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

Submission regarding the Mental Health Act (MHA) 1996

This feedback structure has been provided to assist you in your submission to the Review of the MHA. Using this format will assist the Review in the gathering of information.

Your Details

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Confidentiality

We are concerned about your confidentiality, so please indicate which of the following applies to this submission:

❏ This submission is to remain strictly confidential and is **not** to be shared/distributed to anyone outside of the Review.

❏ This submission may be shared/distributed to any other party, **if** my personal details are removed and kept confidential.

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❏ Other, please specify:

Signature: ______________________ Date: ______________________

Closing Date

The closing date for submissions is **Friday 28 February 2003.** Please send your submission to:

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Executive Officer
Review of the MHA and CLMIDA
11th Floor, Dumas House
2 Havelock St
WEST PERTH 6005

Or to ReviewofMHA@health.wa.gov.au

Or to Fax: (08) 9222 5450

This Review is about the operations and effectiveness of the existing Act and not about writing a new Act. Therefore you do not need to re-write sections of the Act, this will occur after the Review has been completed and is the responsibility of the Parliamentary Counsel's Office.

Please address those areas that are of concern and how you think the Act may be altered. The following is not a comprehensive list of all aspects of the Act. You do not need to comment on all areas. Please use the space available or add pages to include other areas of importance.

NB. Copies of the Act are available from the State Publisher or at www.mhrbwa.org.au/publications/pdfs/The_Mental_Health_Act1996.pdf.

AREAS OF THE ACT

Definitions (including meaning of mental illness) (s.3)

Section 4 currently defines the meaning of "mental illness" as a "disturbance" of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent". The potential breadth of this is then limited in sub section (2) to exclude certain religious, political or philosophical beliefs, sexual promiscuity or preference, "immoral or indecent" conduct, the use of drugs or alcohol, or engaging in anti-social behaviour.

This definition remains very broad and open to interpretation. Further, it significantly fails to meet a number of UN Principles to which Australia is a signatory.

Clients and their advocates commonly raise concerns about how this definition is applied in a range of circumstances by the police, health professionals and others to justify attempts to have "troublesome" people detained for assessment just to "get them off our patch".

Most of these people are rapidly assessed as not having a mental illness, but the trauma and inconvenience faced by them, as well as the costs borne by mental health services in dealing with inappropriate referrals are powerful incentives to ensure people are not summarily detained and subjected to examination inappropriately.

LAWA argues that the definitions applied in Victoria, the Northern Territory and, particularly, New South Wales would provide a clearer indicator of the Act's intention and far greater conformity with international best practice.

Recommendations:

The definition of mental illness is defined simply as a medical condition that is characterized by a significant disturbance of thought, mood, perception or memory. It should also go on to indicate that, for the purposes of this Act.

The definition should include a number of exceptions to which that definition may apply in and of themselves; including:

- a) *Intellectual disability*
- b) *Political belief*
- c) *Religious belief*
- d) *Sexual preference or activities*
- e) *"Immorality"*
- f) *Use of drugs or alcohol*
- g) *Antisocial or personality disorders*

Objects of the Act (s.5)

LAWA urges the review to acknowledge the UN Principles concerning the rights of mentally ill people and to follow the Northern Territory's example in specifically referring to these in an objectives clause at the commencement of the Act. This reference should provide the framework for understanding the legislature's intention and act as a guide for all remaining provisions.

Further, given our diverse cultural and geographic needs, the objectives clause should also indicate specific acknowledgement of and support for services specifically designed to the needs of Aboriginal people, acknowledge ethnic diversity, support people with other disabilities and meet the specific requirements of young people.

In conjunction with the establishment of a body to oversee best practice standards, guide ethical debate, act as a forum for discussion and recommendation around new medications and treatment, such an acknowledgement would serve to provide a sound and visible acknowledgement of the government's commitment to consumers and their families in this State.

Further, given our diverse cultural and geographic needs, the objectives clause should also indicate specific acknowledgement of and support for services specifically designed to the needs of Aboriginal people, acknowledge ethnic diversity, support people with other disabilities and meet the specific requirements of young people.

Recommendations:

The Act should incorporate an acknowledgement that the legislature intends any determination of the provisions of the Act to be read with reference to the UN principles regarding the treatment and care of people with a mental illness.

It should also incorporate an acknowledgement that services should be provided with specific reference to the needs of indigenous people, the particular cultural requirements of various ethnic groups, young people and those with other specific disabilities or needs.

<u>Office of the Chief Psychiatrist (ss. 8-16)</u> (eg Responsibilities, Functions, Powers of Inspection, etc.)

This role is pivotal to the development and maintenance of a healthy, responsive and functional service for mentally ill people in this State.

The present responsibilities establish the power to monitor services, keep registers of facilities and certain professionals, give directions about treatment in certain circumstances, inspect premises etc.

Unfortunately, the Act is not clear on what can or should be done in the event that the Chief Psychiatrist is dissatisfied with outcomes.

The Act should provide for a range of sanctions including deregistration of personnel or premises where circumstances warrant.

Apart from the monitoring and management function, it is important for this position to carry a proactive function. It should be required to establish an advisory body or a “centre of excellence” comprising professionals, consumer representatives and consumer advocates to:

- Investigate and recommend (amongst other things) a range of best practice standards in relation to medications and other treatments
- Identify, receive information about, monitor drug introduction and experimentation, and recommend approval of these treatments with or without restriction where appropriate
- Investigate and make recommendation about a range of best practice standards

This body should report to the Chief Psychiatrist who can accept, reject or accept with modifications, any recommendations from that body.

Additionally, the Chief Psychiatrist should receive a number of reports presently returned to the Mental Health Review Board. Simply reporting these activities to the MHRB who then has no power to investigate or take action on them is a major failing in the present system and allows a number of activities about which the public may be concerned to simply pass unnoticed.

In particular, reports concerning seclusion, restraint, administration of certain procedures or treatments, etc should go to this office. The Chief Psychiatrist should then monitor, audit and distribute an annual public report about these activities both in nature and number and by facility in order to present an authoritative picture of what is happening and how it is being managed across the State.

Recommendations:

The powers of the Chief Psychiatrist should be expanded to include administration of a range of sanctions including deregistration of personnel or facilities that fail to meet statutory, professional or other standards established for the provision of psychiatric services

The Chief Psychiatrist be required to establish and provide administrative support for an advisory body or Centre of Excellence comprising professionals, consumer representatives and consumer advocates to:

I. *Investigate and recommend (amongst other things) a range of best practice standards in relation to medications and other treatments*
II. *Identify, receive information about, monitor drug introduction and experimentation, and recommend approval of these treatments with or without restriction where appropriate*
III. *Investigate and make recommendation about a range of best practice standards*

Reports currently made to the Mental Health Review Board, including those concerning seclusion, restraint and administration of various treatments should be made to the Office of the Chief Psychiatrist. The Chief Psychiatrist must then undertake an audit of these activities to satisfy himself of appropriate use of these interventions, and must annually publish a report on these activities by number, facility and intervention.

Mental Health Practitioners (s.19, 58 & Regulation 10)

No Comment

Authorized Mental Health Practitioners (s.20 Regulation 4,5,6)

No Comment

Authorised Hospitals (s.21, Regulation 7)

No Comment

Involuntary Patients (Part 3)

Becoming an involuntary patient (s.26)

By any reasonable measure, providing the State with the power to detain (in fact, imprison) a person for no other reason than that the person is exhibiting symptoms of an illness is undeniably extreme.

Civil detention of any person must satisfy at least the criteria awarded to people accused of a crime – ie an examination of the circumstances, full disclosure of the facts (or reasons to believe the person should be detained), and an opportunity to be heard within the bounds of natural justice.

The initial step of deciding whether a person should be referred for examination must be stringently circumscribed to give support to the principle that, unless the person's believed condition is such as to be a serious and immediate problem to themselves or others that involuntary detention should not be allowed under any circumstances.

The two factors, then, are

a) Existence of a mental illness, the effects of which cause a professional to believe there is a
b) Serious and immediate risk of harm to that person or others

As has been recognized in UN Principles and in a number of other Australian States, the potential threat of economic, property or reputation harm should *not* be sufficient to empower the State to detain that person in the same way as these threats should never be sufficient to detain any other citizen. If the allegations against the person fall into these categories, they may be better handled through restraining orders or an application to the Guardianship and Administration Board to have someone appointed to manage the person's financial or other affairs.

It should also be clear that detention under this Act should only occur in circumstances where the person's condition requires treatment *and is able to be treated*. Again, if the condition is such as to defy treatment, a guardian should be considered to "step into the shoes" of that person in the longer term. On the other hand, if the illness is treatable but not immediately required on the grounds of health or safety, the serious step of detaining the person should not be countenanced. Equally, detention periods and treatment provided under compulsion should always be undertaken in the least interventionist and for the least time necessary in the circumstances.

Present provisions also facilitate involuntary admission not only where a person is unable to consent to treatment, but where they have refused. It should be recognized that refusal to accept treatment may, in fact be quite rational. For example, a person may refuse a particular procedure or intervention, but would be agreeable to an alternative. Indeed, in some circumstances they may rationally believe that the side effects of some treatments are greater than the adverse effects of the illness. This factor should be modified to ensure that involuntary admission should only occur where a person has <u>unreasonably</u> refused treatment.

Safeguards must exist to have the determination confirmed by a second professional before the determination that the person be made an involuntary patient is completed.

The process must then allow a review of the determination by an independent tribunal or body comprising legal, professional and community representation. This body's functions and determinations must be fully subject to the rules of natural justice; establish a body of precedent and predictable procedure; and be fully reviewable. (see below – Review Board)

All the steps governing civil detention must be meticulously followed, documented and open to review.

It is also of the utmost importance that the process of detaining a person is *not* viewed as providing authority for treatment without consent. Further discussion about treatment follows.

<u>Recommendation</u>:

Provisions relating to involuntary admission criteria should be cumulative and contain the following factors:

a) *The person is believed to have a mental illness as defined in the Act; AND*
b) *The illness requires immediate treatment and that treatment can be provided by admission to an Authorized Hospital; AND*
c) *The person's health or safety is immediately at risk, or the safety of another person is immediately at risk; AND*
d) *The person is unable to consent to voluntary treatment, or because of the effects of the mental illness has unreasonably refused to consent to voluntary treatment; AND*
e) *The person can not receive treatment or care in less restrictive circumstances than involuntary admission.*

<u>Referral for Examination (ss.29, 31, 32, 33 & Consequential provisions Part 2)</u>

Section 31 indicates that a person may not be referred without a personal examination. Some confusion exists within the profession as to what a "personal examination" entails. Given the expanded use of teleconferencing and other services, it may be useful to clarify that a personal examination may include examination using this technology. Alternatively, the Northern Territory's

legislation provides a useful example in addressing this issue whereby it simply requires the practitioner to "assess and determine whether a person is in need of treatment under the Act". This definition allows for a variety of approaches and is simple and clear in application. However, it is urged that a rider be placed on this to prohibit an assessment or determination based solely on third party information, or on telephone interviews or a combination of these. The assessment <u>must</u> be of a nature to allow the referrer to personally determine the issues, and to do this in a manner that enables the full gamut of human responses, not merely voice, to be assessed.

Whilst the Act presently requires professionals to consider the involuntary admission criteria in writing, this requirement is broad and open to abuse. It is acknowledged that there are a small proportion of medical practitioners who generate a significant amount of inappropriate referrals. This is an extremely worrying human rights issue that requires the legislature to tightly control this sort of "loose" practice that directly impacts on the freedom of movement and actions of members of the public to the extent that they can be subjected to police intervention, and in effect, false imprisonment.

Referral forms must be regulated and compel the referrer to address each criteria for involuntary admission to ensure they both understand the criteria and to minimize unnecessary or unwarranted referrals. In the interests of natural justice, good practice standards and inclusiveness, patients should be provided with a copy of this form. The Chief Psychiatrist must also have the power to investigate disproportionately high referrals from particular practitioners and have the ability to impose sanctions if it is determined that these referrals are unwarranted or undertaken in careless or negligent disregard of the Act's requirements.

A further practical step to developing better referral practices and facilitating professional understanding of the Act's requirements would be for the Mental Health Review Board to develop and regularly publish and distribute a set of determinations (as is done in other states and jurisdictions). This would facilitate not only legal precedent and certainty, but also a body of opinion about good clinical and administrative practice, and highlight issues for potential law reform in the future.

<u>*Recommendations:*</u>

The provisions of S31 are amended to require a practitioner to assess and determine whether a person is in need of treatment under the Act. It should clarify that the assessment must be done personally; that it could be done through telecommunications services, but not by telephone alone; and it must not be based solely on information provided by third parties.

Referral forms must be regulated and include a requirement that the practitioner address all the preconditions set out under the Act for referral.

The Chief Psychiatrist should have investigatory powers to examine the practices of practitioners identified as generating significant numbers of inappropriate referrals and the power to impose sanctions where it is determined those practitioners are acting carelessly or in disregard of the Act.

The Mental Health Review Board should be required to develop, publish and distribute a set of determinations relating to these (and other) matters so as to facilitate legal certainty and promote good clinical and administrative practices.

<u>Referral in certain circumstances (s.30)</u>

This provision enables a voluntary patient seeking to discharge from hospital to be detained for a period of up to 6 hours for an assessment about whether or not they should be made involuntary.

It is a constant source of anxiety and resentment amongst consumers who feel it is a threat hanging over their heads and impedes their ability to negotiate or refuse particular treatments.

Whilst it is acknowledged that some safety system must be available where a senior staff member reasonably believes the patient's health or safety, or that of another person is seriously and immediately at risk in the event of self discharge, the Act must require stringent safeguards and practices that accord with the principles of both good clinical practice and an acknowledgement of the patient's right to know what is happening and for what reasons.

It is urged that the Act provide that any decision that the person be detained pending an assessment must be for the least reasonable period necessary in the circumstances, and at any rate, no longer than 6 hours. Further, a regulated form must be completed by the senior staff member authorized under the Act, addressing all the criteria required under the provisions relating to involuntary detention. The Act must specify that no person may be held under this provision unless the authorized senior staff member reasonably believes all the conditions relating to involuntary detention exist at the time the form is completed. Sanctions should exist in circumstances where this procedure is undertaken carelessly or negligently, or in disregard of any provisions of this Act.

A copy of this form must be provided to the patient, together with an explanation about the process and why it is taking place.

It is further urged that the intention of the legislature that involuntary detention be a last choice in treatment be confirmed in this section by a requirement to specifically inform voluntary patients of their right to discharge themselves unless they meet the criteria for involuntary admission. This both conforms to UN Principles, and has legislative precedent in the Northern Territory.

Recommendations:

The Act should include a provision that voluntary patients be specifically informed of their right to discharge themselves.

Any procedure enabling a voluntary patient to be detained pending an assessment about whether they should be admitted as an involuntary patient must include the following provisions:

a) *The period of detention must be for the least reasonable period in the circumstances, and at any rate for no longer than 6 hours*
b) *A regulated form should be required and must include a section directing the senior authorized staff member to address each of the criteria for involuntary admission and satisfy him or herself that they all appear to exist at the time the form is completed*
c) *Sanctions should be included in the event that a voluntary patient is detained without this process being undertaken, or where the process is undertaken carelessly or in disregard of the provisions of the Act*
d) *The patient must be provided with a full explanation of the process and why it is being undertaken, and must be provided with a copy of the completed regulated form.*

Police assistance (ss.34, 35, 41, 42)

No comments

Detention for examination and choices (ss 36,37, 40)

No comments

Examination in another place (ss. 38,39)

No comments

Involuntary status (ss. 43, 44, 45, 48, 49, 50, 51)

Section 45 enables a psychiatrist to receive an involuntary patient into any authorized hospital that he or she believes suitable.

This section should establish a framework for determining suitability, or indicators pointing towards how this determination should be made. In particular, there should be a requirement that the age, cultural or other specific needs of the patient should be taken into account where practical.

Recommendation:

The provisions of section 45 are modified to require a psychiatrist determining the appropriateness of admission to consider whether the authorized hospital concerned can provide the best available services to the patient including consideration of specific needs in relation to:

a) *Age*
b) *Cultural requirements*
c) *Access to family or other significant personal connections*
d) *Other disabilities or specific needs of the individual patient*

Transfer (s. 46)

No comments

Declining to accept (s. 47)

This section allows the admitting officer of a hospital to refuse to accept a referral if it is believed the facilities is insufficient or inappropriate to accommodate or treat the person.

The need for this is not disputed, however it is insufficient to simply provide the opportunity to refuse admission where a person is acutely ill and in need of assistance. This simply does not fulfil the community's obligations to make provision for necessary treatment and care. The provision should require the facility to either temporarily accept the patient pending location of appropriate facilities or to take steps to locate alternative facilities to which the patient may be immediately transported.

It is acknowledged that such provisions could result in particular Authorized Hospitals being used as a "dumping ground" by some services, and provisions should be included in the Act to safeguard against this.

As the person with overall responsibility for the care of mentally ill patients, it is suggested the Chief Psychiatrist have the responsibility to receive reports on any patient referred for assessment as an involuntary patient unable to be admitted into an appropriate facility within 6 hours of arriving at an Authorized Hospital. The Chief Psychiatrist should also have the ability to establish directives or other processes under which organizations such as ambulance operators, the police or other stakeholders seek to transport patients for admission.

Recommendations:

This provision should be amended to require the facility to take steps to locate a suitable alternative facility to which the patient may be transferred, or require temporary admission until the patient can be transferred to appropriate facilities, however this provision should be couched in terms that prevent a patient simply being left in inappropriate facilities without this being reviewed and active steps taken to locate appropriate facilities at least every 6 hours.

The Chief Psychiatrist should be required to monitor, audit and report on the regularity and problems associated with locating appropriate facilities on an annual basis.

The Chief Psychiatrist should have the authority to establish procedures and directives concerning the transport of patients referred for assessment as involuntary patients.

Releasing a detained patient (ss.52, 54, 55, 56)

No Comments

Absence without leave (s.57, 58 & Regulation 10)

These provisions define absence without leave and make provision for the person to be apprehended and returned to the Authorized Hospital.

It is argued that the ability to return a person to involuntary detention should lapse after a period of (say) 28 days. If the person has been able to manage within the community for that period without coming to the attention of authorities, it is arguably because they simply no longer fit the requirements for involuntary detention. If this is so, detaining them and returning them to civil detention is a major infringement of human rights. In these circumstances, involuntary status should lapse.

If or when the person comes to the attention of authorities, it must simply be good clinical practice for a medical practitioner to assess them at the time, so a formal recommendation for initial assessment under the established criteria for involuntary detention is not burdensome.

Further, there should be some limit to the period during which a person can be maintained on involuntary status when on leave from a hospital. It is again argued that 28 days should be sufficient time to determine whether or not the person should return to hospital as an involuntary patient, or should be placed on a CTO, or discharged.

Recommendations:

Leaves of Absence must be limited to a maximum of 28 days, at the end of which time the treating professional must determine whether to return the person to hospital for inpatient treatment, place the person on a CTO, or discharge the person from involuntary status.

Patients who are absent without leave for a period of at least 28 days without coming to the notice of authorities should have their involuntary status "lapse". Any further referrals or admissions must be assessed against the criteria established for any initial admission.

Leave of absence (ss 59-63)

See above.

Community Treatment Orders (CTOs) (Part 3, Division 3)

Making a CTO (ss. 65, 66, 67, 69)

CTOs are designed as a process to ensure treatment of patients who have a history of non-compliance with medication, or where the treating professional has reasonable grounds to believe that treatment can be provided in the community without the necessity of detention in an Authorized Hospital.

They promote the legislature's stated intention that treatment and care should be provided in the least restrictive circumstances.

In practice, many consumers and consumer advocates argue that they are commonly used as a tool of control rather than treatment and care. Whilst they agree that some mechanism to allow community treatment is needed, the need to protect patients from vicarious use of this form of intervention is needed.

Alternatively, health professionals argue that a short initial period on a CTO may obviate the need for involuntary detention in an Authorized Hospital.

It appears CTOs are currently trying to fit two strategic purposes, and are not necessarily designed to do either properly. On the one hand, they are being used as an initial assessment and treatment tool to determine whether treatment can be provided outside an involuntary admission, and on the other, they are being used as a long term coercive management tool that can even define (in effect) where a person may live, what treatment they will receive and at what frequency (without provision for discussion or negotiation), and "such other matters relating to treatment" as the practitioner determines necessary. They can be made for an initial period of 3 months. A second psychiatrist must confirm them within 72 hours of the order being made.

A sensible approach appears to be that the two strategies outlined above, be separated. The Act should provide for two processes as follows:

a) An order that enables initial assessment and treatment for a period of not more than 2 weeks at the end of which time a determination must be made to either discharge the patient, admit the patient to hospital, or place the patient on a community treatment order; and
b) A community treatment order designed to follow an initial assessment period, or an involuntary inpatient admission in circumstances where the treating psychiatrist determines the person has a history of non-compliance or is unable to consent to treatment and would suffer serious and medically imminent deterioration in their condition to the extent that it could result in serious physical harm to themselves or another person if treatment is not continued.

Protections must be put in place to ensure the present criticisms of CTOs being inappropriately used as a tool of social control are met. The Mental Health Review Board should be required to examine the need for a CTO within 2 weeks of it being made, and if satisfied it should continue, be provided with confirmation power to a maximum period of 6 months. No CTO should be able to be renewed without the Board's approval. Prior to any hearing (whether for confirmation or continuation), the patient should be provided with any report the practitioner intends to rely upon no less than 3 days prior to the hearing.

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Protections must be put in place to ensure the present criticisms of CTOs being inappropriately used as a tool of social control are met. The Mental Health Review Board should be required to examine the need for a CTO within 2 weeks of it being made, and if satisfied it should continue, be provided with confirmation power to a maximum period of 6 months. No CTO should be able to be renewed without the Board's approval. Prior to any hearing (whether for confirmation or

continuation), the patient should be provided with any report the practitioner intends to rely upon no less than 3 days prior to the hearing.

Terms of a CTO (ss. 68, 73, 74, 75, 77)

See above

Extension of a CTO (s. 76)

See above

Variation of a CTO (s. 79)

See above

Revocation of a CTO & police assistance (s. 70, 71, 72, 78)

See comments relating to Absent Without Leave and Leave of Absence.

Breach of a CTO (ss. 80, 81)

See comments relating to Absent Without Leave and Leave of Absence.

Order to attend (ss. 82-84)

No comment

Treatment of Patients (Part 5)

Definitions (s. 92, 108)

Part 5 purports to deal with "treatment" whilst in fact it simply defines and circumscribes a number of interventions and confirms that involuntary patients may be treated without their consent.

At best, these provisions poorly comply with UN Principles both in relation to the treatment and care of the mentally ill, and in relation to human rights generally. There is no recognition of a general right for patients to be informed, consulted, included or otherwise involved in decisions concerning their treatment and care. It establishes no requirements for treatment planning, discharge planning or involvement of a range of services other than of a purely medical nature.

Given the range of psychological, social and other difficulties faced by people with mental illness, this is a glaring and damning indictment of neglect of their rights and dignity, and portrays a paternalistic approach to psychiatric services that is no longer acceptable within the greater community.

It is suggested that Part 5 should be completely overhauled to establish two parts; one dealing with the framework upon which the principles of treatment are based, and the other dealing with specifically circumscribed or prohibited interventions.

Patients and patient advocates regularly protest the manner in which treatment is undertaken as a serious impingement on their rights, autonomy and dignity. They also argue that interventions with potentially serious and long term side effects are too readily prescribed and administered unnecessarily, or are set at unnecessarily high levels or for unnecessarily long periods of time. These allegations certainly do not reflect the requirements of the Act that treatment must be provided in the least restrictive circumstances, and with the least adverse impact on the dignity of the individual

Treatment is <u>not</u> defined in Part 5. It is argued that it does require definition to include the range of services, interventions and supports available to assist people with mental illnesses and must clearly establish a best practice framework that promotes genuine collaboration across a range of therapeutic and support services identified in negotiation with the patient and (where appropriate) the patients family or other significant people. There must also be recognition of the specific needs of patients and for treatment and care to be provided in circumstances that take into account age, cultural, other disabilities and locational needs.

It should also reinforce the legislature's intention that treatment should be provided in the least interventionist manner and with the least restriction on the person's freedom of choice and movement necessary in the circumstances. It should <u>not</u> be confused with involuntary detention and should also identify the person's right to receive treatment and care when sought, and promote early intervention in appropriate circumstances.

A consultative body should be established by the Chief Psychiatrist to identify and promote best practice principles and ethical practices in treatment and care throughout Western Australia. The body should comprise the Chief Psychiatrist, psychiatrists, nurses, social workers, psychologists and consumer representatives or advocates. This body should make recommendations about the treatment of mentally ill persons whether in authorized hospitals, prisons, private or general hospitals, nursing homes, day clinics or any other place. Whilst the Chief Psychiatrist should not necessarily be compelled to follow recommendations, this position should be required to consider them, and to undertake the role of establishing standards and practices, and producing information and educational strategies concerning evidence based treatment practices, medication, research and other relevant matters.

The treatment section should also contain provisions for enabling or facilitating general medical treatments (other than psychiatric treatment) where necessary for the immediate health or safety of the patient, or where it is identified as being immediately necessary to prevent serious deterioration of a medical condition or injury.

In circumstances where the medical condition is considered ongoing or needing further less immediate attention and the patient is considered unable to consent to treatment, the issue should be referred to the Guardianship and Administration Board to determine whether a guardian should be appointed to handle these matters. Current provisions in the Act simply assume the patient incapable of providing informed consent. This is anathema both in relation to the provisions of the Act that clearly indicate a person may be able to consent but has simply refused, and in relation to general principles of human rights and must be amended. This approach is currently used in Tasmania to good effect.

<u>Recommendations</u>:

Part 5 should be divided into two parts; one dealing with the framework for general treatment and care, the other dealing with prohibited or circumscribed procedures and interventions.

A definition of treatment should be inserted to include any therapy whether medical, psychological, social, complementary or other therapeutic intervention and whether alone or in combination, that is intended to alleviate, cure or prevent deterioration of a mental illness. Any therapeutic intervention or treatment plan must include provision for cultural, age specific, disability needs, geographic difficulties or other specific needs.

Treatment of patients should be defined to identify the circumstances in which it should be provided, including:

- a) *An acknowledgement that treatment should not be confused with involuntary detention, and must be determined independently of that process*
- a) *Provision of early intervention and response when sought by a patient or by a person seeking admission as a patient*
- b) *Ensuring people with a mental illness are provided with the best treatment with the least interference to their rights and dignity necessary in the circumstances*
- c) *Promotion of genuine collaboration between the patient and the treating team to the greatest extent practical in all the circumstances including during the development and implementation of treatment plans and discharge planning*
- d) *Promotion, recognition and acceptance within the therapeutic relationship that the patient may seek and benefit from a range of interventions and services, and promotion of support for the patient to receive that assistance*
- e) *Treatment and care should be provided through strategies that make specific provision for age appropriate needs, cultural requirements, other disabilities and the need for patients to maintain links with their families or significant supports and local communities*
- f) *A requirement that best practice principles and practices established by the Chief Psychiatrist from time to time be promoted and incorporated into all treatment plans*
- g) *Acknowledgement that it should comprise, as far as reasonably practical, only those interventions requested or agreed to by the patient after having been provided with all reasonable information about the benefits, side-effects, efficiency and effectiveness of the proposed interventions*

Treatment should only be administered involuntarily if:

- a) *The person is unable, or (because of the mental illness) lacks the capacity to consent, or has unreasonably withheld consent; and*
- b) *The illness requires immediate treatment; and*
- c) *If the treatment is not given, there is an immediate risk that the person may harm themselves or another person, or may suffer serious mental or physical deterioration; and*
- d) *The treatment administered is the least interventionist and for the least time reasonably necessary in the circumstances*

The Chief Psychiatrist should establish a consultative body comprising psychiatrists, psychologists, nurses, consumers or consumer advocates and other relevant personnel to identify and investigate treatment issues and concerns, and make recommendations about the treatment standards and requirements regardless of where services are provided throughout the State.

The Chief Psychiatrist should have the power to establish best practice principles and practices that must be incorporated in the provision of psychiatric services regardless of where they are provided across the State, and should undertake the production of information and educational strategies concerning evidence based treatment practices, mediation, research and other relevant matters.

Medical treatment other than psychiatric treatment should not be facilitated under this Act unless it is immediately necessary for the health or safety of the patient and steps have been taken to determine the patient is either incapable of providing informed consent, or has unreasonably refused to do so. Where these circumstances exist, the interventions permitted should be confined to the least reasonably necessary to treat the condition at the time. In all other circumstances where it is believed the patient should receive treatment but is unable to consent, the issue should be referred to the Guardianship and Administration Board to determine whether a guardian should be appointed to act in this regard.

In any review conducted by the Mental Health Review Board it should be required to consider the treatment plan for conformity with the provisions concerning treatment of patients and, in the event of any concerns, it may make recommendations to the treating team. Any recommendations made to the treating team by the Mental Health Review Board should be forwarded to the Chief Psychiatrist for audit purposes.

Informed consent (ss. 95-98)

The first point that should be reinforced under these sections is that there should be a (rebuttable) presumption that patients can provide informed consent. A person may become an involuntary patient because of refusal to consent to treatment, but be perfectly capable of making that determination. Any decision to treat a person without informed consent must be made deliberately and the reasons carefully documented.

The second point is that where informed consent is obtained, there must be evidence of how it was obtained and a regulated framework document to support this.

The present Act establishes the fact that a person may be an involuntary patient because of refusal to consent to treatment, but this treatment section appears to gloss over that fact. It should be reinforced at this point.

A number of Australian jurisdictions provide useful models to reinforce these aspirations, in particular the Northern Territory.

A set of principles should be inserted in this part to clarify that:

1. Consent should be sought and obtained wherever possible

2. Treatment without consent is only allowed in circumstances where the person is unable to consent, or (because of the mental illness) has refused to consent.

3. Where either of the factors in 2 (above) exist, clear documentation must indicate what steps were taken to determine the patient falls within these categories, and then show the following criteria also exist:
   - There is a serious and immediate risk to the patient or another person's mental or physical health, or
   - There is a serious and immediate risk of severe deterioration in the patient's mental or physical health;
   - And
     - The treating team determines the treatment is in the best interests of the person; and
     - The anticipated benefits of the treatment outweigh any risk (including delayed or long term) or discomfort to the person; and
     - Any treatment provided without consent is the least invasive or restrictive reasonably necessary in all the circumstances; and
     - The treatment without consent continues for the least time reasonable in the circumstances

Consent to treatment should be defined as real and uncoerced. The Act should require the following conditions to be observed to indicate consent:
1. There must be no inducement or threat, and no exaggeration or concealment about what might happen if treatment is either given or not given
2. The person must be capable of understanding what consent to treatment means
3. The person must have a clear understanding of what the illness means, what the diagnosis is, what the treatment involves and how long it is likely to last
4. There must be a clear explanation about the benefits, likely side effects, risks or other issues provided to the person in a way the person can best understand it, including, where necessary, the involvement of interpreters, diagrams or other assistance such as tapes, electronic text etc.
5. The person should be informed they can have another person present or can get a second opinion. Obtaining a second opinion should be facilitated by the treating agency
6. All relevant questions must be answered without concealment or exaggeration
7. The person must be told they can withdraw consent at any time

8. If the treatment involves experimental or research aspects, this must be fully disclosed and any financial or other advantage the treating agency or any member of the treating team might get from the experiment or research must be fully disclosed
9. The person must be given time to consider all the information and make a decision. The time provided must be reasonable in all the circumstances
10. Consent must be properly recorded and include the steps taken to ensure it is properly informed.

Consent should be sought from any person over the age of 16 years.

Children under the age of 16 years should be examined to determine whether they have sufficient understanding of the consequences of their decision and whether they fully understand what is proposed. If so, they should be considered competent to consent. If they do not, the consent of a parent or guardian should be required, but best practice processes should be implemented to ensure that (especially) older children have the opportunity to voice their opinions.

<u>*Recommendations:*</u>

The Act should contain provisions requiring consent wherever possible, and a rebuttable presumption that the patient is capable of giving consent.

There should be legislative provisions outlining the following requirements:

1. *Consent should be sought and obtained wherever possible*

2. *Treatment without consent is only allowed in circumstances where the person is unable to consent, or (because of the mental illness) has refused to consent.*

3. *Where either of the factors in 2 (above) exist, clear documentation must indicate what steps were taken to determine the patient falls within these categories, and then show the following criteria also exist:*
4. *There is a serious and immediate risk to the patient or another person's mental or physical health, or*
5. *There is a serious and immediate risk of severe deterioration in the patient's mental or physical health;*
   And
   a. *The treating team determines the treatment is in the best interests of the person; and*
   b. *The anticipated benefits of the treatment outweigh any risk (including delayed or long term) or discomfort to the person; and*
   c. *Any treatment provided without consent is the least invasive or restrictive reasonably necessary in all the circumstances; and*
   d. *The treatment without consent continues for the least time reasonable in the circumstances*

6. *Consent to treatment should be defined as real and uncoerced. The Act should require the following conditions to be observed to indicate consent:*
   a. *There must be no inducement or threat, and no exaggeration or concealment about what might happen if treatment is either given or not given*
   b. *The person must be capable of understanding what consent to treatment means*
   c. *The person must have a clear understanding of what the illness means, what the diagnosis is, what the treatment involves and how long it is likely to last*
   d. *There must be a clear explanation about the benefits, likely side effects, risks or other issues provided to the person in a way the person can best understand it, including, where necessary, the involvement of interpreters, diagrams or other assistance such as tapes, electronic text etc.*

e. The person should be informed they can have another person present or can get a second opinion. Obtaining a second opinion should be facilitated by the treating agency
f. All relevant questions must be answered without concealment or exaggeration
g. The person must be told they can withdraw consent at any time
h. If the treatment involves experimental or research aspects, this must be fully disclosed and any financial or other advantage the treating agency or any member of the treating team might get from the experiment or research must be fully disclosed
i. The person must be given time to consider all the information and make a decision. The time provided must be reasonable in all the circumstances
j. Consent must be properly recorded and include the steps taken to ensure it is properly informed.

7. *Consent should be sought from any person over the age of 16 years.*

8. *Children under the age of 16 years should be examined to determine whether they have sufficient understanding of the consequences of their decision and whether they fully understand what is proposed. If so, they should be considered competent to consent. If they do not, the consent of a parent or guardian should be required, but best practice processes should be implemented to ensure that (especially) older children have the opportunity to voice their opinions.*

Prohibited treatments (s. 99)

Given the controversy surrounding it and the fact that psychosurgery has not been undertaken in this State for the past several years, this would appear to be the perfect opportunity to prohibit it.

In the alternative, it should at least be prohibited for all involuntary patients, and only allowed on voluntary patients where approved by a special review panel convened to weigh up the costs and benefits to the patient, and whether all alternative strategies have been exhausted before giving consent to proceed.

Recommendation:

Psychosurgery is added to the list of prohibited treatments.

Psychosurgery (ss100- 103)

(See above)

Electroconvulsive Therapy (ECT- ss104-107)

ECT is another extremely controversial intervention. Whilst it is accepted there may be good clinical grounds for its use, and that it is a valuable clinical tool in certain conditions, its use should be stringently circumscribed to ensure all steps are taken to determine there is no equally valuable treatment with less impact on the patient, and that there is written evidence that at least 2 independent psychiatrists agree the effects of the procedure would significantly benefit the patient.

If it is determined that ECT is necessary, it should not be administered without a patient's consent except in an emergency. "Emergencies" should be defined as limited to circumstances where it is immediately necessary to save a person's life, or to prevent serious and immediate mental or physical deterioration.

In all other circumstances, consent (as evidenced above) should be a prerequisite. Where it is determined the patient is unable to consent, or has unreasonably withheld consent, an application to the Mental Health Review Board should be required. The Board should only be able to approve treatment if satisfied there is no reasonable alternative, that the benefits outweigh the discomfort and distress the patient will experience and that the procedure will substantially benefit the patient.

Recommendation:

The present safeguards surrounding administration of ECT be supplemented as follows:

a) *ECT should not be administered unless there is no equally valuable treatment with less impact on the patient*
b) *Two independent psychiatrists have provided written opinions that the procedure would significantly benefit the patient*
c) *Informed consent has been obtained*
d) *Where informed consent is not available, the Mental Health Review Board has determined that there is no reasonable alternative, the benefits outweigh the discomfort and distress the patient may experience and the procedure will substantially benefit the patient.*

Consent not required (s. 109)

See sections above, particularly points 2-5 under Part 5 Definitions

Medical Treatment (s.110)

See above under Part 5 Definitions. In essence, only emergency treatment necessary to save a person's life or prevent significant deterioration should be allowed. In all other circumstances, an application should be made to the Guardianship and Administration Board to determine whether a guardian should be appointed to act in the person's best interests and make decisions on his or her behalf.

Second opinions (ss111, 112, 164)

The current legislation permits both the right to seek a second opinion, and compels the hospital to allow a psychiatrist providing a second opinion to enter the hospital and interview the client. Where the opinion recommends modification or discontinuance of treatment, but the patient continues to be dissatisfied the Chief Psychiatrist may transfer treatment responsibility to another psychiatrist, or order the MHRB to review the matter.

The sections fail, however, to require the hospital to actively facilitate a second opinion on becoming aware of the patient's concerns. Further, the practice where an opinion is sought is often to simply require one of the treating psychiatrist's colleagues from within the same facility to provide the opinion. Patients and their advocates have vocally expressed their opinion that this does not fulfil the spirit of the provisions, even if it fulfils the letter of the law.

A system needs to be developed to overcome these procedural shortcomings for the sake of transparency and to eliminate the suspicion of collusion.

It is recommended the legislation be amended to require second opinions obtained from within mental health services to be provided by a psychiatrist from a facility other than the one in which the patient is involuntarily detained, or supervised on a CTO.

Recommendation:

The legislation is amended to require second opinions obtained from within mental health services to be provided by a psychiatrist from a facility other than the one in which the patient is involuntarily detained or supervised on a CTO.

Emergency Psychiatric Treatment (ss. 113-115)

Consent or approval in lieu of consent is not required under these sections that are intended to allow emergency treatment where necessary to save a person's life or to prevent the person behaving in a way that can be expected to harm themselves or another person.

Missing in this definition is the immediacy requirement, leaving it operationally open to a broad interpretation. A simple requirement that the criteria are not met unless the threat is imminent should be sufficient to overcome this difficulty.

Further, in support of the recognition that patients should have the right to consent to treatment wherever possible, and to have input into treatment plans and their implementation, these provisions should be limited to the least interventionist and for as short a time as is reasonably necessary in the circumstances.

Also contained in the section is a requirement that reports of emergency treatment should be provided to the MHRB, but as with so many similar requirements, no further action is required of either that Board, or the facility.

The reporting requirements should be transferred to the Chief Psychiatrist who should then be required to monitor, audit and provide and report annually on numbers and categories under which the treatment was administered, and to do this by facility as well as across the whole State.

Recommendations:

The legislation should be amended to clarify that emergency treatment must only be allowed where there is an immediate risk of death or serious harm to the person or any other person.

Where emergency treatment is required, the level of intervention and the period of time over which it is administered should be the least reasonably necessary in the circumstances.

A report about each intervention carried out under these provisions and the reason for the intervention should be provided to the Chief Psychiatrist within seven days of the intervention and must set out the reasons and what treatment was provided.

Seclusion (ss. 116-120& Regulations 11-13)

The use (or level of use) of seclusion has been criticised in a number of recent reports including the Council of Official Visitors annual report, and the West Australian. It is a highly emotive subject. Again, whilst there is little doubt that there may be occasional need for this strategy, there is also acceptance within the therapeutic communities that the frequency or regularity of its use does appear to be tied to certain facilities and to the experience of staff concerned. This does not reflect well either on those facilities or staff members, or on a clear recognition and understanding of the intention of the Act.

Some safeguards are required. Firstly, there needs to be a recognition that seclusion can occur covertly as well as overtly. If a person reasonably believes they are confined, that is the case! This belief can come about because of a direct act or statement by a nurse or doctor etc, or by a simple omission to explain to a person that they can leave an area either through an otherwise unseen exit, or without adverse consequence.

Given the serious act of solitarily confining a person, authority to undertake that action should be made at the highest level. In the event of an emergency (where that person's or another person's safety is in imminent danger and there is no other less restrictive option available at the time) the Senior nurse on duty in the ward should have the authority to implement seclusion for the least

time necessary in the circumstances, but must seek approval for any seclusion extending beyond thirty minutes from the Senior staff member on duty in the facility at the time.

Legislative provision must be made for a regulated process to be immediately implemented from the time seclusion is commenced. This document must provide a report forming part of the patient's medical record, and contain details about why the person was secluded, who authorised it, where it occurred, what bedding, chairs or other comforts were provided, what steps were taken to ensure adequate food and fluids were offered and taken, how often observations were made and how long it lasted etc.

Notification of the use of any seclusion is presently made to the MHRB, but again, the MHRB is not required or authorised to anything with these reports. This should be amended to require reports of any seclusion regardless of the period of time it was imposed, to be provided to the Chief Psychiatrist, who must monitor, audit and annually report on the number of times this intervention was used, how many times the intervention was used on particular patients and the reasons for its use by facility across the State.

Recommendations:

Seclusion should be defined to cover situations where a person reasonably believes their free exit is prevented.

Authorisation of seclusion must be made by the most senior staff member on duty at the time. In circumstances where the patient or another person's safety is in imminent danger, a limited period of not more than 30 minutes seclusion should be allowed and authorised by the senior staff member of the ward.

The Act should provide for regulated documentation about every act of seclusion including details of why, where and how the person was secluded, for what period, what steps were taken to ensure reasonable comfort, food and fluids, the frequency of observations carried out and any other matters relevant to the particular circumstances.

Notification of each seclusion carried out should be reported to the Chief Psychiatrist who should monitor, audit and report on the number of acts of seclusion (and whether these were carried out under the emergency provisions or otherwise), how many times particular patients were secluded and the periods of time of seclusion. The Chief Psychiatrist should be required to publicly report on these matters by facility across the State on an annual basis.

Mechanical bodily restraint (ss. 121- 124 & Regulations 14-16)

These interventions carry the same concerns as those expressed about the provisions enabling the use of seclusion. There must be clear steps taken to ensure the rights of patients to receive treatment and care in the least restrictive circumstances are required. The same steps taken to initiate, monitor and report on seclusion should be reflected in these provisions.

Unlike seclusion, however, there may be good duty of care and medical reasons for a person who has limited or spasmodic physical control to be supported in beds or chairs by means that would otherwise be caught by the Act's definitions.

In these circumstances, it may be possible for longer term authorisation based solely on the need to provide safety supports to the person, to be recommended by the senior clinician responsible for that person's treatment and care. In order to confirm such an authorisation, however, a second opinion of a senior practitioner must be required.

Longer-term authorisation should be defined as any requirement to restrain the person for that person's physical safety, and for a period not exceeding eight hours.

Recommendation:

Similar authorisation and monitoring requirements as those recommended for Seclusion should be required for bodily restraint.

Where a person requires a period of restraint exceeding eight hours solely because of a physical inability to support themselves or control their movements, the senior clinician responsible for that person's care may recommend, and an independent senior clinician can confirm the need for this to occur in the least restrictive circumstances required at the time.

Protection of Patient Rights (part 7)

Explanation of rights (ss. 156-159 & Regulation 18)

Access to records (ss. 160, 161)

Other rights- Ill-treatment/ Interview/ personal possessions/ letters/ phone calls and visitors (ss. 162-171)

Capacity to vote (ss. 201- 203)

These sections appear to be both unnecessary and a blatant interference with any Australian citizen's human rights.

The mere fact that a person may have (for example) refused medical treatment should never be sufficient to deny them the rights every other citizen has under our Commonwealth and State Constitutions.

The Electoral Act already provides that people who are in hospital or otherwise too ill to register a vote are excused. These provisions should be more than adequate to protect those unable to lodge a vote.

Of even more concern is the fact that people otherwise considered functional and well enough to manage in the community, but who have been placed on CTOs to ensure compliance with medication, could also have their right to vote denied.

It is urged that these provisions be deleted in their entirety.

Recommendation:

These provisions should be deleted as unnecessary, discriminatory and in contravention of the spirit of the Australian and Western Australian Constitutions.

Police Powers (ss. 195-200)

No comments

Mental Health Review Board (Part 6 & schedule 1 & 2) (eg Registrar (ss22-25 and Regulations 8, 9) Establishment, Constitution, Procedure, Reviews, Appeals, Provisions concerning Proceedings)

The major criticisms about MHRB processes circulate about lack of procedural fairness in that applicants have no entitlement to view and respond to any evidence about them prior to any hearing. They commonly fail to receive reports tendered to the Board by clinicians in a timely manner that enables them to be examined and prepare counter arguments where necessary.

Since the Board has not evidenced any willingness to address this issue, it is critical that requirements facilitating this be legislated. At the very minimum, any clinician preparing a report must be required to provide it to the applicant at least two clear working days prior to any hearing.

In a similar vein, the applicant or the applicant's nominated representative or advocate must also have access to clinical records or any other matters pertinent to the hearing not less than three clear working days prior to any hearing.

Of an equally disturbing nature is the fact that the MHRB has consistently neglected or refused to systematise and report on decisions before it. Accordingly, Western Australian applicants and their advocates have no body of precedent law on which to consider basing their arguments. This is in direct contravention of many principles of open adjudication.

On a similar level, there is no legislated requirement that the Board provide a written report about its decisions to applicants. Given the limited nature and the restricted time limits for appeals, it is essential that these both be provided, and be provided within a time that enables consideration of the decision and a determination about appeals (including reasonable time to formulate and lodge the appeal) where necessary.

On the issue of appeals, it is also blatantly discriminatory that appellants are prohibited from acting in-person. Given the limited capacity for providing Supreme Court legal representation for these matters both within the Mental Health Law Centre and Legal Aid, this leaves most unfunded appellants simply locked out of the legal process. In effect and for most people, this simply means that any provision for an appeal against a decision of the MHRB is a farce!

The whole process of review must be overhauled. All evidentiary material or reports to be submitted to the Board must be made available to other parties not less than two clear working days, and the clinical files available not less than three clear working days prior to any hearing.

The MHRB must be compelled to either automatically provide written summaries and reasons, or to advise the applicant both orally and in writing of the entitlement to this at the end of any hearing. Either way, the summary must both set out the reasons for the decision by addressing each and every criteria for involuntary detention and the reasons why the applicant was deemed to either meet or fail to meet each of those criteria, and must be available within seven days of the hearing.

The provisions denying in-person appeals must be repealed.

The Act must require the Department to provide adequate ongoing funding to ensure all applicants the right to representation if they wish it in both MHRB hearings and through the appeals process.

<u>Recommendations</u>:

All evidentiary material or reports to be submitted to the Mental Health Review Board must be made available to applicants and/or their representatives or advocates not less than two clear working days, and the clinical files available not less than three clear working days prior to any hearing.

The Mental Health Review Board must be compelled to either automatically provide written summaries and reasons, or to advise the applicant both orally and in writing of the entitlement to this at the end of any hearing.

Mental Health Review Board reports should both set out the reasons for the decision by addressing each and every criteria for involuntary detention and the reasons why the applicant was deemed to either meet or had failed to meet each of those criteria

Mental Health Review Board decisions should be available and provided to any applicant seeking them within seven days of the hearing.

The provisions denying in-person appeals should be repealed.

The Act should require the Department to provide adequate ongoing funding to ensure all applicants the right to representation if they wish it in both Mental Health Review Board hearings and through the appeals process.

Council of Official Visitors (Part 9 & schedule 3 & Regulation 20) (eg Administrative and Procedural Provisions, Powers and Functions)

The role of the Council of Official Visitors is anomalously restricted within Authorised Hospitals to involuntary patients. Many mental health consumers and their advocates have long identified the difficulty that there are a large number of voluntary patients who feel their voluntary status is in jeopardy if they do not strictly conform to the requirements placed on them by clinical staff and others.

In effect, these patients feel just as "involuntary" as those whose involuntary status has been legitimised under the Act.

To deny these patients access to the body ostensively established to ensure the rights of patients are observed, to hear and investigate complaints from them or their families or guardians and to refer matters to other persons or bodies for enquiry is simply discriminatory and does not facilitate their ability to seek redress or press for their rights either under this Act or otherwise.

Recommendation:

The role of the Council of Official Visitors should be extended to enable them to carry out their duties in relation to any person receiving treatment or care for a mental illness regardless of their legal status or the nature of the facility in which the treatment is provided.

Interstate Movements (Part 4)

No Comments

Miscellaneous (Part 10)

Restrictions on authority to practice (ss. 193,194)

No Comments

Records and information (ss. 204, 205, 212, & Regulations 17, 19)

The issue of patient records remains a bone of contention to many members of the public who fail to understand the legal anomaly that, whilst the information contained in them is extremely personal and may be sensitive, embarrassing or even (from their point of view) incorrect, the patient has no legal right to either view or change them since the ownership of the records lies with the practitioner or hospital concerned.

Medical ethicists and social scientists as well as patient advocates have frequently indicated that this anomaly can not only cause a number of injustices and incorrect conclusions to be perpetuated across time, denial of access simply compounds resentment and suspicion and is often inimitable to good therapeutic relationships.

In this framework, it is urged that provision should be made for patients to have access to their records, and where the patient believes the record does not appropriately reflect either a fact or

observation, the patient should have the right to have the fact amended, or to have their own observations included.

Recommendation:

Provision should be made for patients to have access to their records, and where the patient believes the record does not appropriately reflect either a fact or observation, the patient should have the right to have the fact amended, or to have their own observations included.

Confidentiality (s. 206)

No Comments

Protection from liability (s. 213)

No comments

Inquiries (ss. 207-210)

No Comments

Other areas of concern:

Treatment and Care of Minors

This group has distinct and specific needs.

Accommodation and services are presently inadequate to handle these needs resulting in clearly inappropriate admissions to services such as Graylands Hospital.

As previously urged, specific conditions should be included in both the Objects of this Act and throughout the Act concerning the need for treatment and care to be provided in circumstances that take account of these needs and facilitate access to the broader family or other supports, schooling and, where relevant, independent living skills required to assist them in successful discharge planning and future maintenance of their health.

Additionally, and in support of their unique circumstances and the special recognition accorded to them both in international covenants and in the literature concerning this group, it is strongly urged that any person under the age of 18 years who is admitted to care as an involuntary patient not only have all the safeguards accorded to all other patients, but that time frames are narrowed to ensure early reviews and constant monitoring of their status and care. In particular, the maximum time limits established for reviews of patients under CTOs or other involuntary detention should be halved to ensure this group of patients is constantly monitored and carefully managed throughout the entirety of their care.

Unfortunately, this group of young people is often over represented in jurisdictions like the Children's Court. In view of this, it is urged that the Department be required to extend their forensic mental health skills so that some of the efforts and skills of Bentleigh Clinic staff are extended and available across the State. Treatment and accommodation services should be established for minors on bail or referred by the Court for assessment to ensure timely and effective services for this group, and to minimize any delays and resulting trauma this vulnerable group might undergo.

The Chief Psychiatrist should be required to develop specific best practice standards and processes for managing the treatment and care of young people, and to provide an annual public

report of the numbers of young people in care, where and how they are being managed, an indication of the lengths of admissions or management under CTOs and specific steps to implement particular strategies for better handling this group.

The Council of Official Visitors should develop a specific group of visitors with particular interests and skills in working with young people to work with this group and advocate on their behalf.

Recommendations:

The Act should require specific facilities for young people. These facilities should be geared towards handling the full range of both psychiatric care and the social, educational and other supports required to facilitate successful discharge planning and reintegration.

Specific provision should be made to establish a forensic support service skilled in assessing needs and providing court support for young people. This service should be available State wide. An accommodation service should be provided for young people on bail requiring accommodation, treatment and support.

The review times established for consideration of CTOs and involuntary detention should be halved for young people.

The Chief Psychiatrist should develop specific best practice standards and processes surrounding the treatment and care of minors and to provide an annual public report on the numbers of young people in care, where and how they are being managed and an indication of the lengths of admission or management under CTOs for this group.

The Council of Official Visitors should be required to develop a specific panel of visitors with particular interests and skills in working with young people to monitor their treatment and care and to advocate on their behalf.