purposes of s 81).

Any of these may:

- use reasonable force, and
- restrain the person in any way that is reasonably necessary in the circumstance. Any need to restrain the person must take place in accordance with the NSW Ministry of Health’s policy – Aggression, Seclusion and Restraint in Mental Health Facilities in NSW – PD2012\_035 – This policy can be accessed on the NSW Health website <https://www.health.nsw.gov.au/policies/Pages/default.aspx>

During transportation a person may be sedated:

- by a person authorised by law to administer a sedative
- if it is necessary to ensure the person’s safety.

A frisk search or ordinary search may be carried out when someone is being transported and where there is a reasonable suspicion that the person is carrying anything:

- that would present a danger to the person or another, or
- that could be used to assist the person to escape.

Any such object can be seized and detained.

The Act defines a frisk search as:

- a search of a person conducted by quickly running the hands over the person’s outer clothing or by passing an electronic metal detection device over or in close proximity to the person’s outer clothes, or
- an examination of anything worn or carried by the person that is conveniently and voluntarily removed by the person, including an examination conducted by passing an electronic metal detection device over or in close proximity to that thing.

The Act defines an ordinary search as:

- a search of a person or of articles in the possession of the person that may include requiring the person to remove their overcoat, coat, jacket or similar article of clothing and any gloves, shoes, socks and hat, and any examination of those items.

**Police assistance in transport**

Police can be called upon to assist in transporting a person to a declared mental health facility where:

- a medical practitioner or accredited person who has completed a Schedule 1 has serious concerns about the safety of the person or others if the person is transported without police assistance (s21)
- an ambulance officer is of the opinion that there are serious concerns relating to the safety of the person or others in getting the person to a declared mental health facility (s20).

Where the police receive a request for assistance they must, if practicable:

- either take or assist in taking the person to a declared mental health facility, or
- arrange for another officer to do so.

Where the police become involved because of their own concerns about a person’s mental state ([Guide Book, Chapter 6.1](#)), or where they have received a request for assistance, they may enter premises without a warrant.

**Police involvement in CTO breaches (s59)**

If a mental health worker cannot implement a breach order, it may be given to the police.

The police:

- must if practicable apprehend and take or assist in taking the person to the appropriate mental health facility
- may use reasonable force to enter premises without a warrant, apprehend the person, and transport them to the appropriate mental health facility.

**Police involvement where a person is absent without leave from a mental health facility (s49)**

An authorised medical officer may request that a police officer apprehend, or assist in apprehending, a person who is absent without leave where there are serious concerns about the person’s safety or the safety of others.

The police in these circumstances may:

- apprehend or assist in the apprehension of the person
- enter premises and apprehend the person without a warrant
- return the person to the mental health facility.

# Chapter 15

## GROUPS WITH PARTICULAR NEEDS UNDER THE MENTAL HEALTH ACT

While the provisions of the Act apply generally to people within NSW, some groups require an additional level of service and attention for the objective of ‘the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given’ (s68(a)) to be achieved.

### 15.1 YOUNGER CONSUMERS

The Act in general applies to children (those under 18) who come within the definitions of a ‘mentally ill person’ or a ‘mentally disordered person’. The Act also specifies, under the principles for care and treatment (s68(g1)), that those under the age of 18 should receive developmentally appropriate services.<sup>1</sup> It also contains some specific provisions that are dealt with in this Chapter.

While the use of the coercive powers of the legislation may at times be necessary, it is important to provide opportunities for a young consumer to exercise meaningful choice wherever possible. In assessing and treating young people

who are mentally ill or have a mental disorder, mental health clinicians should apply the NSW Ministry of Health policy: Child and Adolescents with Mental Health Problems Requiring Inpatient Care – Policy PD2011\_016 – This policy can be accessed on the NSW Health website <https://www.health.nsw.gov.au/policies/Pages/default.aspx>

#### Involuntary admission

Young people can be admitted as involuntary patients in the same way as adults ([Guide Book, Chapter 6](#)). However, it may be possible in some cases to achieve the necessary care and treatment through a voluntary admission with the consent and cooperation of the parent(s).

#### Voluntary admission (s6)

The Act contains the following specific provisions in relation to the voluntary admission of children:

- if the child is under 16 years of age, the authorised medical officer must notify the parent as soon as practicable of the voluntary admission
- if the child is 14 or 15 years of age, the authorised medical officer must discharge the patient if a parent objects, unless the patient elects to continue as a voluntary patient
- if the child is under 14 years of age, parental consent is essential for a voluntary admission to proceed
- if the child is under 14 years of age, the authorised medical officer must discharge them if there is a request from a parent to do so.

#### ECT for those under 16 years of age

Where an application is made for ECT for a young person under the age of 16 years, one of the two medical certificates required must be completed by a psychiatrist with expertise in the treatment of children and adolescents. The Tribunal must also give its consent to the treatment regardless of whether the young person is a voluntary or involuntary patient, and regardless of whether or not they are able to give informed consent ([Guide Book, Chapter 11.4](#)).

#### Nomination of a designated carer

The designated carer of a child (i.e. under 18 years of age) is generally the parent. Where the child is over the age of 14 they may nominate someone other than a parent as their designated carer. However, where the child is between the ages of 14 and 18 years of age, the Act states that a parent may not be excluded from receiving notice or information about the child (s72(3)).

#### Rights of young people under the Act

Young people in general have the same rights as adults under the Act ([Guide Book, Chapter 3](#)). However, the Act specifies that persons under 16 years of age must be legally represented, or represented by another person of their choice with the approval of the Tribunal, in all matters before the Tribunal, unless the Tribunal decides that it is in their best interests to proceed without such representation. Children’s inexperience can add another layer of complexity in considering how they can best be assisted to understand and exercise those rights.

<sup>1</sup> Under the *Children and Young Persons (Care and Protection) Act 1998*, a child is a person under the age of 16 years; a young person is a person under the age of 18 years.

**Reporting requirements where concerns about harm from abuse or neglect arise<sup>1</sup>**

If it is suspected that a child or young person may be at risk of significant harm, a health worker should make a suspected risk of harm report to the Child Protection Mandated Reporters Helpline (133 627). Where the risk of harm is not imminent health workers may make an e-report to the Child Protection Helpline. Health workers must make a report to the Helpline where they suspect that a child is at risk of significant harm.

Health workers are mandatory reporters under the *Children and Young Persons (Care and Protection) Act 1998*. Health workers may call the NSW Health Child Wellbeing Unit for assistance in identifying the level of risk to a child or young person, and whether concerns for a child or young person meet the statutory threshold for making a report to the Child Protection Helpline.

When contacting the NSW Health Child Wellbeing Unit and/or the Child Protection Helpline it is recommended, wherever possible, that health workers also consult the NSW Mandatory Report Guide. Where concerns for a child or young person do not meet the threshold for making a report to the Child Protection Helpline, the NSW Health Child Wellbeing Unit may assist health workers by providing advice about service responses, the coordination of service systems,

and information exchange where there are safety, welfare, and wellbeing concerns about children and young people.

**15.2 OLDER CONSUMERS**

The Mental Health Act contains no specific provisions for the care and treatment of older consumers, though psychological disorders occur and recur in older people. It may be necessary at times to use the powers of the Act to involuntarily detain an older person or place them on a community treatment order.

Conditions such as dementia and delirium, which occur more often in older people, can cause difficulties in the application of the Act. However, as with any person being assessed for potential admission, consideration should always be given to the definitions of a mentally ill or mentally disordered person ([Guide Book, Chapter 2](#)). It may also be important to consider whether the Act should be used to transfer an older person to a declared mental health facility, or whether to apply for a community treatment order that will enable effective care and treatment to be provided in the less restrictive environment of the community.

At the time of the initial assessment, it may not be possible to know whether an older person is suffering from dementia, delirium or another

mental illness (such as late onset schizophrenia). Urgent admission for assessment may be necessary and may be possible on the basis that the person is a ‘mentally disordered’ or ‘mentally ill’ person. If the subsequent diagnosis is one of delirium or dementia without any symptoms consistent with the person being mentally ill or mentally disordered, a decision must be made as to whether the use of the NSW Trustee and Guardianship Act 2009 is required. A clear understanding of the relationship between the *NSW Trustee and Guardianship Act and the Mental Health Act* is crucial for those working with older consumers ([Guide Book, Chapter 12](#)).

There are many social and medical factors associated with old age that add to the complexity of diagnosis and effective treatment for this group. It is particularly important that a thorough mental health assessment be conducted in consultation with those with expertise in older people’s degenerative illnesses and other conditions. Specialised Mental Health Services for Older People (SMHSOP) are available in many areas and Aged Care Assessment Teams (ACATs) are located throughout NSW. A list of NSW ACATs can be found at <https://www.myagedcare.gov.au>

In working with older consumers reference should also be made to NSW Older People’s Mental Health Services SERVICE PLAN 2017-2027 which can be accessed on the NSW Health website <https://www.health.nsw.gov.au/policies/Pages/default.aspx>

<sup>1</sup> For further information about health workers child protection responsibilities see the Child Wellbeing and Child Protection Policies and Procedures for NSW Health: [https://www.health.nsw.gov.au/policies/pd/2013/pdf/PD2013\\_007.pdf](https://www.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf); and for guidance on interagency cooperation in child protection see the Child Wellbeing & Child Protection – NSW Interagency Guidelines: <https://www.community.nsw.gov.au/kts>.

### 15.3 CULTURAL ISSUES

The Act specifies that the religious, cultural and language needs of consumers be recognised and taken into account throughout the different stages of their care and treatment, and that they be informed of their legal rights and entitlements in ‘the language, mode of communication or terms that they are most likely to understand’ (s68(i)). The Act also specifies that the cultural and spiritual beliefs of those who are Aboriginal persons or Torres Strait Islanders should be considered during their mental health assessment and treatment (s68(g2)).

Even where language is not an obstacle, aspects of cultural difference may have a profound impact on assessment and treatment issues. Aboriginal mental health workers and Transcultural mental health workers can provide:

- information about cultural, political or religious aspects of an assessment
- advice about a consumer who is reluctant to work with a mainstream clinician
- referral to community support services or bilingual mental health professionals
- consultation on cross-cultural skills
- consultation regarding diagnosis and care planning (see Appendix 5).

#### Aboriginal consumers and Torres Strait Islander consumers

In working with Aboriginal consumers and Torres Strait Islander consumers, the principles outlined in *NSW Aboriginal Mental Health and Well Being Policy 2006 - 2010* still apply. This policy can be accessed on the NSW Health website <https://www.health.nsw.gov.au/policies/Pages/default.aspx>

The current policy outlines the following principles:

#### Respect and Responsibility

- All mental health staff will treat all Aboriginal clients with respect and with sensitivity to the cultural, spiritual, historical, family and community factors that influence their social and emotional wellbeing.
- The mental health needs of Aboriginal people and their communities are a core responsibility of mental health teams and services and of the full range of staff employed in these services: Aboriginal clients and their families have the right to access all mental health services.
- Aboriginal people and their families are to be provided with information about their rights and needs and responsibilities and are to be involved in decisions related to their care.
- The safety of individuals and their families is to be considered a key priority of mental health service delivery to Aboriginal communities.

#### Choice

- Aboriginal clients are to be provided with a choice of services that includes Aboriginal service providers and that closely involves families or carers. Aboriginal people are to be offered a range of service options including, when appropriate and available, shared care arrangements between specialist mental health services and an ACCHS.

#### Appropriate services

- Assessment, diagnosis, treatment and care of Aboriginal clients is to be conducted within an holistic and culturally sensitive and appropriate model of care. It is essential to address, through service delivery or referral, the full range of needs of the client.
- The relationship between mental health and health enhancing behaviours is to be considered integral to the mental health assessment and interventions provided to Aboriginal clients.
- Mental health services are responsible for providing a comprehensive assessment to Aboriginal people with mental health and substance use problems and for the delivery of treatment services, coordinated with drug and alcohol and other health services.
- Distress in Aboriginal people, including despair, anger, grief, loss or trauma, is to be addressed by the provision of culturally sensitive interventions and partnership work with a range of agencies.

- Data collection, research and service development are subject to the principles of the NSW Aboriginal Health Partnership Agreement 2015-2025. This work should occur under the Partnership Agreement and in partnership with Aboriginal people and under that Agreement.

**Culturally and Linguistically Diverse (CALD) consumers**

A number of studies have established that CALD consumers have higher rates of:

- involuntary admission
- police involvement
- ECT
- community treatment orders.

Second language competency may also decrease dramatically in times of crisis. The difficulties and trauma associated with an episode of mental illness can often exacerbate language difficulties, even when a consumer is normally quite confident and fluent in English.

The implementation of practical measures to address language and cultural barriers throughout the assessment, admission and treatment process is therefore essential. This can be achieved through the use of:

- interpreters
- cross-cultural consultants.

The Mental Health Act makes specific reference to the consideration of cultural factors in relation to mental health inquiries with due regard to:

- any cultural factors relating to the consumer that may be relevant
- any evidence given at the inquiry by an expert witness concerning the consumer’s cultural background and its relevance to any question of mental illness (s35(2)).

**Use of interpreters**

Interpreters must be used when necessary:

- at medical examinations under the Act (s70)
- to explain the consumer’s rights under the Act (s68 & s74(5))
- to obtain informed consent, e.g. to procedures such as ECT (s92(2(j)))
- at mental health inquiries and other Tribunal hearings (s158).

Interpreters and/or bilingual mental health professionals should be involved with:

- the examination process prior to admission as either a voluntary or involuntary patient
- ongoing consultations with treating doctors
- informing relatives and carers about aspects of the consumer’s care and treatment
- the development of a discharge plan
- the use of a community treatment order.

**Booking an interpreter**

Each Local Health District has a Health Care Interpreter Service. When making a booking, the following information should be provided:

- country of birth
- language required (and dialect where appropriate)
- consumer’s name
- name and contact details of mental health professional
- location and anticipated duration of the booking
- preferred gender of the interpreter.

If the Local Health District Interpreting Service is unable to provide a service at the time required, the Telephone Interpreter Service is available 24 hours a day, 7 days a week on 131 450.

# Appendices

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# Appendix 1

## AMENDMENTS TO THE MENTAL HEALTH ACT 2007

Information Bulletin: IB2018\_025:

[https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2018\\_025.pdf](https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2018_025.pdf)

Information Bulletin: IB2015\_040:

[https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2015\\_040.pdf](https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2015_040.pdf)

PDFs attached overleaf.



## Information Bulletin



## Amendments to the Mental Health Act 2007 and the Mental Health (Forensic Provisions) Act 1990

**Summary** The Mental Health Act 2007 and the Mental Health (Forensic Provisions) Act 1990 recently underwent changes as part of the Health Legislation Amendment Bill 2017 that passed parliament in February 2018. This Information Bulletin sets out the amendments to the Mental Health Act 2007 and the Mental Health (Forensic Provisions) Act 1990.

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**Branch contact** (02) 9391 9262

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**Policy manual** Not applicable

**File number** H18/50237

**Status** Active

**Functional group** Clinical/Patient Services - Governance and Service Delivery, Mental Health

**Applies to** Local Health Districts, NSW Ambulance Service, Private Hospitals and day Procedure Centres, Public Health Units, Public Hospitals, Specialty Network Governed Statutory Health Corporations

**Distributed to** Ministry of Health, Public Health System

**Audience** Administration, Clinical mental health staff, Emergency departments, Mental health facilities

Secretary, NSW Health



## AMENDMENTS TO THE MENTAL HEALTH ACT 2007 AND THE MENTAL HEALTH (FORENSIC PROVISIONS) ACT 1990

### PURPOSE

The *Mental Health Act 2007* and the *Mental Health (Forensic Provisions) Act 1990* have recently been amended as part of the Health Legislation Amendment Bill 2017 that passed parliament in February 2018. This Information Bulletin sets out the amendments to the *Mental Health Act 2007* and the *Mental Health (Forensic Provisions) Act 1990*. These legislation changes commence on 1 July 2018.

### KEY INFORMATION

The key changes to the *Mental Health Act 2007* are outlined below:

#### **Mental Health Review Tribunal hearings in the absence of patients (Sections 37, 63 and 96):**

The Mental Health Review Tribunal (the Tribunal) can now conduct a review of an involuntary patient, a detained affected person, or an application for electro-convulsive therapy (ECT), in the absence of a patient, if:

- the authorised medical officer applies to have the review or ECT application carried out in the absence of the patient because the patient is too unwell to attend or because the patient has refused to attend, and
- the Tribunal is satisfied that the person has refused to attend or is (or will likely be) too unwell to attend within a reasonable period, and
- the person's representative (being an Australian legal practitioner or other person approved by the Tribunal to represent the person at the hearing) has been notified, and
- the Tribunal has considered the views (if known) of the person, the person's representative, the designated carer of the person and the principal care provider of the person (see changes below to s78 in respect of notifying carers of hearings before the Tribunal), and
- the Tribunal is of the opinion that conducting the hearing in the absence of the person is desirable for the safety or welfare of the person.

In the case of an ECT inquiry the Tribunal is not required to be satisfied that the person's representative has been notified if the Tribunal is satisfied that reasonable steps have been taken to notify the representative.

Every reasonable effort should be made to bring the patient before the Tribunal for all such hearings. The applications to hold a hearing in the absence of the patient should only be made where there is no other viable and safe alternative (such as seeking an adjournment). The authorised medical officer must comply with any practice direction issued by the Tribunal.

### **Apprehension of person not permitted to be absent from a facility (Section 48):**

A person who apprehends someone who is absent from a mental health facility does not have to take that person directly to the mental health facility from which they have been absent from. Instead they can be taken to another mental health facility first, and then transported back to the mental health facility they were originally absent from.

### **Notifications to carers of Tribunal matters (Section 78):**

The authorised medical officer must notify the designated carer and principal care provider of a person of matters before the Tribunal involving the person. A State approved form is being created to ensure the designated carer/principal care provider is notified. This form will be available on the StreamDirect online catalogue for access by mental health facilities. In the interim, the designated carer must be notified in person or by phone, and a note of that fact must be recorded in the patient's medical records. Reasonable steps should be taken to notify carers within a reasonable period to allow the carer to attend the hearing of the Tribunal if they wish. This is particularly important if a hearing is to be held in the absence of the patient.

The key changes to the *Mental Health (Forensic Provisions) Act 1990* are outlined below:

### **Review of forensic Community Treatment Orders (CTOs) (Section 61):**

A forensic CTO is an order for compulsory mental health treatment for a person in a correctional centre. The Tribunal will now be required to review a forensic CTO every 6 months, following an initial review at 3 months.

### **Apprehension of forensic patients who do not return from leave (Section 68A):**

If a forensic patient does not return from leave or fails to comply with a condition of their leave, the authorised medical officer may apprehend the patient, or direct the patient to be apprehended by:

- A suitably qualified person employed at the mental health facility
- A police officer
- A person authorised by the Secretary or the authorised medical officer (any such authorisation should be in writing)
- A person assisting any of the above.

If the authorised medical officer directs a person above to apprehend the patient, a written record of the direction should be made. If a direction is made to a police officer, the officer may apprehend the patient or make arrangements for another police officer to do so. The [NSW Health – NSW Police Force Memorandum of Understanding 2018](#) outlines steps that should be taken to determine whether a police officer may be required to apprehend a patient.

The power of the Authorised Medical Officer to apprehend, or direct the apprehension, of a forensic patient who fails to return from leave or breaches a condition of the leave under Section 68A is in addition to the power of the Tribunal to make an Order for the person's apprehension under Section 68 of the MHFPA. Section 68A may be relevant when it has been identified that action can be taken immediately to apprehend the

patient without the need for an Order for Apprehension from the Tribunal. This is to minimise delays in apprehension.

If the powers under Section 68A are relied upon, the Authorised Medical Officer should ensure that any person authorised to apprehend the patient has the necessary skills, training and qualifications to do so and have considered if the patient can be safely apprehended. They must also consider if an Order for Apprehension should be issued by the Tribunal under Section 68.

The Authorised Medical Officer must notify the Tribunal as soon as possible when they have directed a patient to be apprehended under this section, and again when the patient has been apprehended.

These notifications must be by phone or by email, and must be noted in the patients' medical records.

#### **Training (on the changes to the Acts)**

The *Mental Health Act 2007 Guidebook* which provides practical information to mental health practitioners, as well as those who provide support and advice to persons and carers is being updated to incorporate the changes to legislations detailed above. Once completed, the Guidebook will be available through the NSW Ministry of Health website.

The policy directives PD2011\_003 *Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW* and PD2012\_050 *Forensic Mental Health Service* are currently in the process of being amended to reflect the changes in procedures as a result of the legislation amendments.

The Mental Health Review Tribunal is releasing a Practice Direction that addresses the legislation changes related to the Tribunal functions. The Practice Direction can be accessed at <https://www.mhrt.nsw.gov.au/the-tribunal/practice-directions.html>.

## Information Bulletin



Ministry of Health, NSW  
73 Miller Street North Sydney NSW 2060  
Locked Mail Bag 961 North Sydney NSW 2059  
Telephone (02) 9391 9000 Fax (02) 9391 9101  
<http://www.health.nsw.gov.au/policies/>

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### Amendments to the Mental Health Act 2007

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<b>Document Number</b>	IB2015_040
<b>Publication date</b>	31-Jul-2015
<b>Functional Sub group</b>	Clinical/ Patient Services - Mental Health Clinical/ Patient Services - Mental Health
<b>Summary</b>	The Mental Health Act 2007 has been reviewed and amended by the Mental Health Amendment (Statutory Review) Act 2014. This Information Bulletin outlines the key changes to the Mental Health Act 2007.
<b>Author Branch</b>	Mental Health and Drug and Alcohol Office
<b>Branch contact</b>	Mental Health and Drug & Alcohol Office 02 9391 9953
<b>Applies to</b>	Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Government Medical Officers, NSW Ambulance Service, Public Health Units, Public Hospitals
<b>Audience</b>	Administration, clinical mental health staff, emergency departments, mental health facilities
<b>Distributed to</b>	Public Health System, Divisions of General Practice, Government Medical Officers, Health Associations Unions, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes
<b>Review date</b>	31-Jul-2020
<b>Policy Manual</b>	Not applicable
<b>File No.</b>	15/2206
<b>Status</b>	Active

Director-General

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## AMENDMENTS TO THE MENTAL HEALTH ACT 2007

### PURPOSE

The *Mental Health Act 2007* recently underwent a review and the *Mental Health Amendment (Statutory Review) Act 2014* was passed by Parliament in November 2014. This Information Bulletin sets out the amendments to the *Mental Health Act 2007*.

### KEY INFORMATION

The key changes to the *Mental Health Act 2007* are outlined below:

#### Recovery principles:

- Includes statements in the principles for care and treatment that:
  - Clinicians should make every effort to take into account consumers' views and wishes about their treatment, to obtain consumers' consent for treatment and recovery plans, and to support consumers who lack the capacity to consent to understand those plans
  - Consumers should be supported to pursue their own recovery
  - People under 18 years of age should receive developmentally appropriate services
  - The cultural and spiritual beliefs and practices of Aboriginal and Torres Strait Islanders should be recognised
  - Special needs relating to disability or sexuality are to be recognised in care and treatment.
- Removes the term 'control' from the objects of the Act and replaces this with an object to recognise that treatment is for the purpose of protecting the consumer or other persons from harm
- Adds to the objects the notion of promoting the recovery of persons who are mentally ill or mentally disordered.

#### Consumer rights:

- Requires that voluntary patients be given a statement of rights
- Amends the involuntary patient statement of rights (Schedule 3) to state that consumers have the right to see an official visitor and the right to request discharge at any time and to appeal to the Mental Health Review Tribunal (MHRT) against any refusal to discharge them
- Requires that voluntary patients be reviewed by the MHRT at least once every 12 months of continuous residence in a mental health facility
- Requires the MHRT, when undertaking a voluntary patient review, to consider whether the patient is likely to benefit from further care or treatment as a voluntary patient

- Removes the ability of the Secretary of Health to consent to a surgical operation on an involuntary patient, where that patient has capacity but has not provided consent to the operation
- Enables a person under the Act who is in a non-mental health facility for medical treatment to request to see an official visitor.

#### **Initial involuntary assessment processes:**

- Introduces a requirement that assessing clinicians seek and consider the views of carers, family members, treating health professionals and relevant emergency services personnel when making determinations under Form 1 about a person's potential need for ongoing involuntary treatment
- Allows authorised medical officers to undertake Form 1 assessments at a declared mental health facility of which they are not an employee
- Allows accredited persons (nominated by the Medical Superintendent for a specific facility) to undertake Form 1 assessments face to face only where an authorised medical officer or other medical practitioner is unavailable
- Makes it clear that Schedule 1 and Form 1 assessments may be undertaken by audio-visual, subject to certain criteria being met.

#### **Carers:**

- Replaces the term 'primary carer' with 'designated carer' and allows consumers to nominate up to two designated carers who are entitled to receive certain information about the consumer, subject to restrictions
- Introduces the concept of a 'principal care provider' (the person who is primarily responsible for providing support or care for a consumer) and allowing this person to be provided with similar information about the consumer to the designated carer.

#### **Young persons:**

- Requires that persons under 16 years of age be provided with legal representation for all Mental Health Review Tribunal (MHRT) hearings unless the young person refuses such representation or the MHRT determines that it would be in the person's best interests to proceed with a hearing without representation
- Requires that, where it is proposed to provide electroconvulsive therapy (ECT) to a person under 16 years of age, the person must be assessed by a psychiatrist with expertise in child and adolescent psychiatry, and the matter must go before the MHRT for consideration, even when the young person has capacity and has consented to ECT.

#### **Community treatment orders (CTOs)**

- Removes the requirement for a 14 day notification period for an application for a CTO on a person who is living in the community, if the MHRT decides that it is in the best interests of the person that the application be heard earlier
- Requires the Director of Community Treatment to consult the affected person and their carers before revoking an order

- Requires the Director of Community Treatment to notify the Tribunal in writing if the Director revokes a CTO or decides not to apply to the tribunal for a further order.
- Allows the MHRT to make a CTO at an appeal hearing against a refusal to discharge a consumer.

#### **Detaining a person**

- A person may be detained involuntarily for up to two hours to allow an authorised medical officer to carry out an assessment to determine whether the patient is a mentally ill person or mentally disordered person.
- The length of time that a mental health facility is able to detain a person pending apprehension by a police officer has been extended to a period not exceeding **two** (2) hours.

#### **Forms and documentation**

- A list of all the forms and documents used in the day-to-day operation of the Act is provided below (**Attachment A**). Many of these have been updated, and nine new forms have been developed (some of which exist in the Mental Health Regulation 2013), as highlighted in the attached list.
- A list of all forms and documents is available on the NSW Ministry of Health website: <http://www.health.nsw.gov.au/mhdao/Pages/legislation.aspx>

#### **Mental Health Regulation 2013**

- Amendments to the Mental Health Regulation are currently going through approval processes. The Ministry will notify LHDs / SNs once any such amendments have been approved and provide an explanation of the changes.

#### **Training (on the changes to the Act)**

- Training will be provided throughout NSW to mental health and emergency department staff by the NSW Institute of Psychiatry.
- The *Mental Health Act 2007* Guidebook which provides practical information to mental health practitioners, as well as those who provide support and advice to persons and carers is being updated. Once completed the Guidebook will be available through the NSW Ministry of Health website: <http://www.health.nsw.gov.au/mhdao/Pages/legislation.aspx>

## **ATTACHMENTS**

1. Attachment A: Index of Forms.



# Appendix 2

## MENTAL HEALTH ACT 2007 FORMS

NSW Health staff can order or download Mental Health Act forms from the NSW Health online catalogue, hosted by TOLL:

<https://www.tollstreamdirect.com>. Please note that the preferred process for NSW Health staff is to download or order the form from the online catalogue. The staff member who usually orders forms for your service or facility should be able to assist with access.

Forms can also be found on the Ministry's website at: <https://www.health.nsw.gov.au/mentalhealth/legislation/pages/forms.aspx>

# Appendix 3

## MENTAL HEALTH REVIEW TRIBUNAL

The forms that relate to Mental Health Review Tribunal matters can be downloaded from <https://www.mhrt.nsw.gov.au> (under Documents).

# Appendix 4

## FACILITIES AND SERVICES

A list of declared mental health facilities can be obtained by emailing the Mental Health Branch at [MOH-mentalhealthbranch@health.nsw.gov.au](mailto:MOH-mentalhealthbranch@health.nsw.gov.au)

### USEFUL CONTACTS

**NSW Ministry of Health, Mental Health Branch - Regulatory Services Team**  
[MOH-mentalhealthbranch@health.nsw.gov.au](mailto:MOH-mentalhealthbranch@health.nsw.gov.au)

**HETI Mental Health Portfolio**  
 02 9840 3833  
<https://www.heti.nsw.gov.au/mhact>  
[HETI-MentalHealth-Training@health.nsw.gov.au](mailto:HETI-MentalHealth-Training@health.nsw.gov.au)

### ADVICE ON THE MENTAL HEALTH ACT

**Mental Health Advocacy Service**  
 02 9745 4277  
<https://www.legalaid.nsw.gov.au>

**Mental Health Review Tribunal**  
 02 9816 5955  
 Toll free: 1800 815 511  
<https://www.mhrt.nsw.gov.au>

### CHILD PROTECTION

**Child Protection Mandated Reporters Helpline**

133 627 (13 DOCS)  
<https://reporter.childstory.nsw.gov.au>  
 (for e-reporting when risk of harm is not imminent)

**NSW Health Child Wellbeing Unit**  
 1300 480 420

**NSW Mandatory Reporter Guide**  
<https://reporter.childstory.nsw.gov.au>

**Child Wellbeing and Child Protection Policies and Procedures for NSW Health**  
[https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2013\\_007](https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2013_007)

**Child Wellbeing & Child Protection – NSW Interagency Guidelines**  
<https://www.community.nsw.gov.au/kts>

### COMPLAINTS AND CONCERNS

**Health Care Complaints Commission**  
 02 9219 7444  
 Toll free: 1800 043 159  
<https://www.hccc.nsw.gov.au>

**Official Visitors Program**  
 Toll free: 1800 208 218  
<https://www.ovmh.nsw.gov.au>

### CONSUMER AND CARER ORGANISATIONS

**Mental Health Carers NSW**

02 9332 0700 or 1800 655 198  
<https://www.arafmi.org>

**Carers NSW**  
 02 9280 4744 or 1800 242 636  
<https://www.carersnsw.org.au>

**Way Ahead Mental Health Information Service**  
 1300 794 991  
<https://www.wayahead.org.au>

**BEING**  
 02 9332 0200  
<https://www.being.org.au>

### CULTURAL SUPPORT SERVICES

**Aboriginal**  
**Aboriginal Health and Medical Research Council**  
 02 9212 4777  
<https://www.ahmrc.org.au>

**Aboriginal Community Health Services**  
**Albury Wodonga Aboriginal Health Service**  
 02 6040 1200 or 1800 421640  
<https://www.awahs.com.au>

**Bulgarr Ngaru Medical Aboriginal Corporation (Grafton, Casino, Yamba and Maclean)**  
 02 6644 3500  
<https://www.bnmac.com.au>

**Illawarra Aboriginal Medical Service Aboriginal Corporation**

02 4229 9495

<https://www.illawarraams.com.au>

**Walgett Aboriginal Medical Service Cooperative Ltd**

02 6820 3777

<https://www.walgettams.com.au>

**Services for Culturally and Linguistically Diverse (CALD) people**

**Transcultural Mental Health Centre**

02 9912 3850

Clinical services toll free: 1800 648 911

<https://www.dhi.health.nsw.gov.au/tmhc>

**NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)**

02 9794 1900

<https://www.startts.org.au>

**NSW Refugee Health Service**

02 8778 0770

**Interpretation service**

<https://www.swslhd.health.nsw.gov.au/refugee/>

**Telephone Interpreter Service**

131 450

<https://www.tisnational.gov.au/>

## GUARDIANSHIP

**Guardianship Division of the NSW Civil and**

**Administrative Tribunal**

02 9556 7600

Toll free: 1300 006 228

<https://www.ncat.nsw.gov.au/Pages/guardianship/guardianship.aspx>

**NSW Trustee and Guardian**

02 8688 2600

1300 360 466

<https://www.tag.nsw.gov.au>

**NSW Family and Carer Mental Health Program**

NGO contact list

<https://www.health.nsw.gov.au/mentalhealth/services/carers/Pages/support-framework.aspx>



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