RESPONSE TO THE REVIEW OF THE MENTAL HEALTH ACT 1996

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Thank you for the opportunity to respond to the Mental Health Act 1996 Review. The Ethnic Disability Advocacy Centre is a community based, advocacy service, solely representing people with disabilities from CALD backgrounds and their families. We provide individual and systemic advocacy, information and referral. Although we are not funded directly by the mental health department, 10-15% of our clients experienced mental health conditions. As such we have a keen interest in ensuring that people from CALD backgrounds who experience mental health conditions are given a fair go and funded mental health services are accessible and responsive to their cultural and linguistic needs. Despite the great strides made in the understanding and treatment of mental health conditions there are still Australians from culturally and linguistically diverse (CALD) or non-English speaking backgrounds (NESB) who are missing out on quality mental health care.

In relation to this submission two consultations were held to obtain feedback from people with disabilities from CALD backgrounds on their experience of the mental health services. Information from these consultations formed the basis of this submission. Although not all issues presented were directly related to the Mental Health Act review, we believe many issues were relevant for mental health policy and operational purposes.

The following is a list of recommendations and issues proposed for review of the Mental Health Act (MHA).

1. Part 2 – Administrative provisions - functions of the Minister,
   7 (f) to ensure that the special needs and views of groups within the community are sought by consultation with particular reference to –
   (iii) *ethnic groups*; - this require a definition

   7 (g) to ensure the services for the treatment and care of persons having a mental illness are comprehensive, readily accessible, and *sensitive to cultural diversity*

We commend and support the explicit inclusion of 'ethnic groups' and acknowledgement of 'cultural diversity ' in the Act, however it does not go far enough to specify the means by which this could be achieved. Reference could be made of current multicultural policies and guidelines of access and equity for people of culturally and linguistically diverse backgrounds, such as the principles of the *charter of Public Service in a Culturally Diverse Society* and the state *Language policy.*

We supported (g) of the MHA which states that services for the treatment and care of persons having a mental illness *are comprehensive, readily accessible and sensitive to cultural diversity.* However, it should indicate that strategies in diversity management needed to be established by service providers to ensure that they meet client or patient needs, otherwise the statement is nothing more than a token gesture and empty rhetoric. The language implication of cultural diversity management must also be explicit.

Although MHA 7 (j) *encourages the development of advocacy services to facilitate the work of the Mental Health Review Board and the official visitors* we have yet to

see the development of an independent and adequately funded advocacy service for people from CALD backgrounds with mental health conditions. It has been documented in many studies and in anecdotal reports that people with disabilities from CALD backgrounds, including those with mental health conditions are vulnerable to service abuse and discrimination but the complaints and reporting of abuse would not occur without advocacy support. This is attributed to their sense of powerlessness and fear and a lack of knowledge in the service system. Therefore it is paramount that appropriate advocacy support for this group be established and is independent of direct service provision to minimise the perceived conflict of interest.

2. The Mental Health Act in relation to rights of involuntary patients

- The mental Health Act needs to stipulate that CALD patients should have an interpreter present when rights are being explained.
- Translators and interpreters are not mentioned in the Act, as to how patients can access the service. The Act needs a mandatory statement that professionals should have interpreters present when making a diagnosis; and that interpreters are available within 24 hours.
- A carer, guardian or an advocate nominated by the patient is present when rights are being explained. This will ensure patients who are on medication or unwell have a second person present to receive information.
- Mandatory Review of patient's condition should occur between 2 to 3 days of admission to observe if improvements had occurred and patient's status needed to be changed.

3. Patient rights to be fully informed of treatment received

It is appreciated that involuntary patients placed in hospital or on a community treatment order need to receive psychiatric treatment and medication. However, mental health workers should look at the condition of the patient when treatment and rights are explained. Mental health workers should be culturally competent to conduct the assessment and administer treatment. Patients may not be proficient in English, are confused in a new environment, feel trapped or heavily medicated and therefore not able to comprehend their rights. If they are of CALD backgrounds, a professional interpreter should be provided. Family members, if applicable, should be present when explaining treatment. As often, family members are responsible in ensuring that treatment procedures are followed. However, some migrants are single and they should be allowed to invite close friends as family members.

Patients should also have the right to refuse non-psychiatric treatment. Medication without consent, including treatment plans should be reviewed daily.

3.1 Patients' rights – Access to records

Under the Act, personal records may be inspected by the patient, unless as stated, in exceptional circumstances.

- The Act should allow means of appeal if the patient disagrees with the documentation of his/her records.
- A 'suitably qualified person' may inspect records, as stated in the Act. This is not well defined and besides the patient's confidentiality may be breached in such

circumstances. We believed the person must be supported/approved by the patient and should include an advocate whenever possible.

- If there are any facts that are inaccurate there should be provision within the MHA to amend the information instead of having to use the Freedom of Information (FOI) Act.

3.2 Right of the patient to be interviewed by a second psychiatrist about their condition

Patients interviewed by a psychiatrist can request a verbal or written second opinion by another psychiatrist. This interview may be conducted by audio-visual means which is useful for rural patients. However,

- the question of discomfort for the patient to be subjected to an audio-visual examination/interview needs to be considered.
- The Act should indicate that the second opinion should be an independent 'other' psychiatrist.

3.3 Patients not to be denied personal possessions

If there is misuse of a possession the institution or hospital can deny the resident/patient their privilege to keep the possession, however this should be reviewed daily. If the possession is inappropriate in the setting other arrangements should be made whenever possible. For example if glasses are taken away from people at risk of suicide they should be replaced with glasses that have plastic lenses so the patient is not unnecessarily restricted.

3.4 Discrimination against people with mental illness

There has been assumption made that people with a history of mental illness has no right to use general hospital. Persons presented in A&E were sometimes refused admission and treatment and were transferred immediately to Graylands Hospital. People with mental illness should have the right to access general hospital if they have a medical condition which does not relate to their mental illness.

3.4 Right not to be ill-treated

The MHA states a patient who is ill treated or neglected is given a penalty of $4000 or one year jail term.

- Penalties should be higher and a broader definition in place as to the means of regulating such offences from occurring.

3.5 Right to free legal advice and representation

In WA there is no mandated legal representation though as a matter of practice, all patients are supposedly advised of their right to legal representation and of the MHLC which was established to provide that representation. Consumers feedback indicated that this was not always so and legal advise/representation were poor. There was evidence that notification was either not available or poor. Patients from NESB were at a greater disadvantaged because of language and cultural barriers in receiving or comprehending the implications of this. Most patients don't know they can have a

review every 28 days. However, the number of scheduled reviews was cancelled because the patient was discharged from involuntary status..

- The MHA needs to clearly state these rights;
- The MHA should uphold the right to free legal representation. An example of such, as in the Northern Territory Act where the tribunal appoints a lawyer and the state covers the costs;
- A suggestion that the Act should consider changing review of decisions from 28 days to 7 days. Again in the Northern Territory Act, the legal representation is mandatory and a patient is seen within 7 days for a review of a decision;
- Advocates should be considered as another service to be available to patients, if they feel that their rights are being denied. This should be made mandatory and again patients made aware of the review processes;
- Government funding to independent advocacy services should be adequate and realistic. As indicated an independent advocacy service for people from CALD backgrounds has been long overdue.

3.7 Right to a review by the Mental Health Review Board

As indicated patients of CALD backgrounds are generally unaware that they can make an application for a Review every 28days at no cost to them.

- They should be informed of their rights to a review when they are fully aware and alert not when they are confused, agitated or heavily sedated. Mental health workers should not rely exclusively on written information or brochures to explain consumers' rights. The MHA should stipulate the use of professional interpreter when informing patients of their rights.

3.8 Privacy

- Consumers should have privacy over their mail, telephone access. For example, they may have to ask a nurse to put a call through, but may not want staff to know about their conversation.
- There is a strong need for greater privacy for clients under community treatment orders.

4. Language and use of professional interpreters in general

The problems relating to language difficulties and the use of professional interpreters have been well documented. Patients need to be informed of their rights in a language they can understand. The need for interpreter is not always met. Registered interpreters are not called out as often as they should be, due to,

- cost,
- patients may be aware they can have an interpreter but think they have to pay,
- sometimes staff or patients take the easy way and use family member instead.

It should be mandatory to have interpreter for professional assessment and diagnosis. In some cases, the inability to communicate in English was considered a contributing factor to the (mis) diagnosis of mental illness. However, interpreters also need

training in working with people with disability and psychiatric conditions to ensure information is not misinterpreted. Training is happening to some extent.

5. Dual/mulitiple disabilities

Persons with dual disabilities like acquired brain injury or intellectual disability require different assessment and additional support by a qualified person who has specialist knowledge in the area. They should not be admitted to a psychiatric facility without appropriate liaison with the disability sector.

6. Carers

The rights and the extent of psychological distress on carers are often overlooked. The needs and provision for carers were not indicated in the MHA. The difficulties that CALD Carers have in communicating with mental health service providers are often overlooked. Carers require information about mental illness and subsequent treatment of their family members in order that they could offer better care. At the same time, a copy of an explanation of the Act and rights should be provided to the carer.

7 Discharge planning

Connecting consumers to services for after–care is crucial. Voluntary patients should be referred to community support networks. It is important that these community support agencies develop partnerships with ethnic communities and are sensitive to cultural needs of their clients.

8. Equity and access of mental health service and funding

One of the first guiding principle of equity and access policy in a mental health service is to ensure that mental health treatment and support services are not being delivered in a "non-discriminatory" manner and that people from culturally and linguistically diverse backgrounds have equitable access to a comprehensive range of mental health services. People that we consulted identified the lack of access to culturally and linguistically appropriate multidisciplinary case management as being a significant impediment and suggested the following:

- increase number of bi cultural workers in the mental health area;
- Cultural sensitivity and competency training should be part of medical training;
- greater development of partnerships with ethnic communities; and
- mandatory assessment and reporting of cultural competency in mental health services.