Submission on the issues raised by the review of New South Wales Mental Health Act 2007

Part II: Other issues

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Executive Summary

The Centre for Values, Ethics and the Law in Medicine is pleased to provide this submission on the issues raised by the review of the Mental Health Act 2007 (NSW). The submission is based upon the issues raised in the Discussion Paper: Issues Arising under the NSW Mental Health Act 2007. This Part 2 of the submission deals with issues other than those relating to the criteria for detention and treatment as addressed in parts 4, 6, 7, 17 and 20 of the Discussion Paper. These include electroconvulsive therapy, psychosurgery, treatment for conditions other than mental illness, and seclusion and restraint.

The authors are concerned to see that any new legislation will provide a rights-based approach to mental health care in New South Wales, and in this report, we set out a number of recommendations which we believe will better protect patient rights, focus on supported decision-making, and facilitate voluntary treatment wherever possible. Our recommendations are summarised here:

**Recommendation 14:** The definition of mental illness should be amended to more clearly include the phenomenology exhibited in anorexia nervosa and to delete the word “irrational” from criterion (e).

**Recommendation 15:** Provisions in the MHA relating to non-psychiatric treatment should include a formalisation of the presumption of capacity; a requirement that all persons be provided with appropriate support in making their own treatment decisions; a requirement that substituted decision-making can only occur where a person can be shown to lack decision-making capacity and where supported decision-making has failed; and the introduction of guidelines for substituted decisions that require that the will and preferences of the person must be respected and be given effect to, to the greatest extent possible, and that in any case, must be shown to be manifestly necessary to promote the person’s

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wellbeing, broadly conceived.

**Recommendation 16:** The MHA should allow clinicians to briefly detain a patient when there is reason to believe that he or she could and should be treated under the Act.

**Recommendation 17:** Accredited persons should be permitted to complete one of the Form 1 assessments, but that all Form 1 assessments should involve (at least) a telephone consultation with a psychiatrist.

**Recommendation 18:** The review should clarify the processes around discharge of an assessable person, whom a clinician feels no longer meets the criteria for compulsory treatment.

**Recommendation 19:** Patients should be permitted to participate as fully as possible in decisions concerning treatment. Patients who are the subject of compulsory orders may still retain decision-making capacity sufficient to allow them to make decisions about medication and other treatments. Those with impaired decision-making capacity should be offered support, and where a substituted decision is necessary in respect of some acutely ill patients who lack decision-making capacity, a substituted decision about medication could be made which respects the known will and preferences of the person. The Tribunal should also have a power to review treatment plans as recommended in Part 1 of this submission.

**Recommendation 20:** There should be no outright ban on particular therapies in children and young people, including ECT. However some special therapies (including ECT) should require approval by the Mental Health Review Tribunal or the Supreme Court.

**Recommendation 21:** The ban on psychosurgery in New South Wales should be removed.

**Recommendation 22:** The term “psychosurgery” should be replaced with “neurosurgery for psychiatric conditions”.
**Recommendation 23:** Any use of psychosurgery should be subject to approval by an independent tribunal in which the patient is represented by his or her own advocate, where the patient lacks capacity to provide his or her own consent, whether or not the patient is refusing treatment.

**Recommendation 24:** The revision process should take account of the need to provide compulsory treatment in the emergency department setting and in the setting of the general medical and surgical wards.

**Recommendation 25:** Provisions regarding seclusion and restraint should be added to the MHA in a manner that mirrors those of other jurisdictions.

1 Introduction

The proposed revision of the Mental Health Act 2007 (NSW) will be the first re-drafting of the State’s mental health legislation under the influence of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and offers the opportunity for the first major re-drafting since 1990. The revision provides an opportunity for an extensive modernisation of the mental health laws of New South Wales and a chance to set out innovative measures to better protect the health and rights of people living with mental illness.

2 The definition of mental illness

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

a) Delusions,

b) Hallucinations,

c) Serious disorder of thought form,

d) A severe disturbance of mood,

e) Sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).

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3 Mental Health and Drug & Alcohol Office, above n 1, 20.

4 Mental Health Act 2007 (NSW), s 4.
This definition is unchanged from the original wording of the 1990 Act. As the Discussion Paper notes there are also a series of specific exclusions for determining whether the person has a mental illness.

We believe that this definition, now in operation for 22 years, is a generally effective mechanism for identifying those individuals to whom the mentally ill provisions of the MHA should apply.

2.1 Suggested minor changes to the definition of mental illness
We suggest two minor changes to the definition of mental illness to aid in clarity and to reflect its current use.

2.1.1 Better inclusion of anorexia nervosa
Currently when people with anorexia nervosa are placed on involuntary treatment orders under the MHA\(^5\) the rationale applied is that people with anorexia nervosa suffer a “delusion” — specifically that the person wrongly believes him or herself to be “fat” when they are in fact dangerously underweight and that the presence of this false belief satisfies the plain English definition of delusion.

While the definition of “mental illness” in the MHA is not a medical definition, it relies on medical concepts and a major difficulty with the rationale outlined above is that psychiatry does not regard the beliefs expressed by people with anorexia nervosa as delusions. Neither of the major international diagnostic classification syndromes refer to delusions when defining anorexia nervosa.\(^7\) Instead they refer to a “[d]isturbance in the way in which one’s body weight or shape is experienced, ... or denial of the seriousness of the current low body

\(^5\) Mental Health Act 1990 (NSW), s 3, schedule 1.

\(^6\) Many such people are also treated under the Guardianship Act 1990 (NSW).

weight”\textsuperscript{8} and an “[i]ntense fear of gaining weight or becoming fat, even though underweight”\textsuperscript{9} or “[a] self-perception of being too fat, with an intrusive dread of fatness.”\textsuperscript{10}

In the very least, this causes a deal of confusion among psychiatrists and other doctors, who are required to use the MHA when making clinical decisions about treatment.

We would suggest that, if the MHA is still intended to allow the coercive treatment of people suffering anorexia nervosa (and opinions on this vary), the definition of mental illness be amended to more clearly include the phenomenology exhibited in anorexia nervosa. It might be possible, for example, to add sixth symptom such “severe disturbance of body image” or “intense fear of gaining weight, even though dangerously underweight”.

2.1.2 Deletion of the word “irrational”
Criterion (e) of the current definition is “[s]ustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d)” (emphasis added).\textsuperscript{11} The word “irrational” raises a number of problems in that its meaning in this context is not clear. It might, for example, imply that the behaviour falls below a reasoned or logical standard or that it is made without judgment or not made by someone of sound mind.\textsuperscript{12} Its appearance in a definition of a mental illness, especially one embedded in capacity-based legislation adds no further meaning and is potentially confusing. Overall it seems unnecessary as it is difficult imagine that any rational behaviour would indicate the presence of delusions, hallucinations, a serious disorder of thought form or a severe disturbance of mood.

\textsuperscript{8} American Psychiatric Association, above n 7.
\textsuperscript{9} Ibid.
\textsuperscript{10} World Health Organisation, above n 7.
\textsuperscript{11} Mental Health Act 2007 (NSW), s 4.
\textsuperscript{12} The Macquarie Dictionary (5th ed, 2009).
Recommendation 14: The definition of mental illness should be amended to more clearly include the phenomenology exhibited in anorexia nervosa and to delete the word “irrational” from criterion (e).

3 Treatment for conditions other than a mental illness

As the Discussion Paper notes, the provisions in the MHA relating to the provision of non-mental health treatment vary markedly depending on the type of treatment being considered and the legal status of the person with medical illness. This is not only confusing, but also gives rise to circumstances where competent people with mental illness are not afforded the same rights to refuse medical treatment as competent people without mental illness. These provisions are therefore arguably discriminatory, in breach of the CRPD and at odds with key principles of the recovery that emphasise patient autonomy and participation in decision making relating to medical treatment.

In Part 1 of this submission we have argued that the provisions of the MHA relating to the provision of psychiatric treatment should be revised so as to provide a formalisation of the presumption of capacity; a requirement that all persons be provided with appropriate support in making their own treatment decisions; a requirement that substituted decision-making can only occur where a person can be shown to lack decision-making capacity and where supported decision-making has failed; and the introduction of guidelines for substituted decisions that require that the will and preferences of the person must be respected and be given effect to, to the greatest extent possible, and that in any case, must be shown to be manifestly necessary to promote the person’s wellbeing, broadly conceived.

We recommend that provisions relating to non-psychiatric treatment should operate on the same basis.

13 Mental Health and Drug & Alcohol Office, above n 1, 18.
Recommendation 15: Provisions in the MHA relating to non-psychiatric treatment should include a formalisation of the presumption of capacity; a requirement that all persons be provided with appropriate support in making their own treatment decisions; a requirement that substituted decision-making can only occur where a person can be shown to lack decision-making capacity and where supported decision-making has failed; and the introduction of guidelines for substituted decisions that require that the will and preferences of the person must be respected and be given effect to, to the greatest extent possible, and that in any case, must be shown to be manifestly necessary to promote the person’s wellbeing, broadly conceived.

4 Detention of voluntary inpatients and other persons whom may require compulsory treatment

The Discussion Paper canvasses opinion on the need for legislative reform to cover the circumstance where a voluntary patient wishes to discharge him or herself prior to a planned medical discharge, but an authorised medical officer is not immediately available to examine and form an opinion as to whether the patient should be further detained. It notes the MHA does not currently make any provision for holding the voluntary patient pending the doctor’s arrival.

In fact this is simply one example of a broader issue that arises when a clinician has reason to believe that person may be detainable under the provisions of either the MHA or the Guardianship Act 1997 (NSW) or the emergency provisions of the common law, but is not yet in a position to know either that the person is a mentally ill person (as defined) or that he or she lacks decision-making capacity. This sort of circumstance may arise in a number of situations, outside those envisaged by the Discussion Paper. Other examples might include a 54 year old business man, one day after a heart attack, pulling off his monitor leads and

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14 Mental Health and Drug & Alcohol Office, above n 1, 32
walking out of the intensive care unit in his dressing gown without explanation; or a young woman waking from a presumed overdose, and trying to leave the emergency department before being interviewed by medical staff. In these scenarios, a patient is actively resisting or refusing assessment or treatment, but there is reason to suspect that the person may have impaired cognitive function affecting their decision-making capacity, or they may have a mental illness for which treatment should be given under the MHA.

If, in these types of situations, there were factors that might suggest the patient lacks decision-making capacity or suffers from a mental illness (as defined) and, if there was a foreseeable risk of serious harm to self or others, then the common law probably provides a limited justification in such circumstances to briefly detain a person to assess for the presence or absence of decision-making capacity.\(^\text{15}\)

We suggest that, to aid in clinician’s understanding of the law and therefore improve clinical care and protection of patient rights, it may be helpful to reflect these elements of the common law within the provisions of the Mental Health Act by adding provisions permitting clinicians to detain a person for a very brief period where detention is necessary to determine whether compulsory treatment could be given under the Act.

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**Recommendation 16:** The MHA should allow clinicians to briefly detain a patient when there is reason to believe that he or she could and should be treated under the Act.

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5 Initial assessment for involuntary detention\textsuperscript{16}

5.1 Accredited persons and Form 1 assessments

The Discussion Paper raises the possibility that the MHA be amended so that a Form 1 examination might be undertaken by an accredited person. Accredited persons include specialised nursing staff, psychologists and other highly trained mental health practitioners, and are crucial part of service provision in mental health services, particularly in rural and remote areas.\textsuperscript{17}

Currently only medical practitioners can conduct Form 1 examinations.

The Discussion Paper suggests that in many circumstances accredited persons may “have more mental health expertise and a better working knowledge of the provisions of the Act than some accredited medical officers working in emergency departments” and that the reform might allow more timely access to such examinations. Both these observations are uncontroversially true. On balance we recommend that the MHA should allow accredited persons to complete one of the Form 1 examinations.

The Discussion Paper notes as a point of caution, that if such amendments were adopted a patient could be discharged on the sole opinion of an accredited person without psychiatrist review, which constitutes a potential risk if a psychiatrist may have formed the view that the person required ongoing involuntary psychiatric treatment. However it is worth pointing out in this respect, that under the MHA’s current provisions, a junior medical officer with far less the experience or training than an accredited person may discharge a patient in the same

\textsuperscript{16} Mental Health and Drug & Alcohol Office, above n 1, 33

\textsuperscript{17} Currently at least, application to become an accredited person has been effectively limited to “suitably qualified senior mental health practitioners” and the title can only be obtained after completion of a rigorous training programme: NSW Institute of Psychiatry, Accredited Person’s Handbook (2009), 9. Available from http://www0.health.nsw.gov.au/pubs/2009/pdf/ap_handbook_2009.pdf. In contrast, authorised medical officers in Emergency Departments acting as Declared Mental Health Facilities (DMHFs - emergency mental health assessment class) are frequently junior medical officers whose only experience with psychiatric patients was gained as an undergraduate and who undergo no special training to become authorised medical officers.
circumstances. In any case, to counter the concerns about possible inappropriate discharge of patients, we suggest that all Form 1 assessments should involve (at least) a telephone consultation with a psychiatrist regardless of whether or not they are conducted by an accredited person and regardless of whether or not they result in further detention and treatment.

**Recommendation 17:** Accredited persons should be permitted to complete one of the Form 1 assessments, but that all Form 1 assessments should involve (at least) a telephone consultation with a psychiatrist.

### 5.2 Clarification of the process required to revoke a schedule 1 and form 1

Section 27 of the MHA sets out the steps that are required to continue to detain a person once he or she has been initially detained in a declared mental health facility. While the provisions make the steps for detention very clear, doubt has arisen as to what should be done when the AMO, who completes the first Form 1, ceases to be of the opinion that the person is mentally ill or mentally disordered. It is not clear whether, in that circumstance, the person should be immediately discharged, or must the person be detained while a second, and possibly third Form 1 assessment is carried out by another doctor/s and/or psychiatrist in accordance with the procedures in the section. (Similar concerns arise if the clinician filling in the second Form 1 disagrees with the opinion of the clinician who filled in the first).

In a recent coroners case the coroner expressed the opinion that the MHA did mandate these additional assessments, though this is arguably inconsistent with judicial interpretations of the relevant sections of the 1990 Act as expressed in *Hunter Area Health Service & Anor v Presland* [2005] NSWCA 33.18

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18 For further discussion of this issue see: Christopher James Ryan & Sascha Callaghan, ‘Meeting the Call of the Coroner: Detention and Release of Patients under the Mental Health Act’ (2011) *Newsletter of the NSW Branch of the Royal Australian and New Zealand College of Psychiatrists* 17.
The uncertainty around this issue is problematic for both doctors, who may find themselves in breach of a legal duty, and for patients, whose rights will be affected. The review of the MHA provides an opportunity to clarify this important procedural issue.

**Recommendation 18:** The review should clarify the processes around discharge of an assessable person, whom a clinician feels no longer meets the criteria for compulsory treatment.

### 6 Review of treatment planning and medication

The Discussion Paper canvases a suggestion from stakeholders “that a provision could be inserted in the Act to empower consumers to apply to the MHRT for a review or change in medication, or to access a second opinion from a psychiatrist outside the hospital in relation to appropriate or alternative treatment”. The Discussion Paper notes in this respect the principles for care and treatment include that “every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care” but that the “consumer does not have the right however to refuse appropriately prescribed treatment”.

We agree that improvements should be made in the arrangements for patient participation in decisions about treatment and in the powers of the Tribunal to review treatment decisions. In line with our recommendations about the criteria for compulsory treatment in Part 1 of this submission, patients should be permitted to participate as fully as possible in decisions concerning treatment, and patients who are the subject of compulsory orders may still retain decision-making capacity sufficient to allow them a say in the medications and other treatments they are prescribed. Those with impaired decision-making capacity should be offered support, and where a substituted decision is necessary in respect of some acutely

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19 Mental Health and Drug & Alcohol Office, above n 1, 38.

20 Mental Health Act 2007 (NSW), s 68(h).

21 Mental Health and Drug & Alcohol Office, above n 1, 38.
ill patients who lack decision-making capacity, a substituted decision about medication could be made where the will and preference of the person is the paramount consideration in choosing between treatment options, with the goal of supporting and enhancing the person’s overall wellbeing.

In addition, as suggested in section 8 of Part 1 of this submission, details of any proposed treatment should also be able to be considered by the Tribunal at mental health inquiries as well as other review hearings, to ensure that patient preferences have been properly taken into account and to verify that the treatment plan will promote the person’s wellbeing.

**Recommendation 19:** Patients should be permitted to participate as fully as possible in decisions concerning treatment. Patients who are the subject of compulsory orders may still retain decision-making capacity sufficient to allow them to make decisions about medication and other treatments. Those with impaired decision-making capacity should be offered support, and where a substituted decision is necessary in respect of some acutely ill patients who lack decision-making capacity, a substituted decision about medication could be made which respects the known will and preferences of the person. The Tribunal should also have a power to review treatment plans as recommended in Part 1 of this submission.

7 Electroconvulsive therapy

Drawing on recent reforms in the draft bills published in Victoria and Western Australia the Discussion Paper asks whether the MHA should “include any specifications regarding treatment of children with ECT?”

We believe that the current arrangements around the delivery of ECT work reasonably well, though we would suggest that procedures around consent to ECT for adults should be

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22 Mental Health and Drug & Alcohol Office, above n 1, 40.
brought into line with those set out in relation to treatment under the MHA generally, in line with Recommendation 2 of Part 1 of this submission.

This said, it would be reasonable, in our view, to include additional safeguards around the use of ECT in children and young people as foreshadowed in the Discussion Paper. It is important to note in any case, that some children can and do have decision-making competence – a fact that is now well recognised in common law in Australia.\(^{24}\) The notion of children’s decision-making competence in law is part of a gradual shift in the status of young people in society and recognition that children and young people are individuals with legitimate perspectives to be listened to and respected. For this reason, it is now established in other areas of medicine that children can and do participate and consent to therapies, including major invasive medical treatments and surgeries, where these are necessary to treat illness\(^{25}\). In any case, while children’s rights to autonomy and privacy are certainly important, children also have special vulnerabilities and the authors believe that both should be taken into account when formulating rules regarding psychiatric treatment, ECT and other therapies.

We note that draft mental health legislation in Western Australian and Australian Capital Territory, if enacted, would prohibit the use of ECT in persons under 12, and in Victoria, in persons under 13.\(^{26}\)

The justifications for these proposed bans are unclear. The explanatory memoranda accompanying the Victorian and Western Australian bills gave no explanation for the

\(^{23}\) Interestingly, in the light of our recommendations relating to capacity-based mental health legislation in Part 1 of this submission, Division 3 of Part 2 of the MHA is the only series of provisions that are concerned with a patient’s capacity to consent to treatment.

\(^{24}\) Secretary, Department of Health & Community Services v JWB & SMB [1992] HCA 15 (‘Marion’s case’).

\(^{25}\) For a detailed discussion of the law and medical decision-making by children and young people, see New South Wales Law Reform Commission, Young People and Consent to Health Care (2008).

\(^{26}\) Mental Health Bill 2010 (Vic) (Exposure Draft), cl 144; Mental Health Bill 2011 (WA) (Exposure Draft), cl 153; Mental Health (Treatment and Care) Amendment Bill 2012 (First Exposure Draft) (ACT), cl 77.
suggested change,\textsuperscript{27} although explanatory memorandum for the ACT bill suggested that “new restrictions on ECT for young people align ACT legislation with recent and impending legislation in other jurisdictions, based on the lack of evidence to support ECT under 12 years”, though this statement was not supported by reference to the medical literature.\textsuperscript{28}

We believe that an outright ban on the administration of ECT to children and young people is both unnecessary and potentially harmful. There is no evidence that ECT is being misused in this population and while it is certainly the case that ECT is used in children under 12 in extremely rare circumstances, there is evidence that ECT can be efficacious in some very limited circumstances. The application of ECT to children is so rare that the only evidence available tends to be that derived from case reports, but these indicate that, in these extremely rare circumstances, the application of ECT can be a life-saving intervention of last resort.\textsuperscript{29} Where this is the case, an outright ban could needlessly place a child’s life at risk.

We suggest as an alternative, that use of ECT in children, in the very rare circumstances where it might be required, must be authorised by the Mental Health Review Tribunal or the Supreme Court.

**Recommendation 20:** There should be no outright ban on particular therapies in children and young people, including ECT. However some special therapies (including ECT) should require approval by the Mental Health Review Tribunal or the Supreme Court.


\textsuperscript{28} Legislative Assembly for the Australian Capital Territory, *ACT Mental Health (Treatment and Care) Act Amendment Bill 2012 (First Exposure Draft). Draft Explanatory Statement* (2012), 28.


8 Psychosurgery

New South Wales is the only Australian jurisdiction that prohibits psychosurgery. The Discussion Paper canvasses amendments to the MHA that would permit the use of psychosurgery including deep brain stimulation (DBS) in some circumstances.

Psychosurgery and DBS have established efficacy in the treatment of a variety of psychiatric and neurological conditions. In addition there is reason to believe that DBS may, in the future, provide an effective treatment for some patients currently affected by severe and treatment resistant mental illness. The New South Wales ban on psychosurgery means that patients wishing to access these therapies are required to travel interstate, placing an unacceptable barrier to effective treatment to some citizens for whom such travel is not possible. The ban also means that research clinicians in New South Wales are prohibited from contributing to efforts to establish the efficacy of DBS in treatment resistant depression and obsessive compulsive disorder, and patients are prevented from participating in trials that might benefit them when they may have capacity to consent to participate.

We would suggest that the ban on psychosurgery in New South Wales be removed and, in addition, make the following suggestions.

30 Mental Health and Drug & Alcohol Office, above n 1, 41.


“Psychosurgery” as a term, is not only inaccurate – there is no surgery to the “psyche” – but carries strongly negative connotations associated with early uses of surgical methods in psychiatry. For this reason, South Australia has replaced the term with the more accurate “neurosurgery for mental illness” although we suggest that “neurosurgery for psychiatric disorders” is a better still since the current definition of “mental illness” in the MHA would exclude obsessive compulsive disorder, which is one of the conditions that responds to neurosurgery and is a target of research into DBS.

A definition in similar terms would allow neurologists and neurosurgeons to conduct neurosurgery and DBS for frontal lesions, epilepsy, tremor or dyskinesia without the need for review under the MHA. Under the current drafting of section 83(2), some of these procedures may be captured by the prohibition on psychosurgery if they are intended to affect behaviours associated with those conditions.

In any case, while a complete ban on neurosurgery for psychiatric treatment and research cannot, we believe, be justified, some form of additional legislative safeguard may be appropriate, particularly where patients lack capacity to consent to treatment themselves. Rightly or wrongly, many members of the public are still likely to view such procedures with a degree of suspicion, and to some extent, stigmatisation of these procedures could potentially have impact on patients, in addition to the effects, positive and negative, of the therapy itself.

For these reasons, and because neurosurgery for psychiatric disorders will remain a very rare procedure for the foreseeable future (with the effect that evidence of efficacy will be limited) we believe that review of applications by an independent tribunal will be appropriate. The review conducted by the Victoria’s Psychosurgery Review Board provides an example of such a process. The role of the tribunal should include reviewing the

33 Mental Health Act 2009 (SA), s 3.
35 Mental Health Act 1986 (Vic), part 5, division 1.
decision-making capacity of people who are to undergo neurosurgery for psychiatric conditions and ensuring, in respect of those who lack decision-making capacity, that any proposed surgery respected their known will and preferences, and was necessary to promote the person’s wellbeing.

We also recommend that all patients in respect of whom an application for psychosurgery is made, should be entitled to separate representation by an advocate.

**Recommendation 21:** The ban on psychosurgery in New South Wales should be removed.

**Recommendation 22:** The term “psychosurgery” should be replaced with “neurosurgery for psychiatric conditions”.

**Recommendation 23:** Any use of psychosurgery should be subject to approval by an independent tribunal in which the patient is represented by his or her own advocate, where the patient lacks capacity to provide his or her own consent, whether or not the patient is refusing treatment.

9  **Provisions applicable to declared mental health facilities – emergency type and general medical wards**

On 13 November 2009, certain emergency departments were declared in the Government Gazette to be declared mental health facilities under the MHA. Whilst this declaration had some advantages in bringing within the law the detention of people under the MHA who were cared for in emergency departments, it represented a grafted on solution to this issue that caused a number of anomalies between the requirements of the MHA and practice.
Problems similar to those that promoted the declaration of emergency departments also arise in general medical and surgical wards where patients may be detained for extended periods without clear legal authority.

The revision of the MHA allows an opportunity to re-address these issues.

**Recommendation 24:** The revision process should take account of the need to provide compulsory treatment in the emergency department setting and in the setting of the general medical and surgical wards.

## 10 Seclusion and restraint

New South Wales is the only Australian jurisdiction that makes no specific reference to seclusion and restraint in its mental health legislation. There is an increasing push to minimise and (to the extent possible) eliminate seclusion and restraint from psychiatric practice. An important part of this effort involves the careful monitoring of seclusion and restraint. The legislation of all other jurisdictions, except the Northern Territory, contain provisions pertaining to reporting of seclusion and restraint practices. The National Mental Health Commission recently released Report Card called for all jurisdictions to contribute to a “national data collection to provide comparison across states and territories, with public reporting on all involuntary treatments, seclusions and restraints each year from 2013”. We would recommend the New South Wales add provisions regarding seclusion and restraint similar to those that exist in other Australian jurisdictions.

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36 *Mental Health Act* 1986 (Vic), ss 81,82; *Mental Health Act* 2000 (Qld), ss 141-160; *Mental Health Act* 2009 (SA), s 7(1)(h); *Mental Health Act* 1996 (WA), ss 116-124; *Mental Health Act* 1996 (Tas), ss 34-36; *Mental Health (Treatment and Care) Act* 1994 (ACT), subs 35(2)(c)-(d); *Mental Health and Related Services Act* 1998 (NT), ss 61-62.

37 Mental Health Act 1986 (Vic) subs 81(3), 82(5); *Mental Health Act* 2000 (Qld), ss 147, 160; *Mental Health Act* 2009 (SA), sub 91(b); *Mental Health Act* 1996 (WA) ss 115, 124; *Mental Health Act* 1996 (Tas), s 36; *Mental Health (Treatment and Care) Act* 1994 (ACT), sub s 35(4).

Recommendation 25: Provisions regarding seclusion and restraint should be added to the MHA in a manner that mirrors those of other jurisdictions.