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CENTRE FOR
INTERNATIONAL
ECONOMICS

*NCP review of the
Northern Territory
Mental Health and
Related Services Act*

Prepared for Territory Health Services

FINAL REPORT

*Centre for International Economics
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Contents

Executive summary	v
1 This NCP review	1
Background to the review	1
The NCP process	1
2 The environment in which the Mental Health and Related Service Act operates	4
Involuntary admissions	5
Public responsibility for involuntary admissions	6
Approved procedures	7
3 The objectives of the legislation	8
4 The nature and effects of restrictions on competition	10
Restrictions on entry	11
Restrictions on quality and location of services	12
Effects of the restrictions on competition	13
5 The balance between costs and benefits of each restriction	14
Costs of the potential restrictions on competition	15
Benefits of the potential restrictions on competition	16
The balance between costs and benefits	16
6 Alternative means of achieving objectives and recommendations	21
Recommendation	22
APPENDIX	23
Terms of reference	25
Boxes, charts and tables	
1.1 Acts to be reviewed	2

Executive summary

THE REVIEW OF THE *MENTAL HEALTH AND RELATED SERVICES ACT* is one of 12 reviews being undertaken of the Northern Territory's health legislation under National Competition Policy (NCP) requirements. This report briefly describes NCP principles and procedures and provides some background information about the act and the procedures adopted in its administration.

Subsequent chapters of the report follow the steps that must be taken in any NCP review, namely to:

- clarify the objectives of the legislation;
- identify the nature of every restriction on competition;
- analyse the likely effects of the restrictions on competition and on the economy generally;
- assess the balance between the costs and benefits of the restrictions; and
- consider alternative means of achieving the same results including nonlegislative approaches.

Of all the Northern Territory's health legislation encompassed by the current NCP reviews, the background and objectives of this act are most clearly articulated. This is because the act is new and follows from a nationally integrated strategy prepared by the health ministers in all Australian jurisdictions. Several detailed objectives are specified, all of which are encapsulated by or derivative from the first, namely:

- to provide for the care, treatment and protection of people with mental illness while at the same time protecting their civil rights.

Because much of the legislation is directed at limiting choice of those who are unable to choose for themselves, on the 'demand side' many of its features are anticompetitive. But as these are designed to protect the rights of individuals and of the community, it is judged that they are in the public interest.

Features of the legislation that are identified as potentially restricting competition on the 'supply side' include:

- requirements that, whilst not excluding private sector treatment of involuntarily admitted patients, make it hard for private sector operators to service that aspect of mental health care;
- some professional activities being restricted to persons employed in the public sector;
- the dominance of public sector provision of mental health facilities potentially squeezing out private sector use of public facilities; and
- the prohibition or regulation of certain forms of treatment, including the licensing of premises in which electroconvulsive therapy takes place.

The net public benefits of these restrictions have been assessed in terms of three major features of the act, namely: procedures for giving informed consent for voluntary admission and treatment for mental care; procedures for involuntary admission for treatment; and the prohibition or regulation of certain forms of treatment. The benefits of each of these features, including those aspects that potentially restrict competition, are assessed to exceed their costs by a large margin.

A more flexible approach to the current highly prescriptive manner in which certain forms of treatment are prohibited or regulated in the current act, is discussed. However, no change at this time is proposed. To introduce any alternative, less regulatory means of achieving the outcomes sought would be likely, at this early stage, to compromise the national uniformity of approach thus far adopted.

The assessments made in the review have demonstrated a strong net benefit for the retention of the existing features of the act. No changes to them are recommended.

1

This NCP review

Background to the review

The Centre for International Economics (CIE), a private economic research consultancy, in conjunction with Desliens Business Consultants was commissioned by Territory Health Services to undertake an independent review of the *Mental Health and Related Services Act* in accordance with the principles for legislation review set out in the Competition Principles Agreement (CPA) entered into by all members (Commonwealth, states and territories) of the Council of Australian Governments in 1995. The review forms part of the Northern Territory government's obligation under the CPA to review and, where appropriate, reform all laws that restrict competition by the year 2000. Legislative reviews along National Competition Policy (NCP) lines are currently being undertaken of health and health related acts in other states. The Commonwealth is also conducting NCP reviews of its health legislation.

The *Mental Health and Related Services Act* is one of 12 Northern Territory health acts being reviewed (box 1.1).

In undertaking this review we consulted with stakeholders and asked for submissions from any interested parties. An issues paper designed to facilitate consultations and the preparation of submissions was distributed in March of this year. No submissions were received. However, the review team also made itself available in Darwin (and by teleconferencing hookup with Alice Springs) in early April to receive comment on the issues raised in the paper. There was only response to this later consultation opportunity.

The NCP process

Under the CPA, nearly 2000 pieces of Commonwealth, state and territory legislation are being reviewed over a six year period. The guiding principle behind these reviews and the reforms that follow them is that legislation

1.1 Acts to be reviewed

- ***Mental Health and Related Services Act***
 - *Dental Act*
 - *Optometrists Act*
 - *Radiographers Act*
 - *Community Welfare Act*
 - Community Welfare Regulations
 - Community Welfare (Childcare) Regulations
 - *Health Practitioners and Allied Professionals Registration Act*
 - *Nursing Act*
 - *Public Health Act*
 - Public Health (Barber's Shops) Regulations
 - Public Health (Shops, Eating Houses, Boarding Houses, Hotels and Hostels) Regulations
 - *Medical Act*
 - *Private Hospitals and Nursing Homes Act*
 - *Medical Services Act*
 - *Hospital Management Boards Act*

(encompassing activities of authorities set up under that legislation and any regulations, rules, etc. authorised under it) should not restrict competition unless it can be demonstrated that the:

- benefits of the restriction to the community as a whole outweigh the costs; and
- objectives of the legislation can only be achieved by restricting competition.

It is significant to note that *both* of these criteria are required to be met if a restriction is to be retained. This means that even if a restriction passes a net public benefit test, it should not be retained if there are other less restrictive ways of achieving that outcome. Also, if a restriction is to be retained it is necessary to demonstrate that to keep it will result in a public net benefit. It is not sufficient to demonstrate that its removal would result in no or little net benefit.

It is important when assessing the benefits and costs of a restriction that distinctions are made between private benefits and costs, benefits and costs to an industry or a profession, and communitywide benefits and costs.

The CPA does not define how any piece of legislation should be reviewed. However, it does state that, without limiting the issues that can be addressed, it should:

- clarify the objectives of the legislation;
- identify the nature of every restriction on competition;
- analyse the likely effects of the restrictions on competition and on the economy generally;
- assess and balance the costs and benefits of the restrictions; and
- consider alternative means of achieving the same results including nonlegislative approaches.

The terms of reference for this review (reproduced in the appendix of this report) follow this sequence of tasks. We have also made recommendations, as required by our terms of reference.

The CPA lists a range of public interest issues that are to be taken into account where relevant in assessing the benefits and costs of any restrictions. These include:

- ecological sustainability;
- social welfare and equity;
- occupational health and safety;
- industrial relations and access and equity;
- economic and regional development including employment and investment growth;
- interests of consumers;
- competitiveness of Australian businesses; and
- efficient resource allocation.

Social welfare and equity and the interests of consumers (as interpreted through national agreement between health ministers in all Australian jurisdictions and Australia's international obligations) have been pivotal criteria in the evaluation of public interest in the review of this act.

In this context, it is important to bear in mind that NCP is not based on a view that fewer rules and restrictions are necessarily better. Competition itself cannot operate outside a framework of trust which is underpinned by general commercial, industrial, health and safety, and environmental laws. Nor can competition fully serve the public interest unless there are safeguards to protect those who, because of incapacity or disability, are unable to exercise personal informed choice, which is a prerequisite of efficient and equitable competitive market outcomes.

2

The environment in which the Mental Health and Related Service Act operates

THE MENTAL HEALTH AND RELATED SERVICES ACT is new, being a completely rewritten piece of legislation enacted in 1998. Its precursor, the *Mental Health Act 1980*, was introduced to replace the then *Mental Defectives Act* and shift responsibility for the care of the mentally ill as far as practicable from the police and the courts and place it within the health care system. The then Minister for Health, in introducing the bill, claimed that the previous act was an anachronism long overdue for reform. The new act provided for the admission of mentally ill persons to hospital either voluntarily or compulsorily and specified the procedures that had to be followed to ensure that no one was kept in custody unless this was clearly in his or her own interests.

In 1992 the Northern Territory endorsed the *National Mental Health Strategy* prepared by the Commonwealth, state and territory health ministers. In doing so, this committed the Territory, together with all other Australian jurisdictions, to amend its mental health legislation to achieve consistency with the *United Nations Principles for the Protection of a Person with Mental Illness* and the Australian health ministers' *Mental Health Statement of Rights and Responsibilities*. Parts 2 and 3 of the act embody the fundamental principles and criteria for involuntary admission for mental health treatment which flow from these policy commitments.

Procedures which must be followed in the giving and seeking of informed consent for admission to treatment of mental illness are specified in part 5 of the act. These are designed to ensure that admission is informed and voluntary, and that the liberty of those in care is not needlessly or arbitrarily compromised. However, a major thrust of the act relates to treatment when informed consent for admission is not or cannot be given (parts 6 and 7).

Other features of the legislation relate to treatment following admission, whether voluntary or involuntary (part 8); the regulation of certain forms of treatment (part 9); the treatment of prisoners (part 11); the rights of

patients and their carers (part 12); and a number of issues in relation to complaints, investigations, powers of the courts and a Mental Health Review Tribunal and appeals (parts 13, 14, 10, 15 and 16 respectively). Remaining parts of the act deal with an Approved Procedures and Quality Assurance Committee, interstate orders and transfers, and a number of miscellaneous matters.

Involuntary admissions

In regard to the major thrust of the legislation, where informed consent is not or cannot be given and admissions are involuntary, the act defines:

- an ‘approved treatment facility’, which is essentially an inpatient facility where involuntary treatments can take place;
- an ‘authorised psychiatric practitioner’ who is a specialist psychiatrist working for a government or for a government agency or authority in an Australian jurisdiction, and is authorised to sign an involuntary admission order; and
- a ‘designated mental health practitioner’ who, as well as a registered medical practitioner, can make a recommendation for a psychiatric examination. A designated mental health practitioner can be a social worker, psychologist, registered nurse, occupational therapist, Aboriginal health worker or ambulance officer. He or she must be nominated by the person in charge of an approved treatment facility or an approved treatment agency (essentially an outpatient facility where voluntary treatments take place) and must be employed by that facility or agency.

Anyone can make a request to an authorised psychiatric practitioner, a medical practitioner or a designated mental health practitioner that he/she or another person for whom there is a real and immediate concern be assessed for need of treatment. Such an assessment must be undertaken as soon as practicable, provided it is seen that there are sufficient grounds for it proceeding. A recommendation for a psychiatric examination must be made if the assessment is that the person fulfils the criteria for involuntary admission. Also, the authorised person making the recommendation can take reasonable measures to take the patient to an approved treatment facility. The police may be called, if necessary, to assist in these matters, and there are provisions for emergency treatment in certain circumstances.

A patient detained at an approved treatment facility can be kept there for up to 24 hours during which time he/she must be examined by an authorised psychiatric practitioner (and a different one if the person who pro-

vided the assessment is him/herself an authorised psychiatric practitioner). If, following examination, the approved psychiatric practitioner is satisfied that the patient fulfils the criteria for involuntary admission, the patient may be detained for further periods in the approved treatment facility – otherwise the patient must be discharged. The periods of involuntary detention, and examination requirements during those periods, differ depending on whether the involuntary admission is on grounds of mental illness or of mental disturbance. Criteria for involuntary admission for these two categories are spelled out in the act.

An authorised psychiatric practitioner can also make interim community management orders where he or she is satisfied that a patient fulfils the criteria for involuntary treatment, but this does not have to be in an approved inpatient facility. These are undertaken through an approved outpatient agency, the person-in-charge being required to appoint a psychiatric case manager.

In all cases of involuntary detention, an authorised psychiatric practitioner must notify the patient, a legal practitioner prepared to act for him or her, a principal community visitor, and the Mental Health Review Tribunal. Community visitors are appointed under the act to ensure standards of and accessibility to approved treatment facilities and agencies. The tribunal is established under the act to review admissions and management orders for treatment and to hear appeals. If the tribunal is satisfied that a person fulfils the criteria for involuntary admission or community management orders, it can order extensions of periods of detention and treatment, and in the case of an admission must authorise the treatment to be administered.

Public responsibility for involuntary admissions

It can be seen from these requirements that many safeguards are built into involuntary admission and treatment procedures. These give substance to the *National Mental Health Strategy* principles designed to protect the rights of people who are not able to protect themselves. The functions for making involuntary admissions fall entirely within the domain of the public sector. Authorised psychiatric practitioners must be government employees or employees of government agencies. There are currently 21 authorised psychiatric practitioners in the Northern Territory and three specialist psychiatrists are in private practice.

There is no statutory requirement that designated mental health practitioners be employed in the public sector. However, they are appointed by the secretary of THS on the nomination of the person in charge of an

approved treatment facility or agency, and those persons are themselves appointed by the secretary. There are 65 designated mental health practitioners in the Northern Territory.

There are no regulatory constraints under the act which prevent private psychiatric facilities from being established in the Northern Territory and treating involuntary admissions, but they must have appropriate facilities to be registered. Voluntary admissions for mental health care are accepted by all public hospitals in the Northern Territory and also by Darwin Private Hospital. Currently, there are two approved treatment facilities (one in Darwin and one in Alice Springs) and five approved treatment agencies. All approved facilities and agencies are in the public sector.

Approved procedures

Although the act makes provision for the administrator of the Northern Territory to make regulations, none has been gazetted. Rather, as provided for in the act (section 18), a set of 'approved procedures' has been published by the secretary that constitute the policies, procedures and protocols relating to the operations of the act. Reasons stated in the Approved Procedures Manual for approving procedures rather than gazetting regulations are that:

- the process required to change regulations is quite slow and cumbersome;
- approved procedures are relatively easy to modify; and
- in investigating matters, court and independent complaint bodies place great emphasis upon whether an organisation's policies and procedures were followed.

The act provides for the establishment of an Approved Procedures and Quality Assurance Committee to, among other things, monitor and review the approved procedures.

Although no regulations have been gazetted, the act prohibits or directly regulates a number of forms of treatment. The most extensive consideration in this regard is given to electro convulsive therapy, for which the licensing of premises is required.

3

The objectives of the legislation

AN INITIAL TASK FOR ANY NCP LEGISLATIVE REVIEW is to clarify the objectives of the legislation. These may be stated in the act and/or in its subsidiary regulations, approved procedures, etc. Objectives might also be stated in second reading speeches and government policy statements. If they are not explicit in these ways, they may be implied from ministerial directives and the ways in which these are administered. However, it is not necessary to dig far into secondary sources in the case of the *Mental Health and Related Services Act*. Of all the Northern Territory's health legislation covered by the current NCP reviews, the background to and objectives of this act are most clearly articulated.

In 1992 the Northern Territory endorsed the *National Mental Health Strategy* prepared by the Commonwealth, state and territory health ministers. In doing so, this committed the Northern Territory, together with all other Australian jurisdictions, to amend its mental health legislation to achieve consistency with the *United Nations Principles for the Protection of a Person with Mental Illness* and the Australian health ministers' *Mental Health Statement of Rights and Responsibilities*.

Among other things, this required the incorporation of a clear set of objectives of the legislation, fundamental principles under which the legislation would operate, and a definition of mental illness consistent with the UN principles. None of these had been features of the 1980 act. In the current act they are spelled out in considerable detail. That detail is a feature of and consistent with revised mental health legislation in all Australian jurisdictions.

The objectives of the act (section 3) consist of 17 detailed clauses, though all appear to be encapsulated by or derivative from the first – namely, to provide for the care, treatment and protection of people with mental illness while at the same time protecting their civil rights.

In generality, the remaining clauses seek to:

- establish provisions for the care, treatment and protection of people with mental illness;

- recognise and support appropriate care provided for mentally ill people by relatives, friends and non-professional care givers; and
- regulate the authority of Northern Territory government administrators to treat people involuntarily and deprive them of their liberty.

Although not explicit in these objectives, an implicit objective of some features of the act appears to be to protect the wider community in the processes of providing care and treatment to people with mental illness.

The fundamental principles enunciated in the act focus on human rights and the promotion of a rights based model of treatment and care. In particular, they specify principles relating to:

- the provision of treatment and care;
- involuntary admission and treatment;
- admission, care and treatment of Aborigines and Torres Strait Islanders;
- rights of carers; and
- rights and conditions in approved treatment facilities.

4

The nature and effects of restrictions on competition

HAVING CLARIFIED OBJECTIVES of the legislation and the principles under which it operates, the next two tasks for an NCP review are to:

- identify the nature of any restrictions on competition that operate as a result of the act or the procedures adopted under the act; and
- analyse their effects on competition and on the economy generally.

Although these are identified in the legislative review procedures as separate steps, for legislation such as the *Mental Health and Related Services Act*, which is not commercial in its orientation, it seems preferable to handle them together.

The Competition Principles Agreement (CPA), which underpins the NCP legislative review program, does not define what constitutes a restriction on competition. However, the National Competition Council (NCC) has suggested seven ways in which legislation might limit competition (NCC, *Legislation Review Compendium*, April 1997, p. 4). (These have been incorporated into the review's terms of reference – see appendix.) According to the NCC, an act (together with its subsidiary regulations, procedures, etc.) could restrict competition if it:

- governs the entry and exit of firms or individuals into or out of markets;
- controls prices or production levels;
- restricts the quality, level or location of goods and services available;
- restricts advertising and promotional activities;
- restricts price or type of input used in the production process;
- is likely to confer significant cost on business; or
- provides advantages to some firms over others by, for example, sheltering some activities from pressures of competition.

Because the *Mental Health and Related Services Act* is not oriented to commercial criteria, it is not a straightforward task to match its provisions with the potential restrictions listed above. There are no references in the act to prices or advertising activities, or to types of companies that can operate in the provision of mental health services, though ‘approved’ treatment facilities and agencies are defined. Only a psychiatrist employed by government or by a government agency or authority can make an order to admit a person as an involuntary patient for treatment on grounds of mental illness or mental disturbance, or make an interim community management order. The very concept of ‘involuntary treatment’ is fundamentally anticompetitive from a user’s viewpoint, and the reservation of involuntary admission orders to public sector officers *ipso facto* excludes private providers of that service.

These may be necessary and entirely appropriate restraints for a humane community that protects the rights of those who are unable fully to act in their own best interests. But the nature of these measures needs to be identified and their effects on market structure, and the efficiency and efficacy of mental health care service provision assessed.

For this analysis, the features of the legislation that are potentially anti-competitive appear to be limited to the first and third points raised in the NCC’s list, namely:

- restrictions on entry of firms and individuals to the treatment of people with mental illness; and
- restrictions on the quality and location of mental health services provision.

Restrictions on entry

Some features of standards of care required under the act might make it expensive and therefore difficult to enter the mental health care industry. But provided they do not discriminate between categories of supplier (say, private versus public) they need not impede competition. They might merely form the framework of rules within which firms and people can compete on equal terms. In this context they would only be judged to restrict competition if they conferred significant costs on business to ensure required outcomes which could be achieved in less regulatory and less costly ways. However, certain features of mental health care requirements might restrict service provision by private sector operators.

The act does not appear to restrict voluntary treatment for mental illness that does not require admission to an approved treatment facility, though some particular treatments are controlled. Inpatient treatment facilities must be approved, however, if they treat patients who are admitted involuntarily. Approved inpatient facilities can treat voluntarily admitted patients, but only where informed consent is clearly stated by the patient or by his or her guardian. Outpatient facilities used to treat people involuntarily must also be approved.

Nothing in the act specifies that an approved treatment facility or agency needs to be in the public sector, but features of the legislation may make it hard for a private operator (either a firm or individual) to enter some aspects of mental health care service provision. The secretary of THS must appoint the person in charge of an approved treatment facility or agency. A designated psychiatric practitioner must be a qualified psychiatrist or psychiatric registrar (trainee psychiatrist), and also be employed as a psychiatrist by government or a government agency or authority in an Australian jurisdiction. This means that a private psychiatrist cannot commit a patient involuntarily, though he or she can make a recommendation for a psychiatric examination.

Also, the act allows some categories of professionals, such as social workers or psychologists, to be appointed as designated mental health professionals if they are employed in an approved treatment facility or agency. However, they appear not to be able to be appointed if they are in private practice on their own account.

Restrictions on quality and location of services

Only one section of the act explicitly distinguishes between public and private treatment. Section (169) regulates access by private mental health patients and their psychiatrists to approved treatment facilities. Access by a private psychiatrist is permitted where a patient is admitted as a private patient if the psychiatrist:

- is approved by the person in charge of the facility;
- uses only treatments in accordance with policies of the facility; and
- attends only at times specified by the person in charge of the facility.

Furthermore, the person in charge may charge for the cost of services provided.

None of these requirements of itself is anticompetitive. Users of facilities should abide by the policies and priorities of the provider of those facilities and meet costs of services provided. Also, public facilities cannot be expected to provide the range of services that might be sought for private patients, and it might not be desirable for public treatment regimes to be disrupted to meet requirements of private psychiatrists and their patients. However, where government is a dominant supplier and purchaser of services, there is always a concern that provisions such as those that limit access by private mental health patients and their psychiatrists to approved treatment facilities might be used to lock the private supplier out of the market. There do not appear to be any guidelines in the approved procedures that address this concern.

The act contains a number of provisions regarding treatment after admission. These relate principally to the protection of patient rights rather than to quality of treatment. However, there are also a number of provisions that either prohibit or directly regulate certain forms of treatment, and in the case of electroconvulsive therapy there is a requirement that premises in which it takes place be licensed. All of these restrictions appear to be directed to the prevention of abuse, and to consider any of them to be potentially anticompetitive may be to stretch the concept too far. However, use of some of these treatments requires authorisation or review by an authorised psychiatric practitioner, which might be considered by some to restrict the quality and location of service provision.

Effects of the restrictions on competition

These features of the act, in principle, could discriminate against the supply of mental health care services by the private sector. Whether they do in practise is another matter. The Northern Territory is a very different type of market for psychiatric services than are those of the states where there are larger numbers of specialist psychiatrists and psychiatric facilities.

Whether there is scope for more private mental health care facilities and practitioners in the Northern Territory is not a matter for this review. However, whether the legislation or the size of Territory Health Services as a supplier and buyer of services in the comparatively small Northern Territory mental health care sector have had any effects on private sector providers is an issue that needs to be explored. The review team sought comment on these matters in its issues paper, but did not receive any responses which suggested that the provisions of the act were not having any impact on actual or potential private sector providers.

5

The balance between costs and benefits of each restriction

THE FOURTH REQUIREMENT OF THE NCP review process is to assess the balance between the costs and benefits of any potential restrictions on competition. That is, there is a requirement to consider whether restrictions on competition are in the public interest. The guiding principle of NCP requires the onus of proof in this regard to be with those who argue for the maintenance of any restrictions.

The case for restrictions on competition being in the public interest (that is, their social benefits exceed their social costs) is usually made on grounds of 'market failure' in an unrestricted market. Some of these arguments do not appear to be of any relevance in the case of the *Mental Health and Related Services Act*.

For example, one traditional 'market failure' argument for restrictions is to ensure that those who benefit from an activity pay for it. However, the whole underpinning of the public provision of health care services in Australia is premised on all members of the community sharing basic medical and hospital service costs, irrespective of who benefits. This is taken to be in the public interest. Nothing in this act is contrary to that viewpoint. On the other hand, the provision regarding access by private mental health patients and their psychiatrists to approved treatment facilities does seek to ensure that beneficiaries who seek mental health services beyond basic care do pay for it.

However, the overriding argument for restrictive provisions in this act is that a 'market' driven delivery system of mental health care would fail to deliver community expectations about the protection of individuals and the community where people are involuntarily admitted for treatment of mental illness. This is because such people are incapable of making informed choice, which is a basic premise of an efficient competitive market. It is in terms of this 'market failure' argument in the broad, rather than the traditional components of market failure theory, that the following assessment of public interest is undertaken.

Costs of the potential restrictions on competition

Apart from the public provision of basic mental health care, the social costs of restrictions on mental health care delivery are of three types:

- administrative, enforcement and compliance costs;
- efficiency losses caused by appropriate services not being provided or such services as are provided not being supplied at least cost; and
- restrictions on choice by users.

Such costs appear to be minimal in regard to services where admissions and treatment are voluntary. Where the patient is private and uses a private facility or practitioner, the act does not impose any costs of these types. If the patient is under care of a private psychiatrist and uses a public inpatient facility, the only costs of these types would be those associated with approval being given by the person in charge of the facility. However, there could be some efficiency losses in this situation if approval was denied in order to squeeze out a private psychiatrist, which could happen if limited facilities have to be rationed between public and private use.

The principal administrative cost imposed by the requirements where admissions are voluntary and the patient (whether private or public) is admitted to an approved treatment facility, is the need to ensure that the person or his or her guardian gives consent. An efficiency cost might be imposed by the limited choice of approved treatment facilities to which the person can be voluntarily admitted. This is a normal feature of admission in the public hospital system, and for the private patient is more likely to be a consequence of the small size of the market in the Territory rather than of the restriction on treatment of voluntary admissions.

The costs of the restrictions are potentially more widespread where admissions for treatment are involuntary. Administrative requirements of procedures that have to be followed to ensure that personal rights are not infringed without due cause and in the best interest of the patient are significant. Limits are placed on the provision of some functions by people in the private sector. And choice by users is, in the very nature of the requirements, minimal.

The regulation of certain forms of treatment is also not without administrative, enforcement and compliance costs. Whether there are significant efficiency costs and imposts on users are issues that also need to be explored.

Benefits of the potential restrictions on competition

The benefits of restrictions on mental health care delivery need to be assessed in terms of the objectives of the act that were discussed in chapter 4 of this report. These can be summarised as:

- the assurance of care, treatment and protection of people with mental illness;
- the support of family, friends and non-professional care givers of people with mental illness;
- assurance that government administrators do not needlessly treat people with mental illness involuntarily and deprive them of their liberty; and
- protection of the wider community in the processes of providing care and treatment to people with mental illness.

The balance between costs and benefits

Earlier chapters of this report have described three features of the act in terms of which an assessment of the net public benefit of any potential restrictions on competition might be assessed. These are: procedures for giving informed consent for voluntary admission and treatment for mental care; procedures for involuntary admission for treatment; and the prohibition or regulation of certain forms of treatment. These form the headings under which the following assessments of the balance between costs and benefits are made.

In the preceding chapter it was also reported that comment was sought in the issues paper on whether features of the act that were considered potentially to restrict competition by reserving certain functions to the public sector were having any actual impact on private sector providers. In view of this lack of response, it could not be concluded that the potentially anticompetitive features of the act have had any actual anticompetitive impacts. Therefore, it is the costs of their potential impacts, or of the possibility of actual impacts that have not been observed, that need to be assessed against the benefits which the restrictions are expected to achieve.

Procedures for giving informed consent for voluntary admission and treatment

Notwithstanding approved treatment (inpatient) facilities being essentially places where involuntary treatments can take place, persons over the age of 14 (or parents and guardians of persons under the age of 18) can apply for

voluntary admission. Part 5 and part 8 (division 1) of the act deal with procedures that must be followed to establish that persons seeking voluntary admission to an approved treatment facility and receiving treatment in such a facility are capable of doing so and are doing so with their informed consent.

These procedures are procompetitive in intent to the extent that they are in place to ensure that choice is informed, which is a presupposition for an effective and efficient competitive market. Nothing in the act prevents those voluntarily seeking mental health treatment from using other categories of facilities. And although the only two approved treatment facilities in the Northern Territory are in the public sector, there is nothing in the act that would prevent a private facility from being established.

However, two features of arrangements for those who seek and receive voluntary admission and treatment may limit choice. The first is that, whether public or private, voluntary admission and treatment in an approved treatment facility must involve examination and authorisation by an authorised psychiatric practitioner who, under the act, is a specialist psychiatrist who must work for the government or a government agency or authority. Although this could possibly limit choice, the provision is there to ensure public responsibility that untoward pressure has not been placed on people to seek treatment, and that those who seek it are appropriately informed and can benefit from admission and treatment.

The second limitation on choice is that private psychiatrists (who are more likely to treat those who seek voluntary admission than those who are involuntarily admitted) have access to an approved treatment facility only if they are approved by the person in charge of the facility, only use treatments in accordance with policies of the facility, and attend only at times specified by the person in charge of the facility. Furthermore, fees may be charges for the facilities provided.

As concluded in the preceding chapter, none of these access requirements is of itself anticompetitive, since in any commercial arrangement a user of facilities must abide by policies of the provider. It becomes an issue in the Northern Territory because the government is such a dominant provider and purchaser of mental health services that the needs of private providers of voluntarily admitted patients could be squeezed out. Also, as pointed out in the preceding chapter, there do not appear to be any guidelines in the approved procedures that address this concern.

The benefits of having statutory requirements that ensure that choice about voluntary admission and treatment for mental health care is informed, that

undue pressure is not placed on those seeking it, that publicly supplied services are appropriate and will benefit the patient, and that access by private providers does not compromise public provision in public facilities are undoubtedly large. The review team did not receive any evidence that the potential restrictions on choice or competition in these regards were having any adverse effects in practice. Nor, with the exception that a specialist psychologist employed in the public sector must be involved in voluntary admissions and treatment, does there appear to be any statutory limit on providers of private inpatient facilities being authorised for admission and treatment – whether voluntarily or involuntarily.

It can be concluded that the benefits of those features of the act which regulate voluntary admissions and treatment exceed their costs by a large margin and there is a strong net benefit case for their retention. However, a case could be made for considering changes which reduce biases toward public sector provision.

Procedures for involuntary admission for treatment

The major thrust of the legislation is concerned with circumstance in which informed consent is not or cannot be given and admissions are involuntary. It is largely for these circumstances that approved treatment facilities and the status of authorised psychiatric practitioners and designated mental health practitioners are defined. Although nothing in the act precludes authorised treatment facilities being provided by the private sector, or excludes private psychiatrists or other private mental health care practitioners, the procedures to be followed in the case of involuntary admission and treatment imply public responsibility throughout.

A basic tenet of an efficient competitive market for services is that users have choice and that they can become adequately informed about alternatives available to them at reasonably low cost. Where this is the case, the principle of *buyer beware* is usually deemed to be an appropriate discipline to guide choice of services and service providers. Yet adequacy of alternatives and information about them is a major stumbling block for many health care service users, even if they are fully capable of evaluating such information as they can obtain.

Where admission for treatment is involuntary, the *buyer beware* principle is clearly inappropriate. Thus, a major orientation of the objectives and principles of this act is to guide *anticompetitive* but socially humane actions that defend the rights of the individual and his/her family whilst protecting that individual, mental health care workers, the Northern Territory government and the wider community.

Although the 'demand side' features of the act which limit the choice of individuals are anticompetitive (though socially beneficial), no anticompetitive 'supply side' costs in terms of alternative potential providers of services actually being excluded or appropriate services not being provided in least cost ways were brought to the attention of the review team. It can be concluded that the benefits of the public ensuring that its obligations to protect people who cannot protect themselves exceed their costs by a large margin and there is a strong net benefit from retaining existing procedures for involuntary admission for treatment.

The prohibition or regulation of certain forms of treatment

A number of forms of treatment are directly prohibited or regulated within part 9 of the act. Psychosurgery, coma therapy and sterilisation are prohibited. Limits on the use of mechanical means of bodily restraint and on solitary seclusion of patients are specified at length. Non-psychiatric treatments (as defined) and major medical procedures cannot be performed on an involuntary patient except in some defined extreme circumstances. Clinical trials and experimental procedures cannot be performed on an involuntarily admitted patient unless approved by an ethics committee and informed consent of the patient or of the Mental Health Review Tribunal is obtained.

A separate division of part 9 is devoted to the regulation of electroconvulsive therapy. In ordinary circumstances electroconvulsive therapy must be authorised by the tribunal. It can be performed in emergencies by authorisation of two authorised psychiatric practitioners, but must be reported as soon as practicable after it is performed to the tribunal. Premises on which the treatment is performed must be licensed, the granting of a licence depending on the suitability of the applicant, the premises, the equipment, the qualifications of the persons performing the treatment and such other conditions as may be specified. Licensees are also required to submit a monthly return providing certain details about any treatments performed.

These matters are highly prescriptive and prima facie anticompetitive. However, none appears to exclude a certain class of provider (public or private). They all appear to be directed towards the protection of patient rights and/or the prevention of abuse. It is clearly in the public interest to ensure that certain treatments or techniques that have a high probability of causing serious damage if practised by persons with inappropriate qualifications are practised only by those who are suitably qualified, and to seek to ensure that they are undertaken only with the informed consent of those

on whom they are performed. Where this latter criterion cannot be fulfilled, it is important that strict criteria and procedures be specified to protect individual rights and minimise harm.

Without being able to judge the benefits and costs of specific prohibitions and regulations in part 9 of the act, the review team considers that, as a genre, they are in the public interest. This said, the act is very new and some of the restrictions appear to be reactive to particular adverse outcomes in the recent past in Australian mental health treatment experiences. Care needs to be taken that their highly prescriptive nature does not restrict flexibility of appropriate treatment in a rapidly changing environment of treating mental illness.

Although it can be concluded that the benefits of the prohibition or regulation of certain forms of treatment exceed their costs by a large margin, and there is a strong net benefit from retaining part 9 of the act, with the passage of time many of the particular provisions in this part are likely to date and new provisions will be found necessary. To have to amend the act each time such a change is deemed necessary might be slow and cumbersome. It might be preferable to introduce a mechanism to the act that would allow such evaluations and changes to be made, subject to public consultation and the other normal regulation impact assessment procedures designed to protect the public interest.

6

Alternative means of achieving objectives and recommendations

IN THE PRECEDING CHAPTER it has been concluded that the benefits of all the principal features of the *Mental Health and Related Services Act*, including those which potentially or actually restrict competition, exceed their costs by a large margin, and there is a strong net benefit from their retention. However, a final task in an NCP review is to consider whether there are alternative means of achieving the same result, including non-legislative approaches. This issue must be addressed even if, as in the case of all features of this act, all features have been assessed to be in the public interest.

A more flexible approach to one highly prescriptive part of the act was raised at the end of the preceding chapter. This was to introduce a mechanism that would allow evaluations of certain forms of treatment that might need to be prohibited or regulated because they have a high probability of causing serious damage if practised by persons with inappropriate qualifications. These forms of treatment should be allowed to be practised only by those who are suitably qualified and in circumstances that guarantee the protection of individual rights and minimisation of harm.

However, an issue that must be taken aboard here is that the *Mental Health and Related Services Act* was introduced in response to the Northern Territory's endorsement of the *National Mental Health Strategy* prepared by the Commonwealth, state and territory health ministers and is designed to achieve consistency with the *United Nations Principles for the Protection of a Person with Mental Illness* and with the Australian health ministers' *Mental Health Statement of Rights and Responsibilities*. To introduce any alternative, less regulatory means of achieving the outcomes sought would be likely, at this early stage, to compromise the uniformity of approach thus far adopted. In this context it should be noted that the Northern Territory is the only jurisdiction reviewing its mental health legislation under NCP criteria.

Recommendation

The preceding assessments have demonstrated a strong net benefit for the retention of the existing features of the act. There is no strong case for altering in any fundamental way its principle features. However, there is a case for giving further consideration to measures which reduce the likelihood that private mental health patients and their psychiatrists will be denied access to approved treatment facilities. These could be in the form of stronger guidelines on the use of approved facilities.

Appendix

Terms of reference

THE REVIEW OF THE LEGISLATION shall be conducted in accordance with the principles for legislation review set out in the Competition Principles Agreement. The underlying principle for the review is that legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

Without limiting the scope of the review, the review is to:

- clarify the objectives of the legislation, clearly identifying the intent of the legislation in terms of the problems it is intended to address, its relevance to the economy and contemporary issues and whether or not the legislation remains an appropriate vehicle to achieve those objectives;
- identify the nature of the restrictions to competition for all relevant provisions of the specified legislation. This analysis should draw on the seven ways identified by the National Competition Council in which legislation could restrict competition, which include:
 - governs the entry or exit of firms or individuals into or out of markets,
 - controls prices or production levels,
 - restricts the quality, level or location of goods or services available,
 - restricts advertising and promotional activities,
 - restricts price or type of input used in the production process,
 - is likely to confer significant costs on business, or
 - provides some advantages to some firms over others by, for example, shielding some activities from the pressure of competition;
- analyse the likely effect of any restriction on competition and on the economy generally;

- assess and balance the costs and benefits of the restrictions for each anticompetitive provision identified;
- consider alternative means for achieving the same result and make recommendations including nonlegislative approaches; and
- clearly make recommendations. These should flow clearly from the analysis conducted in the review. If change is not recommended and restrictions to competition are to be retained, a strong net benefit for retention must be demonstrated.

When considering the matters referred to above, the review should, where relevant, consider:

- government legislation and policies relating to ecologically sustainable development;
- social welfare and equity considerations, including community service obligations;
- government legislation and policies relating to matters such as occupational health and safety, industrial relations and equity;
- interests of consumers generally or of a class of consumers;
- government legislation and policies relating to ecologically sustainable development;
- economic and regional development including employment and investment growth;
- the competitiveness of Australian business; and
- the efficient allocation of resources.

The review shall consider and take account of relevant legislation in other Australian jurisdictions and any recent reforms or reform proposals including those relating to competition policy in other jurisdictions.

The review shall consult with and take submissions from those organisations currently involved with the provision of health services, other interested territory and Commonwealth government organisations, other state and territory regulatory and competition review authorities, affected members of the medical profession and their organisations and members of the public.