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

Name of person completing submission: LORNA VIVIAN DRAKE - MRS

Name of Service (if applicable): ______

Address: 78 DEAN ST. P.O. BOX. 365. PEMBERTON 6260.

Contact Number: 97.761126

Do you wish to be placed on our mailing list to receive any information that the Review may distribute (eg updates, Draft Report, etc.). ☑ Yes ❑ No

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.

☑ This submission is public information and **may** be freely shared/distributed to anyone interested.

❑ Other, please specify:

Signature: ______ Date: ______

Closing Date

The closing date for submissions is **Friday 29 November 2002**. Please send your submission to:

Ms Sylvia Meier
Executive Officer
Review of the MHA and CLMIDA
11th Floor, Dumas House
2 Havelock St
WEST PERTH 6005
or
Fax: (08) 9222 5450
or
Or to ReviewofMHA@health.wa.gov.au

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)

Objects of the Act (s.5)

Administrative provisions with regard to the Minister for Health (s.7)

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

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

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

Authorised Hospitals (s.21, Regulation 7)

- **Involuntary Patients (Part 3)**

Becoming an involuntary patient (s.26)

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

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Referral in certain circumstances (s.30)

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

I recently collected a young man in distress on the Nannup road, recognised his condition – delivered him (7.a.m) to the Busselton Police Station. Two police Officers welcomed the young man, washed him, fed him, clothed him, and treated him with friendly care and intelligent consideration. I much admired them. Our patient was off his medication, been roaming the bush for 2 days – but happily identified and re-organised.

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

Examination in another place (ss. 38,39)

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

Transfer (s. 46)

Declining to accept (s. 47)

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

More care should be exercised here. Too often there is nowhere, for a diagnosed, seemingly staple patient, to be cared for in a suitable place.

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

Leave of absence (ss 59-63)

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

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

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

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Extension of a CTO (s. 76)

Variation of a CTO (s. 79)

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

Breach of a CTO (ss. 80, 81)

Order to attend (ss. 82-84)

Treatment of Patients (Part 5)

Definitions (s. 92, 108)

Informed consent (ss. 95-98)

Prohibited treatments (s. 99)

Psychosurgery (ss100- 103)

Electroconvulsive Therapy (ECT- ss104-107)

Consent not required (s. 109)

Medical Treatment (s.110)

Second opinions (ss111, 112, 164)

Emergency Psychiatric Treatment (ss. 113-115)

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

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

Last resort only.

Protection of Patient Rights (part 7)

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

Access to records (ss. 160, 161)

On demand for family members.

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

Capacity to vote (ss. 201- 203)

Police Powers (ss. 195-200)

Police should never use firearms.
As we all know – a patient who has become disorientated is likely to handle a weapon of some sort – not knowing why. Simply because a patient is looking threatening (usually frightened) is no reason for a policeman to shoot to kill. This has happened too often.

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)

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

Interstate Movements (Part 4)

Miscellaneous (Part 10)

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

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

Confidentiality (s. 206)

- Protection from liability (s. 213)

Inquiries (ss. 207-210)

Other areas of concern:

Unfortunately since I do not have a copy of the Act, I cannot comment. All areas are extremely well covered. I would be interested to know how the Boards are comprised and by whom filled.

My concern is that we no longer have specialised State Mental Hospitals since the obliteration of Heathcote. Claremont also vanished and Graylands allowed to deteriorate. I had hoped that Heathcote would have been extended to cope with all areas of the drug scene. Many lives could have been saved. Considering the number of patients, both permanent and short term and geriatric dementias that were always treated at Heathcote, there is nothing now to compare with it. Any person feeling stressed could walk into Heathcote at any time and be accepted and attended to. No more, anywhere. Giving a million dollars to each of the big hospitals to make a safe ward, was no exchange for Heathcote.

*** Now, at least upgrade and <u>extend</u> Graylands immediately.* This so urgent.**

My son, after unsatisfactory results in Manjimup, was flown to Perth under sedation and restraint. There was no bed available – a patient was moved out of the high security ward, to make way for him. Wonder where the patient went? There was no bed anywhere. Members of our family were with him at Graylands, day and night. He was recovered enough to move to a 'free' room, but supposedly secure. The room was so filthy that he walked out overnight – barefoot to South Perth. In due course we took him voluntarily back to Graylands, but waited most of the day, till we were given a bed, then checked the area for cleanliness. My son was lucky that he had three strong caring brothers and a triple certificate sister, 2 others and myself also a trained nurse. He had been diagnosed 20 years ago by Professor German, and on regular medication a successful member of society, family man and a responsible businessman. We are loosing too many young Australian men because our State is not doing its duty in providing and maintaining a complete health facility. And in many cases exposing the general community to disruption and risk.

I am very concerned that the Health Department spends millions of dollars towards mental health, that is of little or no help to the many people requiring attention. For instance – there is no place now, where a sick person can simply walk in and seek attention, without seeing a GP or fronting at a hospital foyer, answer questions, fill in forms and be told to get an appointment or come back at another time. Mentally distressed people are often beyond all those suggestions. They need help, a refuge and diagnosis. As for expensive options that are now used since Heathcote closure-Three private houses were purchased in Chidlow, made into secure houses. One dangerous mental patient is resident in one house, with male attendants full time by day and night. One, sometimes two patients in each of the other houses, with one male attendant on duty all day, and another all night, at each house. These carers are to be admired, but I know that they have no relief during their period of on-duty – they do not complain because they are very well paid. This is only one situation around the city/state – I am sure there are others.

The expense must be enormous, compared with a "ward's" in one specialist complex. It is inconceivable that the department can afford a one to one patient staff ratio.

I also question how, and if, psychiatric nurses are being trained. Apparently only a crash course in mental illness is now deemed sufficient. I know there was a fully qualified skilled staff when Heathcote functioned and I know many male nurses left the profession at the time it closed.

Please extend and upgrade Graylands now before the present mental health situation further deteriorates. It is not only the distressed patient who suffers, but the whole community. There are glaring examples – Toodyay, Forrestfield, and many other similar tragedies. When Heathcote was in commission there were three doctors houses on site – a skilled qualified staff throughout general hospitals cannot be expected to accept mental patients, or experiment with their diagnosis. As for the police called in to mind patients for the hospital night staff, as happens frequently – it proves that the present situation is unacceptable for all concerned. A general hospital cannot, should not be expected to deal with mental patients other than as a temporary refuge.

Submission regarding the Criminal Law (Mentally Impaired Defendants) Act (CLMIDA) 1996

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Your Details

Name of person completing submission: LORNA DRAKE - MRS

Name of Service (if applicable): ______

Address: P.O. BOX. 365. PEMBERTON W.A

Contact Number: 97 761126

- Do you wish to be placed on our mailing list to receive any information that the Review may distribute (eg updates, Draft Report, etc.). ☑ Yes ☐ No

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☐ Other, please specify:

Signature: Lorna Drake Date: 5. September. 2002

Closing Date

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AREAS OF THE ACT

Interpretations (s.3)

General Provisions (Part 2) (eg Relationship to the Mental Health Act 1996)

Mental Unfitness to Stand Trial (Part 3)

It is a waste of time and expense to consider a mental patient to go through the trauma of a court proceeding. A diagnosed, recognised mental health criminal should be dealt with by his specialist, the appropriate board.

Defendants acquitted on account of unsoundness of mind (Part 4)

Mentally Impaired Defendants (Part 5)

Place of Custody (ss 24-26)

Leave of Absence (ss 27-32)

Reports about Mentally Impaired Defendants (ss 33-34)

Releasing Mentally Impaired Defendants (ss 35-37)

Miscellaneous (ss 38-40)

Mentally Impaired Defendants Review Board (Part 6) (eg Members, Functions, Decisions)

Other areas of concern:

It is a fact that general country hospitals cannot care for mentally disturbed patients. They are a potential threat to the staff, patients and themselves. I know many times the police are asked to mind patients over-night. This is not acceptable, our police have more than enough to do. In an undiagnosed case, the person should be sent to a specialist hospital for diagnosis. Not experimented on with various sedations, medications, that in many cases are disastrous in the long term – as happens all too often. Police should NOT shoot to kill a threatening person. There are less final alternatives.