Submission template

Response to *Review of the Mental Health Act 1986 Some key questions*

Introduction

This template is designed to assist people in making a submission in response to the *Review of the Mental Health Act 1986 Some key questions* paper. It contains a list of the questions posed in the paper. Comment is welcome on any matter related to the Act, and need not be limited to the questions in the paper or the *Consultation paper*.

Please note: Closing date for submissions is 5:00pm on Friday 27 February 2009. The use of this template is optional.

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List of questions in *Review of the Mental Health Act 1986 Some key questions* paper

Framework for reform (Ch.2)

(a) What other reforms could the new Act include?

Southwest Advocacy Association (SWAA) supports the reform objectives that have been established in this review and would like to see the objects and principles in the Act amended as suggested in section 2.6 on page 14 of the MHA Review Consultation Paper.

SWAA would also like to see the National Standards for Mental Health Services strengthened, with compliance being mandated in the Victorian Mental Health Act.

Involuntary orders (Ch.3)

(b) When should people who are seriously mentally ill be able to be placed on an involuntary order under the new Act?

SWAA supports the introduction of assessment orders as part of a staged process for involuntary treatment. The criteria for continuing involuntary treatment should be more strict at each successive stage of the process. Assessment orders should last no more than 72 hours, although mental health services should be able to apply for 24 hour extensions of the assessment order period if the service can demonstrate a genuine need for an extension. This

assessment order extension process should be scrutinised by and independent review body, such as the Mental Health Review Board (MHRB).

During the assessment order period, people should be independently assessed by two psychiatrists and the opinions of both psychiatrists should be documented and made available to the patient and the review authority.

Legislative provisions that emphasise that involuntary treatment should only be considered as a last resort and that the least restrictive option must be pursued need to be strengthened in the new legislation.

SWAA believes that the criteria for involuntary treatment should be more strict and clear than is currently the case. SWAA supports legislative changes that focus on whether a person's ability to make decisions about treatment are significantly impaired; that require mental health services to show that treatment is necessary and will benefit the patient; that require evidence that any risk to the patient and/or others is significant; and that require mental health servives to establish that involuntary treatment is necessary because there is no less restrictive option available.

(c) How could the new Act improve ITOs and CTOs to better meet patients' needs?

There should be distinct definitions and criteria for ITO's and CTO's in the legislation and the MHRB should have the power to review and make approriate determinations in relation to each respective type of order. Under the legislation the definition and legal criteria for a CTO should make it a less restrictive option than involuntary treatment as an in-patient at a mental health service.

SWAA is of the strong view that the role of the MHRB needs to be broadened so that, in addition to determining whether a person meets the criteria for involuntary treatment, the MHRB should also be empowered to review decisions about treatment made by mental health services.

Moreover, mental health services should be accountable to the MHRB for showing that treatment is achieving or likely to achieve a desired outcome that is in the best interests of the patient or, alternatively, should be required to show why treatment is not achieving the desired outcome or goal and how the mental health service plans to address the issues at hand.

SWAA supports the safeguards around involuntary treatment that exist in Scotland's mental health system in relation to consent to treatment, 2 month time limits, and independent psychiatric opinions, as referred to in section 3.3.4 on page 22 of the MHA Review Consultation Paper.

SWAA supports the introduction into legislation of specific minimum timelines for clinical review and independent external review by the MHRB, as provided in the NSW legislation, and referred to in section 3.3.5 on page 23 of the MHA Review Consultation Paper.

Patient participation (Ch.4)

(d) How could the new Act improve patient participation in decisions about treatment and care?

SWAA believes that there is an inherent conflict of interest for mental health services in treating involuntary patients and providing information to them on their rights at the same time. SWAA believes that the Act should require that involuntary patients be actively assisted to understand their rights and issues in relation to their treatment by an independent person, preferably a trained advocate.

SWAA strongly supports the concept of involuntary patients being able to nominate key person's to receive information on their rights and treatment. A general statement of patient rights should automatically be provided to all patients and to the patient's guardian and primary carer or partner. These statements should also be provided to a family member or friend, if nominated by the patient.

SWAA would also like to see the legislation require that an independent advocate be appointed to assist every involuntary patient to understand and exercise their rights and negotiate with the mental health service in relation to treatment issues on behalf of the patient.

To promote consistency and a benchmark standard for treatment plans, the format and minimum content of treatment plans should be prescribed in legislation or associated regulations. It is also essential that patients, guardians and primary carers be involved in the development of treatment plans. Family members nominated by the patient and any advocate nominated by the patient should also be involved in the development of treatment plans.

The legislation should require that treatment plans be reviewed by mental health services in consultation with patients, guardians, primary carers and family members nominated by the patient and any advocate nominated by the patient, at least once every 6 months and more frequently at the request of the patient . There should also be legislative provision for an independent body, such as the MHRB, to review treatment plans at the request of patients and to authorise changes to treatment plans.

To promote fairness and a comprehensive approach, it is SWAA's strongly held view that a patient's right to obtain access to a second psychiatric opinion that is completely independent from the treating mental health service must be included in a new legislation.

SWAA strongly supports the introduction of legislative provisions for the use of advance statements into legislation and recommends that mental health services be required to take any advance statement into account in making treatment decsions. The wishes of patients set out in advance statements should only be discounted where there are good clinical or legal reasons to do so. Patients and carers should be entitled to have disputes regading advance statements referred to and determined by an independent external review or complaints body with the power to make binding decisions on mental health services.

Electroconvulsive therapy (ECT) (Ch.5)

(e) How should the new Act deal with ECT?

SWAA supports the licensing and monitoring of ECT providers through legislative provisions.

Adherence to international best practice standards for ECT should also be mandated under legislation.

It is SWAA's view that under the new legislation patients should not be able to consent to ECT without a completely independent second psychiatric opinion and review by an independent review body, such as the MHRB.

Restraint and seclusion (Ch.6)

(f) How should the new Act deal with restraint and seclusion?

SWAA believes that restraint and seclusion should only be used as a last resort: when there is an immediate or imminent risk to someone's health and safety; to prevent the persistent destruction of property; or where there is a significant and imminent risk of absconding and absconding would create a immediate or imminent risk to health and safety.

Restraint and seclusion should always be reviewed and endorsed by the authorised psychiatrist as soon as practicable, regardles of how such treatment is initiated.

Instances of restraint and seclusion should also be documented by mental health services and reported within 24 hours and recorded by an independent complaints authority, such as a mental health commissioner.

Instances of restraint and seclusion should also be subject to an independent complaint process overseen by an independent complaints authority, such as a mental health commissioner.

SWAA supports enhanced clinical monitoring of instances of restraint and seclusion, by an independent authority, such as a Senior Clinician.

SWAA also believes only way that the mental health legislation can be consistent with its obligations to respect human rights is to require that restraint and seclusion should be ended immediately when the grounds for their use under the legislation cease to exist.

SWAA believes that it is entirely reasonable and desirable for the legislation to require that restraint and seclusion only be applied by appropriately trained personnel.

With adequate safeguards in place, restaint and seclusion may be required in some circumstances during the period of an assessment order, but would seem less likely to be required in relation to voluntary patients generally.

Instances of restraint and seclusion should be reported to guardians, primary carers and family members nominated by the patient and/or to a person nominated by the patient. The wishes of patients expressed in advance statements regarding this matter should be applicable.

External review (Ch.7)

(g) How should the new Act deal with external review of involuntary orders?

Many of the existing legislative provisions designed to safeguard the rights of patients are commendable and should either remain in place or be strengthened. The main deficit under the existing legislation is that the timelines for review are too long and it is too difficult for patients to obtain an independent second psychiatric opinon.

Involuntary treatment orders should be reviewed by an independent and external review body, such as the MHRB, within 7 days and not less than every 3 months thereafter.

Community treatment orders should not apply for more than 4 months and the treating mental health service should be required to show that the treatment plan is achieving desired outcomes or to give reasons why it is not achieving outcomes and be required to consider adjustments.

Review proceedings should remain as informal as possible; patients should have the right to legal representation; and patients should be actively assisted to access independent advocacy. The mental health system should contribute to the funding and specialised training of independent advocacy organisations.

Mental health services should be required to have an independent second psychiatric opinion documented for the review authority to consider and a copy of this report should be provided to the patient and their legal representative and/or advocate at leaset 3 business days prior to the review hearing.

Subject to the existing exemptions, the legislation should strengthen the rights of patients and their legal representatives and advocates to view the patient's file at any time and particularly in the lead up to review hearings.

Review hearings should generally be conducted in person at a neutral, non-threatening, non clinical venue. Review hearings should not be conducted by video-conference, unless there are advantages for the patient and the patient does not object, and review hearings should not be conducted at mental health services, unless the treating mental health service can satisfy the review authority that there would be a serious risk to health and safety if a hearing were conducted outside a clinical setting.

Guardians, primary carers, advocates and other interested persons nominated by the patient should be notified of review hearings. Key adult family members should also be notified of review hearings, but the patient should have the right to object to the participation of third parties in review hearings and the reviewing authority should be empowered to decide whether a third party should be heard and whether they should be allowed to remain present after giving their evidence.

The legislation should require that a key member of the treating team from the mental health service and the treating psychiatrist be present at all review hearings.

The new legislation should incorporate the functions of the existing Psychosurgery Review Board within the functions of the external review authority that reviews involuntary orders.

Monitoring patient wellbeing (Ch.8)

(h) How could patient rights and wellbeing be protected and monitored in the new Act?

SWAA believes that the roles and responsibilites of the Office of the Chief Psychiatrist and the OPA Community Visitors Scheme under the current system are confusing, are not well understood by patients and are generally inadequate.

SWAA strongly supports the creation of a Mental Health Commissioner with a resposibility to visit mental health services on a frequent and unannounced basis; to monitor the adequacy and appropriateness of facilities and patient care and treatment; to provide advice and assistance to patients in regard to their rights; to ensure that mental health standards and legislative requirements in relation to patients are being met; to receive and investigate complaints from patients, guardians, primary carers, family members and advocates; to investigate and review the deaths of involuntary patients and voluntary in-patients of mental health services; and to make determinations (not just recommendations) that are binding upon mental health services.

SWAA also supports the establishment of a Senior Clinician under the Mental Health Act, with similar functions to the Senior Clinician created under the Disability Act 2006, as outlined in section 8.3.3 on page 63 - 64 of the MHA Review Consultation Paper. In fact, with increased resources and ehanced expertise, SWAA does not see why the Office of the Senior Clinician established under the Disability Act could not perform functions in relation to both the Disability Act and new mental health legislation.

The activities and major findings of the Mental Health Commissioner and the Senior Clinician should be published in publically available annual reports.

SWAA would like to see compliance with appropriate clinical standards mandated under legislation and there are a range of penalties that could be imposed upon mental health services and/or practitioners for non-complaince , including prosecution, fines, suspension of accreditation until standards are met, and referral of individuals to professional registration bodies, such as the Nurses Registration Board and the Medical Practitioners Board.

Complaints (Ch.9)

(i) How could the new Act improve the complaint system for mental health?

SWAA believes that the current system of complaints is inadequate, fragmented, confusing and in urgent need of reform to make it simpler and more streamlined, transparent and meaningful. There should not be multiple avenues of complaint and the complaint process should have as few tiers as possible. The goal should be to establish a process that is quick, simple to use, consistent, transparent and accountable.

In order to promote clarity and consistency, SWAA believes that there should be a uniform "local level" complaints sytem, based on international best practice principles, that all mental health services in Victoria are required to adhere to. SWAA believes there should be mandatory requirements on mental health services that link local level complaints to quality improvement and transparency measures, such as those that apply in the Northern Nerritory, referrred to in section 9.3.1 on page 68 of the MHA Review Consultation Paper.

SWAA strongly supports the legislative introduction of an independent Mental Health Commisioner to deal with complaints and a Senior Clinician to monitor and uphold compliance with clinical best practice and mental health service standards (please refer also to SWAA's comments in relation to Chapter 8 of the Consultation paper above).

To uphold the rights of patients, it is absolutely vital that external complaints bodies have the power to make binding decisions upon mental health services. A

complaints body that cannot do more than endeavour to conciliate disputes or that can only make recommendations to mental health services is inadequate. SWAA does not want to see the creation of another "toothless tiger" that just mediates or makes recommendations and issues reports. A mental health complaints authority must be able to require mental health services to take reasonable and appropriate measures to resolve disputes.

In the interests of balance, if a mental health service disagreed with a determination of the independent complaints body, the legislation could provide for an appeal process to an independent adjudication body, such as VCAT.

In SWAA's view the powers of the HSC in relation to health information privacy complaints as outlined in section 9.3.3 on page 70 of the MHA Review Consultation Paper have a number of desirable features, but still need to be stronger. For example, the HSC can only issue a "legally enforceable compliance notice following a serious or flagrant contravention of legislation". Rather, compliance notices should be able to be issued for any breach of the legislation or to ensure that a mental health service is following "best practice" in its policy and procedure.

It is also essential that the legislation clearly establish that patients have the right to utilise the assistance of an advocate or another nominated person at each step of both local level and external complaint processes and that the advocate or nominated person have access to all relevant documentation.

The new legisaltion should also require that mental health services' complaints handling processes and the reporting of complaints and outcomes must be linked to continuous quality service improvement processes and this should be monitored and enforced by the Senior Clinician.

Confidentiality and information sharing (Ch.10)

(j) When should patient information be shared with others?

SWAA believes that it is very important to strike an appropriate balance between the privacy rights of patients and the need to disclose information to ensure that a person receives appropriate treatment and care and support. SWAA believes that many of the privacy safeguards and exemptions that currently apply, as outlined in section 10.2 on pages 73 - 75 of the MHA Review Consultation Paper are valuable and that it is important not to "throw the baby out with the bathwater" in relation to privacy protection and metal health.

It is difficult to make hard and fast rules in relation to the families of patients because family dynamics are so complex and familiy relationships are so varied. The interests, motivations and views of family members can be quite diverse. SWAA does not believe that information should be disclosed to family members without a patient's consent, unless one of the exemptions under existing privacy legislation applies.

At the same time, SWAA believes that the situation of "primary carers", who are actively involved in the ongoing care of patients, and the standing of the guardians of persons under 18 years of age and legally appointed guardians should be different to that of family members generally. The definition of terms such as "primary carer" and "ongoing care" should be set out in detail in the legislation and primary carers should be consulted and informed about significant treatment decisions unless it is demonstrably not in the best interests of the patient.

Guardians should also be provided with all relevant information in regards to a patient and guardians should be allowed to consent to the disclosure of specific and relevant

information about a patient to other parties where the guardian believes it is in the best interests of the patient for the guardian to provide such consent.

Significant and/or relevant information should be released to persons that a patient nominates to receive such information, including the patient's advocate or nominated representative.

Significant and/or relevant information should also be released to key service providers involved with a patient, such as other medical practitioners, drug and alcohol services, and disability services, where there is a practical need for such service providers to be provided with the information and it is in the best interests of the patient, however the patient should be informed and the patient's consent should be sought first.

Please attach any further comments.

Southwest Advocacy Association ("SWAA") is an independent, not-for-profit, community organisation that has been funded by the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs to provide advocacy and information to people of all ages and with all types of disabilities throughout south west Victoria since 1993. South west Victoria is comprised of some 24,000 square kilometres and has a dispersed regional population of some 100,000 people. It includes the municipalities of Warrnambool City and the Shires of Moyne, Glenelg, Southern Grampians and Corangamite, with major population centres in Warrnambool, Hamilton and Portland.

People with psychiatric illnesses and disabilities comprise a significant proportion of SWAA's clients. SWAA regularly provides representation to people on ITO's and CTO's before the MHRB and regulalrly liaises with mental health services on behalf of patients/clients in regards to treatment issues and patient/client concerns.

SWAA believes that Victoria' Mental Health Act is in urgent need of modernisation and reform to strenthen patient rights and the quality of mental health services and to comply with the requirements of international human rights conventions and best practice in mental health.

SWAA welcomes the opportunity to contribute to this review and is hopeful that the recommendations it has made in this submission will be accepted.

Please keep SWAA informed of opportunities for further input and of future developments in regard to the review.