Review of the *Mental Health Act 1996* & *Criminal Law (Mentally Impaired Defendants) Act 1996*

Protection of Patients Rights (Part 7 & 10 of the MHA), including Complaints Processes and Carers Rights Working Party

Background to working party recommendations.
The working party meet on a number of occasions from late October to early March, and in researching the parts of the Act with which it was dealing a number of strategies was used.

The working party consisted of most of the relevant stakeholders, however limited input was received from a representative of indigenous people and there was no police representation.

These included

⇒ Role play with a psychiatrist and consumer advocate – this highlighted a number of areas of concern – including lack of clarity in relation to various timelines, lack of consistency in the interpretation of timelines, the numerous forms to be completed, and where there were gaps in notifying someone about the fact that a person was being detained under the Act.

⇒ Presentation by Carers

⇒ Brainstorming of ideas.

⇒ Researching other legislation including Guardianship and Administration.

⇒ Researching the operations of Mental Health Legislation in other States and Territories. Like many other working parties the legislation from the Northern Territory was viewed as a good model.

⇒ Written material provided by a number of participants including;

- A set of Regulations
- Sections of the Act including the 'Seclusion" section.
- Principles of the National Standards
- A copy of the equivalent to Section 7 from each State

The first meetings included discussion on the Terms of Reference, the Review process, confidentiality and conflict of interest issues. At the second meeting the issue of taping meetings for the purpose of the Minutes was discussed and consent was given to this.

Appreciation;
SUPPORT STAFF*;*

- Ms Rachelle Davies
- Ms Sylvia Meier
- Ms Jill Rapp
- Mr John Titmus

PROTECTION OF PATIENTS RIGHTS WORKING PARTY;

Ms Ann White Convenor	WA Association for Mental Health
Ms Maxine Drake	Health Consumers Council Representative
Mr Kevin Hogg	Council of Official Visitors Representative
Ms Pam Mikus	Graylands Health Service
Mr David Broughton	Graylands Health Service
Mr Chris Mulhall	Mental Health Consumers Advocacy Program
Ms Elaine Smith	Carer Representative
Ms Cushla Leach	Carer Representative
Ms Janet Peacock	Office of the Chief Psychiatrist
Ms Elaine McKewan	Office of Health Review Representative
Dr Steve Baily	Alma St & Peel Mental Health Services
Ms Peta Melbin	Bentley Mental Health Service
Ms Julie Crews	Office of Women's Interest
Dr Jenny Sudbury	GP Division of WA
Ms Marion Hood	Nursing Graylands Health Service
Ms Selva Stenross	Mental Health Law Centre
Mr Peter McGlynn	Department of Community Development
Ms Jennifer Stott	Derbarl Yerrigan Health Service
Ms Jo Ann Foy	Mental Health Nurse Clinician - Graylands
Mr Patrick Byrnes	Nurse – Graylands Health Service
Mr Alan Brook	Nurse Rep – Graylands Health Service
Dr Julia Alexandra Charkey-Papp	Graylands Health Service
Dr Nathan Gibson	Graylands Health Service
Ms Pieta McCarthy	Complaints Officer
Ms Sandra Collard	Office of the Aboriginal Affairs
Ms Jenny Au Yeong	Ethnic Disability Advocacy Centre

Current system and problems identified.
The reason for the role-play was to depict the interface between the law and the clinical process, as there are many variables. The requirements of the Act are supposed to assist when making a decision. However as was highlighted during this process there were a number of areas of concern.

A person with an alleged mental health crisis is generally introduced into the mental health system for the following reasons:

- There is a request from somebody regarding the person's behaviour; or
- The person themselves may request assistance; or
- The person may have a previous history, or
- The person may have become agitated and behaving strangely and there is some cause for concern. Therefore, someone close to the person (relative, spouse, neighbour) notifies the authorities regarding the state of the person.

Some of the issues that arise are:

- A triage officer is called and the matter reported. It was noted that the person reporting the situation might not wish to be identified.
- The person may be willing to go with the triage officer. If the person recognises there is a problem – they can be given their medication to alleviate the problem temporarily or be taken to hospital. If they are not willing to go they may be taken on an involuntary basis or by being escorted.
- However sometimes when the crisis team is called, the person may not allow the PET/crisis team or social worker into their home – if this person is classed as a high level of risk then the Police are called and, if the Police suspect a person is psychiatrically unwell, the person can be forcefully removed.
- It was noted that reporting a person to the police could cause damage to the person's relationships and also to their reputation.
- If the situation is not reported the person can be a risk to his or her self.
- The person in question has a choice of either voluntary going to the hospital or being taken into care. It is important at this point that the assessment of the person is handled delicately so as not to jeopardise or stress the person.
- The Police will assess if a person is psychiatrically unwell and the person is a risk to themselves or to others. The **Police do not need any forms** to remove or escort the person - they have the powers in accordance with the Mental Health Act to do so. The person can be escorted to any Emergency Department or General Practitioner.
- If there is need to move a person from one place of assessment to another centre - a Form 1 is completed by an Authorised Mental Health Practitioner or a Medical Practitioner and the person is taken to a Psychiatrist or an authorised hospital where the person must be seen by a Psychiatrist.
- (*Noted* that at present Form 1 & 3's filled in by the Authorised Mental Health Practitioners are audited and these forms are filled in correctly because of adequate training. It was noted that it is not always easy to audit the General Practitioners though the Office of the Chief Psychiatrist are currently in the process of educating the General Practitioners to complete the forms correctly.)

Overview of Forms 1-11.

These forms do not have any legislative status, and were created solely by the Department of Health for convenience and consistency. It is not a legal requirement that these forms by used however the Act does specify information that must be included in any order.

- *Form 1* – Referral for examination by a Psychiatrist – initial assessment for a person with a mental illness. This is an authority to accept the person and the authority to detain a person in a specific hospital.
- *Form 2* – Order for detention when Voluntary patient referred – another track of a formal assessment by a Psychiatrist. *Note* - Form 2 can be signed by a Mental Health practitioner and is an order used under S 30 Referral of voluntary patients.
- *Form 3* – Transport Order (s34, 41, 71, 84)
- *Form 4* - Order to continue detention for further assessment – for up to a time of 72 hours from the time the person is first received.
- *Form 5* – Order for receival into and detention in hospital for further assessment –
- *Form 6* – Involuntary Patient Order - if the Psychiatrist thinks the patient meets the criteria of S26 they can make an order under S43 to hold the patient.
- *Form 7* – Referral Elsewhere for examination by a Psychiatrist. There was an explanation regarding the Form 7 – if a patient is referred to a specific authorised hospital this information must be reflected on the Form 7 Under s47 of the Act, the person in charge of the hospital can refuse to see the patient if the hospital is on hospital by-pass.
- *Form 8* – Patient no longer an Involuntary Patient – s49 (2), 52(a), 62(2)(a), 63(2)(a), 78. This is when an Involuntary status is changed to Voluntary Status and the patient is released. (S 54 requires that the patient receive a copy of this advice that they are no longer detained.)
  Some Concerns discussed regarding this change of status were:
    - Should a patient not want to be released – the patient may choose to stay on as a Voluntary patient
    - Shortage of beds (resource issue)
    - A patient is discharged when they are not quite well enough
- *Form 9* – Continuation of Involuntary Patient Order – s49(3), 50(2)
  A concern regarding this review was that a patient should be reviewed at least monthly and the length of the Order should be reviewed.
- *Form 10* – Community Treatment Order s43(2)(b), 49(2)(b), 52(b), 62(2)(b), 63(2)(b), 67
- *Form 11*- Revocation of Community Treatment Order – s70

Concerns regarding Forms:

- Forms have no legislative status or legal recognition - the forms have been developed as a matter of convenience for practitioners
- Form 1 is a negotiation process and does not meet any criteria in the Act
- S26 criteria is not addressed at all
- Most general practitioners are not experienced and inadequately trained in the completion of these forms.
- The issue of using the least restrictive avenue when transporting patients with mental health problems had been discussed between the Office of the Chief

Psychiatrist and with St John's Ambulance, Emergency departments and by mail out to General Practitioners. It was noted that there it was usual practice to issue a Form 3 at the same time as issuing a Form 1.

Issues that arise when the person is taken to an institution:

- There are *no forms or paper work* given to the person to explain to them that they have been admitted into the hospital. Even though the Form 1 accompanies the patient it is not given to the patient because it could reveal the identity of the complainant. A possible solution was to block off the information on the Form 1 and then hand the form to the person, or alternatively to have a tear-off section attached to the Form 1.

Recommendation 1:
The person should be informed in writing that they have been admitted into hospital - a copy of Form 1 / or a tear off section of Form 1 should be given to the Patient.

Timelines / time limits.

- When a person reaches an institution the person is not yet a patient until they have been seen by a Psychiatrist and confirmed as having a mental health problem. The time-span for this process commences from the time a Form 1 has been signed and can range from 24 to 72 hours with 7 days being the maximum. A 7-day clock starts from the moment a Form 1 is completed. It was noted that most patients are seen within the 24-hour period. However as the Act covers all of WA and includes Christmas Island, there are some difficulties if a person has to be transported to the Metropolitan area from a remote/rural area for example in a 4 wheel drive. Once the person arrives at the hospital the 24 hour clock beings.

  It was identified that a lack of training for Doctors was a definite problem in interpreting the Act. It was suggested that s30 should be rewritten. The issue of some timelines discussed – with different interpretations by mental health practitioners and lawyers.

  S32 Time Limit.
  The Act states that a referrer is not to refer a person under section 29 if a period of more than 48 hours has lapsed since the referrer personally examined the person.
  S38 Time Limit
  An examination is not to be made by a psychiatrist for the purposes of a referral under section 29(2)(b) if more than 7 days have lapsed since the referral was made.
  S43.4
  An order in respect of a person referred for examination under section 29 can be made under this section only if it is made before the end of the 7th day after the referral was made.
  In this instant 7 days overrides 72 hours and a Form 1 can be extended by issuing a Form 4.

It was obvious from the discussion that there was some confusion over how the different sections regarding timelines interacted. There is a need to clarify this – either through "plain English" legislation or in training and education sessions with those who use the system.

Recommendation 2:
Clarify the timelines in the Act either through "plain English" legislation and / or in training and education sessions with those who use the system.

Duty of Care vs. Patients Rights
At the point of admission as the admitted person is not a patient yet there is no authority to give a person psychiatric treatment without consent except for emergency psychiatric treatment. It was noted that many patients are heavily medicated to alleviate their stress. This can leave the person with partial amnesia where the patient does not recall any previous mental health problems. It was suggested there should be a balance of the amount of medication prescribed in order to alleviate stress.

Recommendation 3:
Review the issue of the amount of medication prescribed in order to alleviate stress

When is a patient a patient or a person or a received person – needs clarification as it currently causes confusion.

Recommendation 4:
1. *Define the "non-patient" status.*
2. *Clarify when is a patient a patient or a person or a received person or an admitted person.*

S109 Consent not required for psychiatric treatment
An Involuntary patient or a mentally impaired defendant, who is in an authorised hospital, may be given psychiatric treatment without his or her consent. This is usually the case in an emergency.
S114 Consent or approval dispensed with
Emergency psychiatric treatment may be given without any consent or approval that would be required if it were not deemed emergency psychiatric treatment.

Recommendation 5:
Reinforce the limitation on emergency treatment – it needs to have reference to individual rights.

Treatment and use of force:
There is no provision in the Act to allow for the use of force or treatment by force, yet Police are allowed to use reasonable force if needed.

An issue in the facing some Mental health workers is in apprehending patients, the workers do not have the same powers as the police have – they have the powers of apprehending people but do not have the powers to use reasonable force. There are times when patients need restraining and Due to Occupational & Safety issues 6 people are involved in restraining the patient.

Recommendation 6:
Define "use of force" with particular reference to mental health staff

In certain circumstances the Act states the application of section 29 extends to a case where a person who is a patient at an authorised hospital, other than an involuntary patient or a mentally impaired defendant, seeks to be discharged from the hospital and a psychiatrist is not available to examine the person.

The question of receiving a person into an authorised facility was discussed. In a *non-patient in-transit period*, the person is still under a Form 3. S42 states *that a person maybe detained under a transport order until the order lapses (a Transport Order is valid up to 72 hours) or the person is received into an authorised hospital under S40 (1).*

The person responsible for the Transport Order is responsible for the care of that person. Transport Orders for a person arriving from the North West is an issue for concern, if the person is being transported by road, it could take more than 72 hours to being a person to the metropolitan area.

Who decides a person is received?
There are a number of ways a person may be brought into a hospital

- The person may choose to get to the hospital themselves
- The person may be brought in by ambulance or in a Police vehicle.

Depending on the well-being / mental health state of the person – the vehicle will be taken to a secure area of the hospital. At this point the Triage nurse will check the forms to ensure they are correct. *The authority to take a person elsewhere other than an authorised hospital must be nominated on a Form 1 and Form 3*. If the hospital is on a bypass then there is an authority to take them to another hospital.

A form 1 is an authority that a person be received into a hospital and the authority to detain them there until an assessment is made. It is a dual-purpose form as it is an authority to detain a person and it specifies a particular hospital.

Once a person is received they go into a ward and are seen by the admitting Doctor. This can take place either in a ward, in a police vehicle, by a triage officer in the ward, there is no set place for the assessment, and then within 24 hours there is a requirement that the person must be seen by a Psychiatrist if not the

order lapses under S54 and the person is free to leave the hospital. When the person has been assessed the person is taken under the care of the hospital (Form1) the following could occur:

- The person does not meet the criteria and is discharged
- If the person meets the criteria the person is detained as an Involuntary patient (Form 6)
- After discussion the person may decided to be a Voluntary patient, will comply with the medication and is taken into an open ward; or
- The person will be placed on a Community Treatment Order (CTO); or
- The person is detained for 72 hours until the Psychiatrist decides the course of action to be taken.

The Form 1 can lapse due to fluctuation of time or because there is an assessment made of the patient that either results in a further Order to detain them for 72 hours or no Order.

It was suggested that when a Form 6 lapses and a period of detention ends the person should be given written advice on the same form that this has occurred.

Recommendation 7:
When a Form 6 lapses and a period of detention ends the person should be given written advice (on the same form) that this has occurred

It was suggested that this Review should be working towards ensuring that the Mental Health Act *has clarity so that everybody's right and obligations are clearly set out and that there is a clear understanding*. One of the examples of a definition is the term 'being received' the Act explains it 'as a patient who has been admitted' hence a layperson can get confused with the meaning. Another example was that there is no reference to a Voluntary patient in the current Act. The Act also mentions Involuntary Patient's right in the community but there is no mention of Voluntary patient's rights in the community.

Protection of Rights for Voluntary patients. The issue of "coercion" with reference to "we do not want to make you involuntary but if you do not come in as a voluntary patient we will have to make you Involuntary' – "gentle duress" – **it was noted that this would still be detention under the Act.** Voluntary patients need to be acknowledged in the Act – they need specific rights under the Act, and they need access to specific people who can advocate for them

Recommendation 8:
Definition for the term "being received" needed.
(See also recommendation 4

Recommendation 9:
1. *Reference needs to be made to Voluntary patients in the Act.*
2. *If reference is made to Voluntary patients there may be a need to make reference to their rights within the community.*

Currently under the Act the treating Psychiatrist informs the patient of his/her rights. There was a discussion regarding *who should be responsible for informing the patient of his/her rights*. Should the receiving officer or the treating Psychiatrist do it? Some of the concerns raised were that there are times when the consulting psychiatrist does not see the person initially when the person is first received and hence is not aware of the information given to the person.

The person may not be well enough to understand what is being told to them when they first arrive. S 158 of the Act states that the treating Psychiatrist being the person making the order is responsible for ensuring that the Patient is informed of their rights.

Recommendation 10:
This needs debate however most people recommended that the person ultimately responsible is the treating psychiatrist.

WHO ASSUMES CARE OF PATIENT.
Who can decide not to receive the person?
The Registrar or the Psychiatrist in charge can refuse a person entry - S47
Person in charge of hospital may decline to accept: The Registrar can refuse a person entry according to S 47 of the Act).

When a Form 6 is filled in, a copy must be provided to the patient and relative or friend. There was a general discussion that if a person did not have any relative or friend, who does then take responsibility for the person. There is provision in the Act (S158) for the treating Psychiatrist to nominate another person. *It was identified that many of the people who were appearing for medical treatment did not have anyone to turn to – they may be living on their own or itinerant. The concern raised was is there a body that could fulfil the role of significant 'other'.* People in hostels do have the care provided by the Hostel, although it was acknowledged that there was potential for conflict of interest.

Concerns were raised if the patient was not well enough to specify the name of a close relative or carer? It was identified that the hospital/doctor still had an obligation to follow this information through. Concerns were raised that sometimes this did not happen and some patients did not know what their rights were.

It was identified that sometimes Carers are not told of the Patient's status. The issue regarding a Carer to be notified was discussed that at the point and time a carer may not be the best possible person to represent a patient because of the situation – there was potential for conflict of interest.

The issue of access to interpreters was also raised.

It was suggested that it might be possible to ask the Office of the Public Advocate and make the Public Guardian take responsibility for such a person. Alternatively the Council of Official Visitors could be informed.

It was identified that in S 156 – S158 Rights and Entitlements - there seems to be a lack of clarity as to what the Rights and Obligations of the Patients are.

Recommendation 11:
Someone outside the "system" should be informed when a person is admitted as an involuntary patient. This could be the Council of Official Visitors.

Recommendation 12:
- *Clarify S156 – S158 Rights and Obligations of the patients.*
- *Include in the principles underlying the Act reference to patients' rights.*

LEGAL REPRESENTATION:
Should there be a right to representation? - Some issues raised included who should pay for this representation, it was reported that since this Act has been in place there have only been 3 appeals to the Supreme Court, and some practitioners feel intimidated if the patient has legal representation. However the majority indicated that there should be a right to legal representation.

The issue of advocacy is important – access to advocates for voluntary and involuntary patients – pre mental Health Review Board and to cover "rights' issues.

Recommendation 13:
- *There should be a right to legal representation.*
- *There should be a right to access an advocate of the patient's choice.*

A RIGHT TO TREATMENT
- Should a person have a Right to Treatment?
- What treatment do they have a right to?
- What Quality of treatment?
- Does the person have a right to be seen by a Psychiatrist – and assessed after the initial assessment.
- The issue of medical treatment was also raised at this point.
- The issue of treatment –is a greater / better definition needed.

Recommendation 14:
- *Discuss further.*
- *To debate and decide on whether a better definition is needed for "Treatment"*

RIGHT TO 2ND OPINION:

Issues discussed included;

- 2nd opinion's being sought from a Psychiatrist from the same system.
- If there is a 2nd opinion is this more valid than a 1st opinion?
- Legal Aid does not fund 2nd opinions.
- The issue of the views of a GP being taken into consideration was raised
- There is a need to identify who is the relevant expert – identify areas of interest.
- There is a need for the appearance of independence
- Sections 111, 112 and 164 were relevant.

It was commented that every patient should have the right to a second opinion. One of the issues that have been raised is for a second opinion by an independent psychiatrist, preferably from another team or a private psychiatrist. It was suggested to look at the wording from the model legislation.

Recommendation 15:

Clarification is needed on this issue."

Areas of concern needing further discussion and debate.

Sexual Rights –There was a fairly lengthy discussion and it was suggested that there was no necessity for legislation but that a policy be developed with input from relevant Stakeholders and the policy could be adopted by Hospitals and Hostels.

Should long term patients be able to access prostitutes – it was noted that this happens in Victoria. The issues of competency and informed consent were raised, as was physical safety and safe sex issues with access to condoms and vibrators.

The issue of contraception was also raised, and the practice of long term contraception by injection was a matter of concern.

Recommendation 16:

- *A working party is set up to review the issue of "sexual rights" and develop a policy on the issue.*
- *The issue of contraception is discussed further.*

Children / Minors.

The **Act is silent on the issue of children**. Children can be patients or carers of a parent with a mental illness. DCD are looking at the broader issues in regard to Children's Rights and have provided a submission to the Review. The issue of children being included in the Mental Health Act is a fairly contentious issue and a wide discussion took place

Some of the concerns raised by the group were:

- Consent
- Competency v capacity

- The maturity of a child under the age of 18 years to consent is a concern.
- There have been times when a child is put under the Mental Health Act – this causes anxiety for parents and inn some instances there is a potential for conflict of interest issues.
- When children are accommodated in adult facilities.

Recommendation 17:
To clarify within the Act the issue with regard to children and minors.

Guardianship and Administration Board – Appointment of Guardians.
It was noted that a guardian could be appointed by an application being made to the Guardianship and Administration Board either by a member of the family or anyone with an interest. After the application is received the Board does some preliminary investigations and often refers it to the Public Advocate to investigate. If it an Administrator is appointed the financial side is taken care of, if a Guardian is appointed they look after lifestyle issues and health issues.

There was confusion as to the authority of the Guardian to consent to psychiatric treatment on behalf of the person under the current Mental Health Act. It was indicated that could be viewed as an area of authority falling under the Chief Psychiatrist.

Advice from the Office of the Public Advocate was that when a Guardian is appointed the Guardian has the ability to make decisions regarding the healthcare issues of a person including psychiatric treatment. They have had discussions with the Chief Psychiatrist in order to clarify that is a guardian is appointed the Guardian has the responsibility rather than the Chief Psychiatrist.

Recommendation 18:
Clarification is needed on this issue – part of the interface between two pieces of legislation."

Other areas of general concern needing discussion and debate;

- Competency is not addressed in the Act **–** This can impact on, amongst others - children / elderly / intellectually disabled.
- Elderly – those suffering from dementia are not recognised by the Act. Psycho-geriatric issues and safe care of older people. Old age – being used as the basis of admission and the use of "holding" in facilities.
- Dual diagnosis issues
- Understanding that in some Cultural diverse backgrounds there is a need to acknowledge that the family expect involvement in their children's issues.
- Noted that the Interpreter service has been transferred to Melbourne and is a resource issue that needs to be addressed.
- Rural & Remote patients were a concern.
- Paying for "board and lodging" as involuntary patients in the public and private system.

Recommendation 19:
To ensure that the matters raised are clarified and debated for possible inclusion in the Act or Report to the Minister as matters of concern.

S162 Offence of ill-treatment
There was discussion around the penalty imposed for a person ill-treating a patient or for wilful neglect. It was agreed that the dollar value for the penalty should be raised similar to the fine imposed by the RSPCA.

Recommendation 20:
Increase the dollar value of the penalty for S162.

S163 Definition of 'patient.

Recommendation 21:
Retain the definition.

S 164(1) Patient to be afforded interview –
There was discussion regarding how many times can a patient request an interview? Should it be a medical practitioner or a psychiatrist? The general consensus was that the patient had a right to an interview.

Recommendation 22:
Retain the right to an interview.

S 165 Personal possessions
165(1)(2) (a) it was suggested that patients be provided with secured facilities and to include medical prosthesis or personal aid to daily living and not limited to be reviewed daily. Articles that cannot be appropriately stored at the hospital facilities include perishables or dangerous items, pets or very valuable items.

Recommendation 23:
Patients should be provided with secured facilities for personal possessions.

S166 (1) Letter of Patients and other postal articles
The patient has a right to receiving and sending mail without it being interfered with. It was identified that there have been problems with internal mail in some instances.

Recommendation 24:
Retain the right.

S167 Access to Telephone

Recommendation 25:
Retain the right.

S168 Visitors
The Psychiatrist restricted visitors that were considered to be “undesirable”.

Recommendation 26:
Discuss further and what does undesirable mean.

S169 Restriction or denial of entitlement
There was discussion around who should be restricted or denied and the explanation should be held on the patient’s file. There is a need to clarify this section, as the interpretation is quite broad – clarify “interests of the patient”

Recommendation 27:
Discuss further and clarify this issue.

S170 Application to Board
It was suggested that the rights for review be extended to Voluntary patients to be included in the Act.

Recommendation 28:
Discussion is needed to decide if Voluntary Patients should be covered by the Act.

S171 Restriction or denial of right to be reported on review
It was suggested that if there is a restriction or denial of rights the Council of Official Visitors should be notified.

Recommendation 29:
If there is a restriction or denial of rights the Council of Official Visitors should be notified.

Internet access for residents of Caesia residents
It was noted that some residents were allowed Internet access just as mobile phone and mail facilities were available– there was discussion around the abuse of these facilities and there are steps taken to protect the abuse of these facilities. The Principle that communications should be allowed for patients – with usage of what is usually available for people with mental illness in the non forensic system when and as it becomes available

Recommendation 30:
That the principle that communications should be allowed for patients – with usage of what is usually available for people with mental illness in the non forensic system when and as it becomes available

Part 10
Division 1 –S 193 – S194 Restrictions on authority of practitioners
Division 2 –S 195 – S200 Police Powers

S198 There was discussion around the disposal of goods seized, as there are a number of laws that cover this area – which one applies – clarification is needed.

Recommendation 31:
S198 - Clarification as to which "law" covers this is needed.

Division 3 – S 201 – S 203 Capacity to Vote
There was discussion if an involuntary patient should have the right to vote and should a Psychiatrist have the power to say that a patient should not vote.
It was suggested that Psychiatric patients should be encouraged and assisted to vote and this section of the Act should be enforced only if a person was psychotic or there were very strong reasons why a person should not vote. However it was agreed to recommend that sections 201, 202 and 203 should be removed.

Recommendation 32:
Remove 201, 202 and 203 from the Act.

Division 4 – S 204 – S 206 Records and information
This is not limited to medical records. It was noted that the records on seclusion, bodily restraint and ECT are required to be kept.

Access to records – who is "suitably qualified".

It was noted that in a number of jurisdictions an entry could be made on your own records if a patient was aggrieved by its contents and this was missing in our Mental Health Act. Hence there should be powers included in the Act to amend a

person's record - Letters / statements could be added with cross referencing in the notes There was a discussion raised if the issue would be a 'matter of facts' or a 'matter of opinion'.

It was suggested that S94 of the NT Act be included in this section of the WA Mental Health Act which states that '*a person–in-charge of an approved treatment facility or an approved treatment agency must ensure that all written comments made by a person in an approved treatment facility or while being treated by an approved treatment agency, or by his or her representative, are included in the person's records maintained at the facility or by the agency'.*

Recommendation 33:
- *Clarify who is "suitably qualified".*
- *Include in the Act a section similar to S94 of the NT Act.*

Division 5 – S 207 – S 211 Inquiries

Recommendation 34:
S207 – S211 - Retain all sections.

Section 215

Recommendation 35:
S 215 - The Mental Health Act should be reviewed every 5 years.

Complaints.

Currently complaints are channelled either as:

- Ministerials
- Mental Health Law Centre
- Mental Health Review Board
- Council of Official Visitors
- Chief Psychiatrist/Psychiatrist
- Ombudsman
- Office of the Health Review – noted in 2001/02 74 complaints including 28 regarding treatment/involuntary status received. In 2002/03 to January 53 complaints received.
- At local level of service

It was noted that there was the development of an across Government model for complaint handling.

Most of the complaints are directly from Consumers/Carers so the clinical component in a complaint should be identified. It was agreed that complaints

should be treated seriously, even if a patient is very agitated when they present for treatment. A patient should not be medicated so they can speak for themselves and think clearly.

Recommendation 36:
Complaints need to be monitored and reviewed by some "Central body" – it was suggested that the Office of the Chief psychiatrist might be the appropriate place.

Carer's Rights.

Some of the discussions around the issue of carer's rights included;

- Carers and Families should be given consideration
- Confidentiality for Carer's as well as Consumers was an issue
- Information sharing between the treating team and the carer
- Carer's needs should be given consideration.
- Lack of Resource was identified as an Issue.
- Psychiatrists felt that there are times when the patient does not want their information discussed with carers and hence there are reasons for not passing on information.
- Professionally the issue was frustrating.
- It was suggested that the family needs should be considered in the Act – it was acknowledged that patients have a right to say "no".
- It was suggested that there should be a set of principles outlined in the front of the Act to encompass Carers and confidentiality.
- Issue of Carers rights to confidentiality when giving information to the treating team.
- Confidentiality was often used as a defence for legal reasons.
- The Act should allow carers having access to as much information as possible.
- There is a need to include a Principle about Carer Involvement.
- Professionals noted that they are aware that by informing families the patient/consumer may disengage from the treating team. It would therefore be good practice to explain this to families/carers.
- Carers issues and age appropriate issues were raised i.e. children under 16.

There was comparison drawn to the Northern Territory Act, which has encompassed the UN Principles and incorporates the needs and rights of Carers within a broad set of Principles detailed within the Act. This was seen as a good way to deal with this issue. The suggestion was to use the NT Objectives, which were seen as excellent. It was also suggested that the National Standard of Mental Health is looked at and some of the principles are included in the Act.

Recommendation 37:

- *Include a set of principles at the beginning of the Act to encompass Carers.*
- *Include the issue of Confidentiality.*