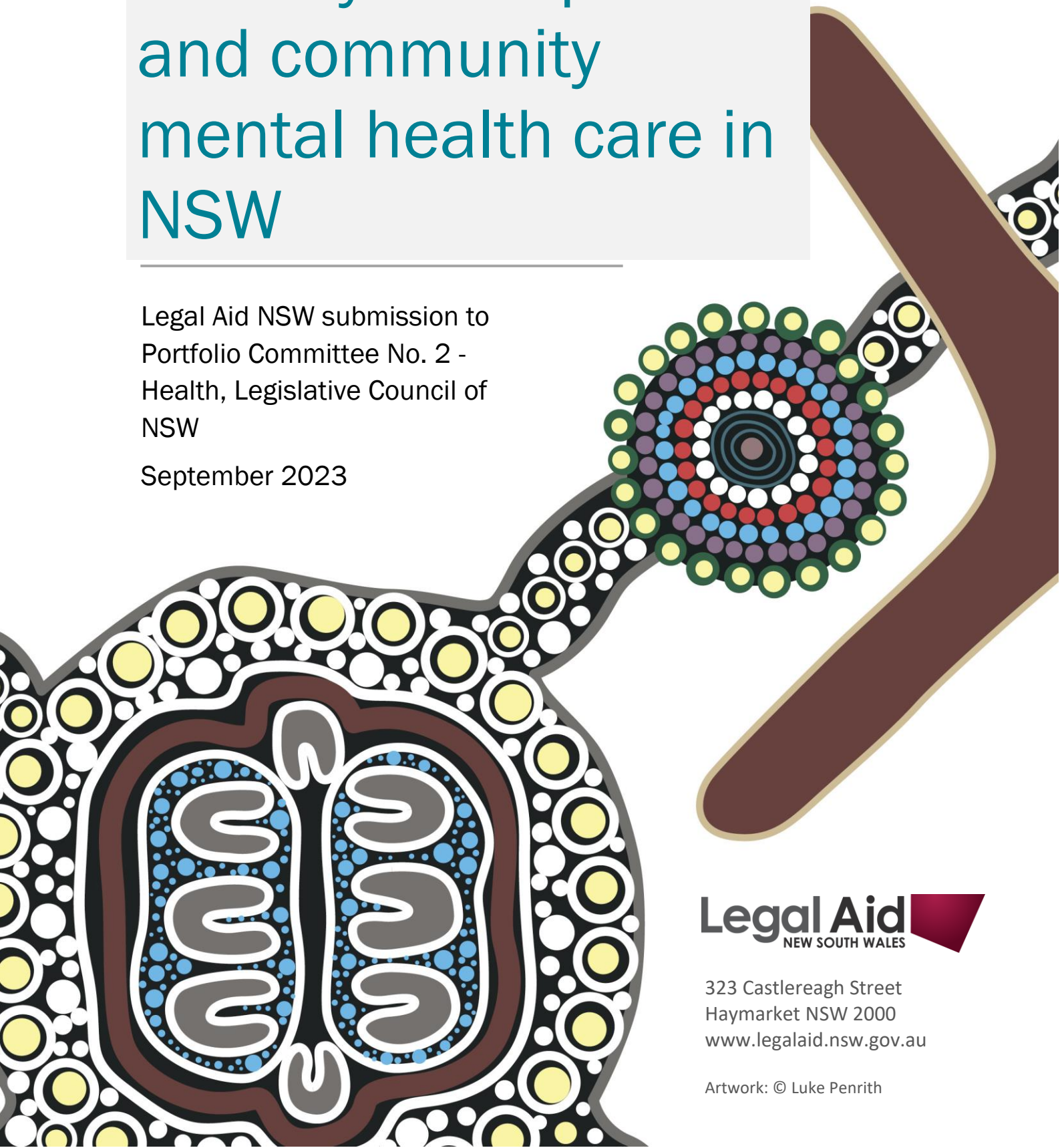
Equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW

Legal Aid NSW submission to Portfolio Committee No. 2 - Health, Legislative Council of NSW

September 2023



Legal Aid NEW SOUTH WALES

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Acknowledgement

We acknowledge the traditional owners of the land we live and work on within New South Wales. We recognise continuing connection to land, water and community.

We pay our respects to Elders both past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

Legal Aid NSW is committed to working in partnership with community and providing culturally competent services to Aboriginal and Torres Strait Islander people.

1. About Legal Aid NSW

The Legal Aid Commission of New South Wales (**Legal Aid NSW**) is an independent statutory body established under the *Legal Aid Commission Act 1979* (NSW). We provide legal services across New South Wales through a state-wide network of 25 offices and 243 regular outreach locations, with a particular focus on the needs of people who are socially and economically disadvantaged. We offer telephone advice through our free legal helpline LawAccess NSW.

We assist with legal problems through a comprehensive suite of services across criminal, family and civil law. Our services range from legal information, education, advice, minor assistance, dispute resolution and duty services, through to an extensive litigation practice. We work in partnership with private lawyers who receive funding from Legal Aid NSW to represent legally aided clients.

We also work in close partnership with community legal centres, the Aboriginal Legal Service (NSW/ACT) Limited and pro bono legal services. Our community partnerships include 27 Women's Domestic Violence Court Advocacy Services, and health services with a range of Health Justice Partnerships.

The Legal Aid NSW Family Law Division provides services in Commonwealth family law and state child protection law.

Specialist services focus on the provision of family dispute resolution services, family violence services, services to Aboriginal families and the early triaging of clients with legal problems through the Family Law Early Intervention Unit.

Legal Aid NSW provides duty services at all Family and Federal Circuit Court registries and circuit locations through the Family Advocacy and Support Service, all six specialist Children's Courts, and in some Local Courts alongside the Apprehended Domestic Violence Order lists. Legal Aid NSW also provides specialist representation for children in both the family law and care and protection jurisdictions.

The Civil Law Division provides advice, minor assistance, duty and casework services from the Central Sydney office and most regional offices. The purpose of the Civil Law Division is to improve the lives of people experiencing deep and persistent disadvantage or dislocation by using civil law to meet their fundamental needs. Our civil lawyers focus on legal problems that impact on the everyday lives of disadvantaged clients and communities in areas such as housing, social security, financial hardship, consumer protection, employment, immigration, mental health, discrimination and fines. The Civil Law practice includes dedicated services for Aboriginal communities, children, refugees, prisoners and older people experiencing elder abuse.

The Criminal Law Division assists people charged with criminal offences appearing before the Local Court, Children's Court, District Court, Supreme Court, Court of Criminal Appeal and the High Court. The Criminal Law Division also provides advice and representation in specialist jurisdictions including the State Parole Authority and Drug Court.

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2. Executive summary

Legal Aid NSW welcomes the opportunity to provide a submission to the Legislative Council of NSW Portfolio Committee No. 2 – Health (**Committee**) inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW (**inquiry**).

We provide legal services across NSW in criminal, civil and family law, with an emphasis on assisting socially and economically marginalised people. This includes frequently providing legal assistance and other support to people who experience mental health issues and who are in contact with a community mental health service. Our submission is particularly informed by the work of our Criminal Law Division, our Mental Health Advocacy Service and our Coronial Inquest Unit.

Through our case work, we have first-hand experience in seeing how challenging it can be for our clients who experience mental health issues to access and maintain appropriate levels of support in the community, particularly outside of a coercive framework. We observe the serious consequences that can occur when someone's mental health is not well managed in the community, such as repeated involuntary admissions to a mental health facility, repeated interactions with the criminal justice system, and in the case of our Coronial Inquest Unit, a person's untimely death.

In this submission, we confine our response to the following terms of reference:

> b) navigation of outpatient and community mental health services from the perspectives of patients and carers
>
> c) capacity of State and other community mental health services, including in rural, regional and remote NSW
>
> f) the use of community treatment orders (**CTOs**) under the *Mental Health Act 2007* (NSW), and
>
> i) alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (**PACER**).

The submission raises concern with:

- the widespread use of CTOs in NSW in the absence of clear evidence of their efficacy
- the inability of the Mental Health Review Tribunal (**MHRT** or **Tribunal**) to be able to make a CTO unless presented with a treatment plan from a designated mental health facility
- the criteria for the making of a CTO

- the use of CTOs to ensure that a patient is provided with a higher level of care in the community than would otherwise be the case
- access to mental health care in regional, rural and remote areas of NSW
- the coordination of mental health care following a person's release from custody, and
- the fact that the PACER program is not available in all Police Area Commands in NSW.

Recommendations

Recommendation 1: CTO use, efficacy and data

- The NSW Government should work with the Commonwealth and other State and Territory Governments towards establishing nationally uniform and public reporting of CTO data.
- The NSW Government should fund a multi-disciplinary research project into the use and efficacy of CTOs in NSW.

Recommendation 2: Treatment plans

The *Mental Health Act 2007* (NSW) should be amended to provide the Mental Health Review Tribunal with an express power to recommend that a declared mental health facility prepare a treatment plan and put it before the Tribunal for consideration.

Recommendation 3: Criteria for the making of a CTO

Section 53(3)(c) of the *Mental Health Act 2007* (NSW) should be amended by deleting the words "if the affected person has been previously diagnosed as suffering from a mental illness".

Recommendation 4: Failure to specify the length of a CTO

Section 56(2) of the *Mental Health Act 2007* (NSW) should be amended to provide that where a CTO does not specify the length of the order, the order is to expire six months after it is made.

Recommendation 5: Better care or "service" when subject to a CTO

The *Mental Health Act 2007* (NSW) should be amended to expressly state that any perception that a patient will receive better care or "service" when subject to a CTO is not a relevant consideration for the Tribunal when determining whether a CTO should be made.

Recommendation 6: Mental health services in regional, rural and remote areas

The NSW government should take immediate steps to ensure equal access to mental health care for people in regional, rural and remote areas of NSW.

Recommendation 7: Release from custody

- The NSW Government should consider rolling out the services of the Community Transition Team to all correctional centres in NSW.
- The NSW Government should explore options for providing better coordinated mental health care for inmates who are released from custody on bail.

Recommendation 8: PACER

The NSW Government should consider providing sufficient resources to roll out PACER to all Police Area Commands in NSW.

3. Community treatment orders under the *Mental Health Act 2007* (NSW)

Care for serious psychiatric illnesses is mostly provided in a community setting, and not in an inpatient setting.[1] Of the mental health services that are provided for in the Australian community, approximately 14.5% are provided on an involuntary basis under a CTO.[2] This substantial figure is, in part, the result of the process of deinstitutionalisation of mental health care that has occurred in recent decades.[3]

However, while the provision of care in the community under a CTO is preferable to involuntary care in an inpatient setting, there is a need for closer attention to be paid to the extensive use of CTOs in NSW. This includes investigating why their use in NSW is higher than in most other jurisdictions, what evidence exists around the efficacy of CTOs, and how CTOs fit with Australia's human rights obligations and a recovery-oriented approach to mental health care.[4] As the Mental Health Commission of NSW has noted, it may be that the high rate of CTO use in NSW "is a marker of a system which is not intervening early or effectively".[5]

We welcome the Committee considering this important issue, and highlight matters relating to the use of CTOs in NSW and how the legislative provisions relating to CTOs could be improved.

3.1 Rate of use of CTOs in NSW

In NSW, a CTO can be made by the Tribunal, which authorises "compulsory treatment in the community".[6] A CTO requires:

> the affected person to be present, at the reasonable times and places specified in the order to receive the medication and therapy, counselling, management, rehabilitation and other services provided in accordance with the treatment plan.[7]

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[1] Department of Health and Ageing, *National Mental Health Report 2010*: *Summary of 15 years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2008* (Report, December 2010).

[2] Australian Institute of Health and Welfare, *Mental Health Services in Brief 2019* (Report, 2019) 12.

[3] Edwina Light et al, 'How shortcomings in the mental health system affect the use of involuntary community treatment orders' (2017) 41(3) *Australian Health Review* 351, 352.

[4] For an explanation of a "recovery oriented approach" see 'What is a recovery oriented approach?' *NSW Health* (Web page, 24 August 2022) <What is a recovery oriented approach? - Principles for effective support (nsw.gov.au)>.

[5] Mental Health Commission of NSW, *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* (Report, October 2014) 125.

[6] *Mental Health Act 2007* (NSW) s 51(1).

[7] Ibid s 56(1)(b).

A CTO can be made irrespective of whether the affected person has capacity to consent to the treatment. In that regard, CTOs are exceptional. As has been noted by the Court of Appeal of NSW:

> [i]n this country, as in other civilised countries, enforced medical treatment is… wholly exceptional, both to ordinary medical practice, and to the legal requisites for lawful medical attendances.[8]

Given the exceptional nature of CTOs, it is important for the Committee to consider the purpose and efficacy of CTOs because, as the UN Special Rapporteur on the right to health has noted, involuntary mental health practices have "normalised coercion in everyday practice, widening the space for human rights violations to occur".[9]

While CTOs are exceptional, studies have indicated that their use is much higher in Australia compared to other parts of the world.[10] In 2021-22 the number of CTOs made in NSW was 6,767, an increase of 6% on the previous year[11] and 35% on a decade earlier.[12] Studies in 2005, 2012 and 2017 found that the rate of persons subject to a CTO in NSW were 37.4,[13] 46.4,[14] and 48.1[15] per 100,000 people, respectively.[16]

Noting the steady increase in the use of CTOs in NSW, a 2005 study found that CTOs "seem to act as something of a 'safety valve' for the criminal courts and inpatient facilities, which are under considerable pressure", and that this had occurred in parallel with the deinstitutionalisation of mental health care and without adequate investment in community mental health care.[17] This is consistent with our experience.

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[8] *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315, 323B.

[9] Dainius Puras, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc A/HRC/35/21 (18 March 2017) [23].

[10] Simon Lawton-Smith, *A Question of Numbers: The potential impact of community based treatment orders in England and Wales* (Working paper, Kings Fund, September 2005) 6.

[11] NSW Mental Health Review Tribunal, *Annual Report 2022* (Report, October 2022) 14.

[12] Ibid 48.

[13] Simon Lawton-Smith, *A Question of Numbers: The potential impact of community based treatment orders in England and Wales* (Working paper, Kings Fund, September 2005) 22.

[14] Edwina Light et al, 'Community Treatment orders in Australia: rates and patterns of use' (2012) 20(6) *Australian Psychiatry* 478, 480.

[15] Edwina Light, 'Rates of use of Community Treatment Orders in Australia (2019) 64 *International Journal of Law and Psychiatry* 83, 85.

[16] We note that these statistics relate to the number of people subject to CTOs per 100,000 population, as opposed to the number of CTOs made per 100,000. See Edwina Light, 'Rates of use of Community Treatment Orders in Australia (2019) 64 *International Journal of Law and Psychiatry* 83, 84-85.

[17] John Dawson, *Community Treatment Orders: International comparisons* (Report, Law Foundation New Zealand, May 2005) 62, 78.

A 2005 study, which looked at the varying rates of CTOs across comparable jurisdictions internationally, found that the presence in legislation of the following pre-requisites for the making of a CTO correlated with the jurisdictions with the lowest use of CTOs:

- the patient being required to have a prior history of hospitalisation
- the patient needing to pose a specific significant or substantial risk of serious harm to others, as opposed to an unspecified level of harm, and
- the treatment proposed in the CTO being likely to be of therapeutic benefit.[18]

While in NSW there is a requirement that the MHRT be satisfied that a person has a "previous history of refusing to accept appropriate treatment" before making a CTO, which is similar to the requirement that a person have a history of hospitalisation, there is no requirement for the Tribunal to be satisfied that the patient poses any risk of harm to themselves or others, let alone a significant or substantial risk of causing serious harm.[19] Furthermore, there is no express requirement for the MHRT to be satisfied that a CTO is likely to be of therapeutic benefit. Although, we note that if the Tribunal is satisfied of the criteria in section 53(3) of the *Mental Health Act 2007* (NSW), this only engages the Tribunal's discretion to make a CTO, and the Tribunal may have regard to other matters in determining whether to exercise that discretion.

While CTOs are in widespread use in NSW and in other jurisdictions around Australia and the world, their efficacy remains the subject of debate. For example, one study across England and the United States found that for people who were the subject of the equivalent of a CTO, there was "no clear difference in service use, social functioning or quality of life compared with voluntary care or brief supervised discharge".[20]

Another study that reached a similar conclusion did note that the qualitative data identified benefits with a person being placed on a CTO, including the responsiveness of treating teams.[21] However, it noted that:

> [l]ittle evidence came to light to suggest that the other benefits about personal and social support identified could not have accrued independently of the CTO, if the service was appropriately responsive to patients' needs.[22]

This is an issue we address further below at section 3.2.4.

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[18] Simon Lawton-Smith, *A Question of Numbers: The potential impact of community based treatment orders in England and Wales* (Working paper, Kings Fund, September 2005) 40.

[19] *Mental Health Act 2007* (NSW) s 53(3).

[20] Steve Kisley, Leslie Capmbell and Richard O'Reilly, 'Compulsory community and involuntary outpatient treatment for people with severe mental health disorders' (Cochrance Database of Systemic Reviews, Issue 3, Art No. CD004408, 2017) 2.

[21] Michael Dunn et al, 'An empirical ethical analysis of community treatments orders (CTOs) within mental health services in England' 11(4) *Clinical Ethics* 130.

[22] Ibid 12.

Given the high rate of use of CTOs in NSW and Australia more broadly, questions regarding the efficacy of their use, and that case law makes clear they are exceptional in nature, we support the suggestion from experts that there be greater transparency around their use, including through regular and nationally uniform public reporting of CTO data.[23]

We also submit that the NSW Government should fund a multi-disciplinary research project into the use and efficacy of CTOs in NSW. The research should address matters such as:

- whether coercive treatment damages the therapeutic relationship between clinicians and patients
- whether CTOs are an impetus for community mental health services in NSW to provide a higher level of care or "service" to a patient
- whether NSW should consider including "risk of harm" to self or others as a criterion for the making of a CTO, and
- whether NSW should consider moving towards a purely "consent" based model for the making of a CTO.

The research should consider such matters in the context of Australia's international human rights obligations, particularly those under the *Convention on the Rights of Persons with Disabilities.*

Recommendation 1: CTO use, efficacy and data

- The NSW Government should work with the Commonwealth and other State and Territory Governments towards establishing nationally uniform and public reporting of CTO data.
- The NSW Government should fund a multi-disciplinary research project into the use and efficacy of CTOs in NSW.

3.2 Legislative issues

We submit that there are a number of issues with the current legislative provisions under the *Mental Health Act 2007* (NSW) relating to CTOs.

[23] Edwina Light, 'Rates of use of Community Treatment Orders in Australia (2019) 64 *International Journal of Law and Psychiatry* 83, 87.

3.2.1 Preparation of treatment plans

For the MHRT to make a CTO, it must consider "a treatment plan for the affected person proposed by the declared mental health facility that is to implement the proposed order".[24] To engage the Tribunal's discretion to make the order, the Tribunal must be satisfied that "a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it".[25]

In our view, this requirement unnecessarily curtails the powers of the Tribunal, as a decision by the Tribunal to make a CTO is contingent on a declared mental health facility having prepared a treatment plan.

This is primarily an issue in proceedings where the treating team is requesting the Tribunal to make a further involuntary patient order. For example, if the Tribunal is being asked to make an involuntary patient order, they will not have a treatment plan in front of them because the treating team will not have prepared one as they are not asking the Tribunal to make a CTO. A patient will then have difficulty advancing an argument that they should be released on a CTO, instead of continuing to be detained as an involuntary patient. Furthermore, the Tribunal is unable to properly consider whether "care of a less restrictive kind, that is consistent with safe and effective care… is appropriate and reasonably available".[26]

To overcome this issue, we submit that the *Mental Health Act 2007* (NSW) should be amended to provide that when the Tribunal is considering an application for an involuntary patient order, they must still have regard to whether a CTO may be "care of a less restrictive kind, that is consistent with safe and effective care" irrespective of whether it has a treatment plan prepared by a declared mental health facility before it. If the Tribunal forms the view that a CTO is likely to be a less restrictive form of care, we submit that it should have an express power to recommend that a mental health facility prepare a treatment plan and put it before the Tribunal.

Such an approach is also consistent with the fact that other than an authorised medical officer of a mental health facility where the patient is detained or is a patient, the following people can also apply for a CTO:

- a medical practitioner who is familiar with the clinical history of the patient,[27] and
- a designated carer, or the principal care provider, of the affected person.[28]

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[24] *Mental Health Act 2007* (NSW) s 53(2)(a)

[25] Ibid s 53(3)(b).

[26] Ibid ss 35(5)(c) and 38(4).

[27] *Mental Health Act 2007* (NSW) s 51(2)(b).

[28] *Mental Health Regulations 2019* (NSW) r 9(b).

At present, there is little utility in the *Mental Health Act 2007* (NSW) providing for either of these two cohorts to be able to apply for a CTO when they are reliant on a treatment plan being prepared by a mental health facility. If a mental health facility prepares a treatment plan, it is likely it will just make the application for a CTO in its own right.

Recommendation 2: Treatment plans

The *Mental Health Act 2007* (NSW) should be amended to provide the Mental Health Review Tribunal with an express power to recommend that a declared mental health facility prepare a treatment plan and put it before the Tribunal for consideration.

3.2.2 Previous history of refusing to accept appropriate treatment

For the Tribunal's discretion to make a CTO to be engaged, it must be satisfied that the following criteria in section 53(3) of the *Mental Health Act 2007* (NSW) are met:

> (a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and
>
> (b) a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it, and
>
> **(c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.**

The drafting of subsection (c) has caused some confusion. Due to the word "if", it is unclear whether a CTO cannot be made unless a person has been "previously diagnosed", or that a CTO can be made when a person has not been "previously diagnosed", but the making of a CTO in such an instance can occur when the Tribunal is only satisfied of subsections (a) and (b).

There are sound policy reasons for preferring the former interpretation. This interpretation is also consistent with the broad objectives of the Act, which include providing people with an opportunity to manage their illness in the least restrictive manner.[29] It would also be illogical for the threshold for the making of a CTO to be lower in the case of a person who has not been "previously diagnosed" versus a person who has been "previously diagnosed".

[29] For example, see *Mental Health Act 2007* (NSW) s 68(e)-(f).

We therefore submit that the words "if the affected person has been previously diagnosed as suffering from a mental illness" should be removed from subsection (c). The definition of "previous history of refusing to accept appropriate treatment"[30] is then capable of separating who has, or has not, previously been afforded the opportunity to "accept appropriate treatment".[31]

Recommendation 3: Criteria for the making of a CTO

Section 53(3)(c) of the *Mental Health Act 2007* (NSW) should be amended by deleting the words "if the affected person has been previously diagnosed as suffering from a mental illness".

3.2.3 No time period specified in the order

The *Mental Health Act 2007* (NSW) provides that the Tribunal cannot make a CTO for a period longer than 12 months.[32] It also provides mandatory considerations for the Tribunal to have regard to when determining the length of a CTO.[33] The Act goes on to provide that where the length of an order is not specified, the order is to expire 12 months after it is made.[34]

We submit that where an expiry date is not specified, the length of the order should be six months. This is because as a matter of practice, CTOs are most commonly imposed for a period of six months.[35] The imposition of a CTO for a longer period is not only an exception to the norm in practice, but also out of step with the legal framework for CTOs, given the statutory presumption is in favour of the maximum period of time, which is inconsistent with the principle of least restrictive care throughout the Act. One would expect that if the Tribunal wished to impose a CTO for a period of 12 months, it would have considered the factors in section 53(7) of the Act, and therefore a failure to specify the length of the order would be unusual.

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[30] Ibid s 53(5).

[31] Ibid s 53(5)(a).

[32] Ibid s 53(6).

[33] Ibid s 53(7).

[34] Ibid s 56(2).

[35] For example, in 2021-22 CTOs of more than six months were made in only 10% of cases: NSW Mental Health Review Tribunal, *Annual Report 2022* (Report, October 2022) 14.

Recommendation 4: Failure to specify the length of a CTO

Section 56(2) of the *Mental Health Act 2007* (NSW) should be amended to provide that where a CTO does not specify the length of the order, the order is to expire six months after it is made.

3.2.4 Imposition of a CTO for a better "service"

An additional concern relates to the issue of people subject to a CTO receiving a better "service" than voluntary patients of community mental health services. In our experience, this can be both a perception and a reality.

A study that examined clinical and legal decision making relating to CTOs in NSW noted that all participants[36] reported that CTOs increased access to care for people with a mental illness.[37] The study found that, based on its communication with participants, "CTOs were frequently acknowledged as a deliberate strategy to counter known deficiencies in the 'system' acting as a compulsion on the 'system' (rather than just on the patient) to engage in treatment".[38]

This is consistent with the experience of our lawyers appearing before the MHRT, where Tribunal members will often refer to a CTO as being as much about creating an obligation on a community mental health service, as it is about creating an obligation on a patient.

However, the purpose of a CTO is not to create an obligation on a community mental health service, nor is there anything in the *Mental Health Act 2007* (NSW) to suggest that it does. It is important that the exceptional nature of a CTO is not lost.

We therefore submit that the Act should be amended to expressly state that any perception, whether grounded in reality or not, that a person on a CTO will be better cared for or receive a better level of "service" when subject to a CTO is not a relevant consideration for the Tribunal in determining whether a CTO should be made.

Recommendation 5: Better care or "service" when subject to a CTO

The *Mental Health Act 2007* (NSW) should be amended to expressly state that any perception that a patient will receive better care or "service" when subject to a CTO is

[36] The participants included persons currently or previously the subject of a CTO, carers, clinicians from community mental health services and MHRT members.

[37] Edwina Light et al, 'How shortcomings in the mental health system affect the use of involuntary community treatment orders' (2017) 41(3) *Australian Health Review* 351, 353.

[38] Ibid.

not a relevant consideration for the Tribunal when determining whether a CTO should be made.

4. Capacity of State and other community mental health services, including in rural, regional and remote NSW

Legal Aid NSW represents the overwhelming majority of forensic patients in NSW in proceedings before the MHRT. Through our work, we have become aware of some issues in relation to the provision of community mental health care in regional NSW.

4.1.1 Release from Bloomfield Hospital

We have observed capacity issues faced by community mental health services in Orange. One of NSW's three forensic medium secure units is the Macquarie Unit at Bloomfield Hospital near Orange. While forensic patients are detained at the Macquarie Unit, they are incrementally given greater leave from the facility by their treating team and the MHRT until they are eventually deemed suitable for conditional release. During this transition period, which ordinarily occurs over years, forensic patients become immersed in the Orange community through employment, volunteering, studying at TAFE, and engaging in pro-social activities such as attending the gym. When it comes time for a patient to be conditionally released, they often wish to remain living in the Orange area.

We have had occasions where patients have been told that they will not be supported to live in the catchment area of the Orange Community Mental Health Service because the community mental health service does not have sufficient resources to case manage all the forensic patients, who require a higher level of oversight compared to voluntary patients or persons subject to a CTO.

We submit that this is an issue for the Committee to consider, and to perhaps seek further clarification about from NSW Health and Western NSW Local Health District, given the obvious benefits to the forensic patients and the broader community from them being able to remain in a community they have been carefully and well-integrated into.

4.1.2 Patients on clozapine in regional areas

We are also aware through our forensic practice of the barriers to people who are on clozapine being able to live in certain parts of NSW. This is because some GPs are not able to prescribe clozapine as they are not registered with a clozapine provider as is required, or not willing to prescribe clozapine. Clozapine is an oral anti-psychotic medication that requires routine four weekly reviews from a medical practitioner, as well as a blood test every four weeks. While community mental health services may have oversight of a forensic patient's conditional release order or a patient's CTO, they are not ordinarily involved in prescribing clozapine or completing the necessary four weekly reviews due to their own resource constraints.

Such a limitation reduces the areas where people who are on clozapine may wish to live, which is particularly problematic given this tends to be areas where the cost of living is cheaper, which appeals to people who are of limited means.

4.1.3 Mental health services in Broken Hill

Frequently, the solicitors in our Broken Hill office make applications to Magistrates for matters to be dealt with under sections 14, 19 and 20 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).

Section 14 provides a Magistrate with the power to dismiss a charge if it appears that the accused has, or had at the time of the alleged offending, a mental health impairment or cognitive impairment but is not a "mentally ill person" or a "mentally disordered" person.[39] A Magistrate can discharge a defendant:

> on the condition that the defendant attend on a person or at a place specified by the Magistrate for assessment, treatment or the provision of support for the defendant's mental health impairment.[40]

Section 19 allows for a person to be taken to a mental health facility for an assessment. Section 20 provides a Magistrate with the power to discharge a defendant subject to them being placed on a CTO in accordance with the *Mental Health Act 2007* (NSW).

However, the current resourcing of the mental health system in Broken Hill limits the ability of Magistrates to make such orders. Broken Hill does not have a permanent psychiatrist and is instead serviced by locum psychiatrists. Furthermore, there is no Justice Health nurse at the court facility. There is only one Justice Health nurse, but their role is limited to Aboriginal defendants who are on bail, and they are located in Dubbo some 700km away.

Often clients who are sent for an assessment of their mental health are sent back to court within an hour, and the assessment of their mental health is that they are "currently at baseline". This determination is made by visiting locum psychiatrists who often have little knowledge of the individual, their diagnosis, or their circumstances.

Limited spaces in the mental health inpatient ward in Broken Hill mean that those detained under this section are exceptionally limited. Only a few clients have been detained following a section 19(b) referral in the last four years, even though clients have been noted to be subject to CTOs and not compliant with their treatment at the time of the request. A number of mentally ill clients have been refused bail on their return to court as a result.

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[39] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) ss 12 and 14.

[40] Ibid s 14(1)(b).

These locum staffing arrangements have contributed to our solicitors finding it very difficult to have a psychiatrist create a community treatment plan that can be put before a Magistrate in the Local Court where our solicitors believe the defendant may be a "mentally ill person" or a "mentally disordered person".[41] As a result, from time to time Magistrates have instead relied on previous CTOs made in relation to the defendant, rather than the preparation of a new treatment plan by a psychiatrist. However, such an approach is less than ideal.

Even in circumstances where a Magistrate has made a CTO under section 20 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW), staff in our Broken Hill office report care not being provided by the community mental health service in accordance with the order, and breaches of the orders have often not led to any action being taken.

Recommendation 6: Mental health services in regional, rural and remote areas

The NSW government should take immediate steps to ensure equal access to mental health care for people in regional, rural and remote areas of NSW.

[41] Ibid s 18(1).

5. Navigation of outpatient and community mental health services

An ongoing issue relates to the ability of prisoners who have been on remand or sentenced, to link into community mental health supports on their release.

The Justice Health and Forensic Mental Health Network (**Justice Health**) has established the Community Transition Team, a multi-disciplinary team of health clinicians who assist sentenced inmates, who are receiving mental health treatment from Justice Health, with their transition to the community. This includes through linking them with housing, National Disability Insurance Scheme supports, drug and alcohol treatment, and their community mental health service. This program was first established in October 2020 on a temporary basis, but we understand has since received ongoing funding. However, we understand it is currently limited to the Metropolitan Remand and Reception Centre, Silverwater Women's Correctional Centre, and parts of Long Bay Correctional Complex.

We strongly support the work of the Community Transition Team and would support such a service being available in all correctional centres across NSW. We note that inmates commonly lose contact, or are unable to make contact, with mental health supports on their release from custody, and this can contribute directly to their risk of reoffending. This is especially the case with inmates who are on remand and receive bail, and no clinical handover has occurred to the person's community mental health service.

The challenges for Justice Health clinicians to follow up on patient care in the community was outlined in Audit NSW's report *Mental Health Service Planning for Aboriginal People in NSW*.[42] The report noted the need for a systemic approach to release planning for prisoners with mental health issues rather than reliance on "local leadership initiatives".[43] This was due to the fact that:

> [w]orking groups can be disbanded, key staff can leave services, and memoranda can become outdated. Without formalised guidelines or policy directives for case management, leadership can be diminished over time and patients can be lost to care.[44]

We strongly support this view and submit that more work is required to create a uniform model for release planning for inmates who are receiving mental health care from Justice Health. The Community Transition Team is a positive start, but it should be resourced to

[42] Audit Office of NSW, *Mental Health Service Planning for Aboriginal People in New South Wales* (Performance Audit, August 2019).

[43] Ibid 19.

[44] Ibid.

provide services in correctional centres across NSW. Furthermore, the model is only suitable for inmates who have a fixed date of release, and some adaptation will be required for people who are on remand.

Recommendation 7: Release from custody

- The NSW Government should consider rolling out the services of the Community Transition Team to all correctional centres in NSW.
- The NSW Government should explore options for providing better coordinated mental health care for inmates who are released from custody on bail.

6. Alternatives to police for emergency responses

Legal Aid NSW strongly supports the PACER program. We submit that consideration be given to rolling it out in as many areas of NSW as possible. This is a recommendation that has also been made by the State Coroner.[45]

PACER is currently operational in 13 of 45 Police Area Commands or Police Districts, and clinicians are available for eight hours per day.[46] The Law Enforcement Conduct Commission supports a comprehensive rollout of PACER across NSW, however it noted in its recent report that the NSW Government had informed it that, at the time of writing, there was no government funding available to expand PACER.[47]

From our case work experience, we have observed the value of health professionals being present to de-escalate situations, and to prevent situations from escalating in the first instance, when NSW Police are responding to a person who is experiencing a mental health episode. We have observed that the training and skill levels of NSW Police are not adequate in responding to a person experiencing an acute mental health episode, and the use of health professionals in at least some capacity will always be preferable.

We also refer the Committee to the findings and recommendations of the State Coroner following the inquest into the death or Mr Ian Fackender.[48] Specifically, we refer to the recommendations directed to NSW Health, NSW Ambulance and NSW Police in relation to their individual and collective roles in responding to an alleged breach of a CTO.[49]

Recommendation 8: PACER

The NSW Government should consider providing sufficient resources to roll out PACER to all Police Area Commands in NSW.

[45] *Inquest into the death of Jack Kokaua* (Coroners Court of NSW), State Coroner Teresa O'Sullivan, 12 May 2021) 3.

[46] Law Enforcement Conduct Commission, *Five Years (2017-2022) of Independent Monitoring of NSW Police Force Critical Incident Investigations* (Report, May 2023) 44.

[47] Ibid 44-45.

[48] *Inquest into the death of Ian Fackender* (Coroners Court of NSW, State Coroner Teresa O'Sullivan, 13 September 2022).

[49] Ibid 3-5.