Sylvia Meier  
Executive Officer  
Review of MHA and CLMIDA  
11th Floor, Dumas House  
2 Havelock Street  
West Perth WA

15th February, 2003

Dear Ms. Meier,

It is with great pleasure that the Australian Association of Social Workers, West Australian Branch undertook and completed the attached submission on the review of the Mental Health Act 1996 and Criminal Law Mentally Impaired Defendants Act 1996.

As the Association has outlined in the submission, the social work profession has an integral and critical role in mental health services. Social workers aim to promote social justice, an individuals independence and family and community overall well being. The AASW/WA attached submission and comments reflect this perspective.

Congratulations on the State Government's initiative to review the state’s current mental health legislation. The law sets an acceptable standard for our society to abide by and this is particularly crucial for our most vulnerable members.

Yours faithfully,

[Signature]

Dr. Barbara Meddin MAASW, Acc SW.
President
Introduction

The AASW/WA Branch is pleased to be actively involved with the process of reviewing the Mental Health Act 1996 and Criminal Law Mentally Impaired Defendants Act 1996, as part of the broader community consultation enacted by the Health Department (WA). The AASW/WA mental health sub-committee has disseminated information regarding the review process, to social workers within the State, who are employed in mental health services (or who have an ancillary involvement with mental health service users). The sub-committee has sought feedback from individual workers, with a view to forming a single AASW/WA presentation, as well as reminding workers that individual, or team responses, are also welcomed by the Office of the Review. The AASW/WA mental health sub-committee has also been active in developing the proposals (outlined), via discussion within the committee structure as well as through holding a workshop (in Nov 2002) for social workers. Therefore this submission channels material gleaned from a range of different sources.

The AASW/WA acknowledges the significant reform achieved and additional resources that have been directed to Mental Health since 1996. However, the demand for mental health services in our communities continues to rise. Data on the incidence and prevalence of mental illness and the health and social impact on individuals, their families and on health costs are well documented in State, Commonwealth and International reports. A recent WA study also outlines the very poor general health outcomes for adults with mental illness. Therefore the AASW/WA recommends that reform of the Act also is accompanied by adequate resources.

The AASW/WA notes the clear comments made by the Hon Bob Kucera (Health Minister) and Professor D'arcy Holman to the Stakeholder Committee (Nov 2002), that the review process of the Acts should focus on developing a future ‘vision’ for mental health services in the State.

Our proposal is based on the profession’s Code of Ethics whose principles focus on:

1. Human dignity and worth.
2. Social justice.
3. Services to humanity.
4. Integrity.

We also wish to take the opportunity of highlighting the role of social work in mental health services more clearly. Specifically the domain is one of social context and social consequences of mental illness. Practice focuses on restoring individual, family and community well being, to promote the development of each individual's power and control over their lives and to promote the principles of social justice.

In respect to the social context, the focus is on the environment of the individual which shapes his/her experience of mental illness. This includes consideration of personality, vulnerability/resilience, family functioning, strengths/stressors, support networks, culture, community, class, ethnicity and gender. Beyond the intrapsychic and interpersonal aspects, broader concerns include economic well being, employment, housing and legal
issues. Inclusion of mental health promotion and illness prevention interventions in the Act is therefore recommended.

In respect to the social consequences, social work considers the impact of mental illness on the individual, the family, personal relationships, the broader community and economic/welfare matters. Social work in mental health also considers the interface between mental illness and broader health/welfare issues (including child protection and domestic violence).

In respect to social justice, social work is concerned with issues of stigma and discrimination, civil rights, access to treatment and support services, and promoting consumer/carer rights as to participation and choice in mental health services. The AASW/WA acknowledges the inclusion of these issues in the National Mental Health Standards and recommends that the Act ensures the ongoing review and monitoring of standards for treatment for all consumers (not just involuntary consumers) by the Office of the Chief Psychiatrist. Social work has a diverse professional background including practice, teaching and research in areas including family welfare, counselling, community work, group work, migrant/ethnic minorities welfare, social action, planning and policy development. Therefore as a result of this diversity, social workers generally demonstrate an ability to look beyond the illness and treatment issues in mental health, and are able to consider the broader human, social and political issues in this area. This breadth, analysis and focus are the specific strengths of social work in mental health services.

The focus for social work practice in mental health is individual, family, group and community.

The particular competencies of the social worker are advocacy, educating clients and families, working with families, case management, intensive casework, treatment services, seeking out resources and community work. In 1999 the AASW developed competency standards for social workers working in mental health services. This demonstrates the priority of mental health in the social work profession.

It is with these underlying beliefs, and the clear message from the Minister of Health and the Chairperson of the Review, that the AASW/WA Branch members have compiled the following comments for the review of the Acts.

Recommendations:

Mental Health Act (MHA) 1996

Section 5 – Object of the Act:

- The AASW/WA believes that the preamble in this section needs to be framed in a positive manner as the Act is mainly concerned about detention and involuntary treatment. For instance, an additional focus on ‘mental health’ (as opposed to mental illness), through emphasising community development, education, prevention and the role of user/carer groups, would fit well with areas of priority identified in the Second National Mental Health Strategy (1998-2003).
Family members of people within the system are a significant component of support and long term care for affected relatives. This caring role and the impact it has on family life, could be acknowledged at the outset of the Act. The issue of the needs of children affected by a parent with a mental illness also needs to be mentioned.

The Act also doesn’t mention the needs of children/adolescents with mental health problems, especially the inappropriate admission of adolescents to adult locked wards.

The preamble could also reflect the change in stakeholders and roles that people within the mental health system often experience. For instance a service user could also be a carer, a parent or advocate, simultaneously, or change quickly.

The AASW/WA notes the alarmingly high rate of general health problems for consumers with mental illness. It is therefore recommended that the Act include a statement guaranteeing mental health consumers equal access to all domains of general health services.

General Issues;

- Reference to “patients” should be changed to “consumer” or “client”. The precise term used, should be that identified from proposals made by service users or groups. Terms such as “consumer” or “client” emphasises active participation whereas the term “patient” emphasises passivity.
- We raise the issues of the assistance to GP’s in respect to assessments and referrals under the Act. We raise the issue of mental health services attempting to more closely support and link with GP’s in respect to the appropriate assessment and provision of mental health services, especially in rural/remote locations.
- The AASW/WA acknowledges the important role general GP’s have also in referring persons for involuntary treatment. It is recommended that the Office of the Chief Psychiatrist provide support and monitoring of this role as it does with Authorised Mental Health Practitioners (AMHPs).
- The AASW/WA raises the issue of diagnosis of consumers. In the current system, all mental health practitioners are able to provide diagnosis of clients and record this on client notes and central data basis. It is recommended this practice be reviewed and as a minimum, all practitioners be required to have mandatory training and testing of competencies in diagnosis.
- The AASW/WA further notes the lack of Psychiatrists in the public system, particularly in rural areas and in sub-speciality areas such as child and adolescent psychiatry and older persons psychiatry.
- Enhancing guidelines as to the process of assessment in respect to more thoroughly considering psycho-social factors, e.g. the impact on distress/presentation caused by domestic violence (as opposed to purely medicalising the presentation).
- Section 7F – This section to include reference to families and carers.
Aspects of the Mental Health/CLMIDA Acts specifically relevant to social work;

- Section 3: There should be a definition of social worker as: “means a person who is a full member of the Australian Association of Social Workers, or who is eligible to join”.
- Section 19(1) (MHA) should include ‘social worker’, (the definition having now been identified in amended section 3). Section 19 (2) (MHA) should be abolished in respect to referring to social work. As the section 19(2) (MHA) stands, it implies discrimination against foreign trained social workers. All full members of the AASW, irrespective of the country of initial training, have been assessed as acceptable for membership.
- Section 20 (MHA): The AASW/WA proposes that Authorised Mental Health Practitioners, who are social workers, should be actual full members of the AASW. We make this recommendation as membership and eligibility for membership, aren’t the same things. Full AASW members are bound by a code of ethics, can be held accountable to standards of practice and sets of values. Full AASW members are also covered by personal indemnity insurance. Membership of the AASW also offers the opportunity for ongoing accreditation (i.e. via an audited, bi-annual process of ongoing professional development and competency, through the Continuing Professional Education (CPE) program). We feel that these are all crucial aspects in regards to personal responsibility and liability. Therefore practising social worker AMHP’s offer a certain protection in practice, to service users and employers. We note that this recommendation would involve consideration by the Office of the Chief Psychiatrist in regards to identifying how many of the current (22) AMHP social workers in the State may be affected.

‘Vision’ as to some components of a good community mental health system:

- The AASW/WA notes that considerable amounts of resources have begun to be dedicated to mental health services in the State. It is felt that all matters of concern regarding service provision don’t always relate to the need for extra resources or additional, new legislation. Our proposal in regards to a ‘vision of services’ is that a priority emphasis on greater interagency cooperation and planning is pursued. The AASW/WA feels that coordination and inter-departmental protocols can be enhanced. With this in mind, the Branch raises the issue of enhancing the power of the Office of the Chief Psychiatrist in auditing services and instructing those deemed at inadequately using resources allocated, to streamline and improve services. The AASW/WA also wonders whether an interagency forum, with the specific brief of a user centred approach, to prevent people ‘falling through cracks’, may be useful.

- The AASW/WA feels that mental health practitioners may benefit from standardised training and accreditation in multi-disciplinary areas including the mental state examination, suicide (and deliberate self harm) prevention, dual diagnoses (e.g. substance abuse, learning disability), working with culturally and linguistically diverse consumers, working with indigenous people, working with families and working with
personality disordered clients. This would involve a resource commitment, but may be efficient in the context of group training. It is noted that other States provide core skills development.

- A conceptual process regarding assessing individual needs, as opposed to fitting people into standard, existing programs and services, is also raised for further consideration, i.e. focusing on developing an individual package of care, rather than what is available (‘one size fits all’) in the system. This approach may involve budgetary devolution. Such a ‘package’ can be reviewed but should not fundamentally change if a service user moves locality.

- Client rights for respect and competency in practice must be a priority and openly illustrated via ‘plain speak’ literature and in a range of linguistically diverse languages.

- Research indicates that greater success in providing mental health care, has been achieved when the client/significant other has been actively involved in care planning. A more formalised approach whereby the service user actively participates with devising a care plan, including ‘wishes’ for specific interventions, should mental health decline, develops a more interactive and rapport based connection (and meets current National Mental Health Standards). The Community Treatment Order (CTO) could also be evolved along these principles.

- Working towards stigma free community awareness could be assisted and evolved by community development work undertaken by mental health practitioners. For instance, each local mental health service could take on responsibilities for proactive outreach to local community groups and senior high schools, educating and clarifying a greater understanding of mental health. This is an aspect of prevention and could be stated as a specific standards requirement for each service.

- The AASW/WA raises the issue of how hospital services could become part of the community and not so segregated from community life.

Criminal Law (Mentally Impaired Defendants) Act (CLMIDA) 1996

General Issues:

Amended definitions (where relevant) as per the Mental Health Act 1996.

Section 5 – The current legislation empowers referrals by a Magistrate to the Frankland Centre, for an assessment of up to seven days. The AASW/WA believes that people should not be referred unless they are assessed by an AMHP, as there is currently a risk of inappropriate referral. This screening process could be flexibly done, using options including tele-conferencing to more rural/remote court locations.

Mentally Impaired Defendants (Part 5)
The AASW/WA believes that people placed on custody orders, should have legislative rights for access to prison based programs, whilst incarcerated.

Clear decisions need to be made regarding consent issues and the many facets of implied and informed consent that may present.

The needs of mentally impaired defendants must be addressed in a proactive manner. Evidence suggests that a standard and thorough assessment exploring a person’s history, social-emotional functions and economic circumstances is a of great use in judicial decision making. Social work could be more utilised in this respect.

A dedicated co-ordinator managing the needs, assessments, care and follow up arrangements of mentally impaired defendants in the justice system, should be established.

The AASW/WA finds that the lack of a ‘declared place’, as defined under section 23 and mentioned under the ‘general effect of a custody order’ (section 24), to be of great concern as the default outcome is therefore prison, an authorised hospital or detention centre. As a ‘declared place’ is stated in law, it should be provided as an option to the Mentally Impaired Defendants Review Board (MIDRB) in considering the needs and circumstances of the person under the custody order.

In respect to the decision making processes of the Mentally Impaired Defendants Review Board, we feel that the mental health consumer in question should have the option to present his/her case to the board (for instance in respect to an application for leave of absence or release order), as would individuals who are applying for parole to a parole board. We feel that the option of the individual to present his/her case is a basic justice right.

Prepared by the Mental Health Sub-Committee of the WA Branch of the Australian Association of Social Workers.

4th February 2003.