

Ms Sylvia Meier,
Executive Officer
Review of the MHA and CLMIDA
11th Floor
Dumas House
2 Havelock Street
WEST PERTH 6005

Dear Sylvia,

Re: Submission regarding the Mental Health Act (1996)

Thank you for providing an opportunity to feedback into the review process. I found the document for the feedback useful and I enclose it with this letter. Most of my comments are from the perspective of a reasonably experienced Consultant Psychiatrist who performs clinical duties in an approved inpatient unit as well as the community. Therefore I have experience of the practicalities and technical deficiencies of the Act in the major settings for the Mental Health Act.

Differentiating between roles and responsibilities of the Service and Psychiatrists

My main issue with the Act is that there is excessive focus on the roles and responsibilities of “the Psychiatrist”, but no apparent acknowledgment that it is a local mental health service with a managerial structure that is actually responsible for the delivery of services. While the Psychiatrist may be the, or one of the, senior clinicians they are not necessarily the team leader, and rarely are they manager of the service. The Consultant Psychiatrist’s capacity to influence standards of care, therefore, can be limited and in some cases the expectations placed on that Psychiatrist by the Act are unreasonable. The Act’s focus on the individual Consultant Psychiatrist also reduces flexibility, which is an absolute necessity in the field of any health delivery system which deals with acute situations. The administrative inadequacy of the Act failing to make allowances for a Psychiatrist becoming sick, going on leave, etc, is a glaring deficiency. Most of my comments regarding sections of the Act are the Act’s inability to separate the role and responsibility of the Service (managers) with the role and responsibility of the Consultant Psychiatrist as a senior clinician who has an important role under the Mental Health Act.

Eliminating punishment clauses from the Act

The Acts purpose is to ensure appropriate care is provided with guardianship of the rights of patients. However, it is also a document that incorporates “punishment” for acts that would be deemed non-professional or criminal, which would be dealt with other professionals, through either the Health Act or criminal or civil courts. I believe the “punishment” element within the Mental Health Act should be removed as these sections are not congruent with the stated aims of the Act.

Changing the emphasis from a hospital focussed Act to a community focussed Act.

The bill is excessively hospital focussed. Psychiatrist's duties under the Act appear to assume psychiatrists are either hospital or community based. The National Mental Health Standards promote integrated services which inevitably will mean psychiatrists being involved in both the hospital and community aspects of treatment. Ultimately community focussed services means the bulk of clinical activity is in the community. The Act should reflect this and structure the Act accordingly, making realistic allowances for some psychiatrists being mainly community based and mobile. Community Treatment Orders are cumbersome with many unnecessarily bureaucratic processes which presume hospital type administrative structures. If the Act were less focussed on psychiatrists being readily available in hospital and more on viewing treatment in the community as the optimum setting it could promote this through less cumbersome processes. At present it is administratively easier and much less risky to manage people in hospital than the community. The Act's hospital based view of acute treatment is an impediment to developing innovative community treatments for the acutely unwell under the Mental Health Act.

Standardised National Mental Health Act and precedents

I strongly support the case for a National (Federal) Mental Health Act to ensure that all individuals in Australia with a mental illness have the same rights. The Act should also set out guidelines for, and the rights and responsibilities of, mental health professionals which also should be the same throughout Australia. At least when specific sections of the Act are interpreted by Federal Judges, patients and health professionals alike could be confident that judgments providing precedents under the Act are likely to be interpretations of the Act which are not merely technical, limiting and "black letter" interpretations. Some of the interpretations, both by Crown Law and in WA courts appear to me flawed possibly due to the poor structure of the Act and a tendency to hide behind literal interpretations of flawed phraseology/wording.

Specifically regarding the sections of the Act, my feedback is as follows:

- I believe the **definition** is good and should not be changed.
- I think also there should be no change to the **object** of the Act.
- **Section 7** – there needs to be a statement to ensure that under law the Minister of Health has a responsibility to ensure services are delivered by staff trained to best standards with appropriate numbers and skills for the populations (benchmarks).
- The Office of the Chief Psychiatrist should also be responsible directly to the Minister of Health and report to Ministers dealing with the provision of social services.
- **Section 21** - A statement that authorised hospitals should provide services and trained staffing levels to ensure appropriate safe management of patients admitted under the Mental Health Act to allow management **in the least restrictive circumstances** should be emphasised.
- **In Section 26, Subsection 2** – Harm to physical wellbeing (secondary to mental illness) should also be added.
- **Section 32** – A time limit of 7 days is much more practical, as in the community, if an individual who is deemed psychotic attempts to avoid services, 2 days goes by very quickly.
- **Section 30** – Appears to me almost incomprehensible and needs to be rewritten in simpler language.

- **Section 30, Subsection 6** – If a voluntary patient requires treatment and tries to leave I can see no reason why the treating Consultant Psychiatrist cannot see and complete a Form 6. At times another psychiatrist is extremely difficult to organise and I cannot see what advantages, in terms of rights, the patient has with this sub section.
- **Section 44** – The Psychiatrist is not the authorised hospital or service. The receiving service, not the “person making the Order” should be responsible for ensuring the copy of the Order is provided to the Review Board. As stated above, this is an important principle, which I believe the Act should clarify. The Psychiatrist has expert status and skills. However, the Act also assumes that he/she is responsible for processes that are service commitments and responsibilities.
- **Section 47** – There is no provision for circumstances in which the Psychiatrist (responsible Medical Officer) does not believe the authorised hospital is safe for the patient, ie it is full, has poor staffing levels, is dangerous, or is therapeutically unsuitable.
- **Sections 49 and 50** – As above. The Psychiatrist is the responsible Medical Officer with medical expertise but sometimes has no authority in the treating system. If the Act expects the Psychiatrist to ensure certain administrative processes are followed, it should state the Psychiatrist has the authority to direct the Service to provide administrative processes or the monitoring or backup. There is so much power and responsibilities invested in the single Psychiatrist, in the Act complications arise when that individual is away. This clearly is taking the Medical Model too far, and in fact, the Act almost enshrines the Medical Model and ensures that most of the checks and balances are in hospital. The treating practitioner (Psychiatrist) has in reality responsibility for an appropriate treatment plan and psychiatric treatment within the guidelines of the Act.
- **Section 54a** – There is no stipulation of whose responsibility this is. Again, this is an issue for the Service or authorised hospital management.
- **Sections 59 – 63** – Leave of Absence – These sections are too bureaucratic and prescriptive. Specific forms stating how long an individual is allowed out of hospital smacks of a justice not health system. Leave of absence should not have to be documented by the Psychiatrist – a senior practitioner on the treating team should be sufficient following discussion with the patient and within restrictions of the management plan. These sections are written in a way that keep the Psychiatrists linked to or remaining in the hospital to be involved in relatively petty administrative issues. It certainly does not allow for them to be in the community, and reinforces the Medical Model that is hospital based, rather than create good provisions supporting community care.
- The Act should state that Psychiatrists and mental health practitioners must be approached and asked to be part of the treatment plan.
- **Section 68B** – Is far too prescriptive for Community Treatment Orders. Within the Act there has to be some inbuilt understanding about the fluidity of circumstances and individuals’ decision making and motivation in the community.
- **Section 68 (2)** – It is inappropriate to allow **directions** from one Consultant Psychiatrist to another. Professionals should be given the same respect as patients, ie contracts should be negotiated with all parties. The wording should be changed.
- **Section 69** – There is little logic in having only one Psychiatrist signing a Community Treatment Order in hospital, but two Doctors required in the community. Hospital is part of the community, and rights and responsibilities should not be different.
- **Section 74/75 – Monthly reviews by the Psychiatrist** are often not practical or possible. Registrars, even General Practitioners, can do so with supervision. Writing in shared notes should be enough evidence of communication. I realise exceptions are made later in the Act, but this section is very prescriptive and non-flexible with too much unnecessary documentation demanded.

- **Section 76** – Extension of a Community Treatment Order – I have no difficulty with 3 monthly formal extensions. However, reviewing Community Treatment Orders every 6 months requiring two Doctors in the community for individuals known to require long term management leads to unnecessary bureaucracy and use of staff time. I believe for a cohort of individuals with long term mental illness and lack of insight who nevertheless conform under the direction of a Community Treatment Order, can be renewed every 2 years with 6 monthly extensions.
- **Section 76 (6)** – The Service, not the Psychiatrist, should provide the copy of the request to the Mental Health Review Board.
- **Section 79** – Variation of a Community Treatment Order – At present it seems every Variation requires a new document. The Mental Health Act should specify that only major changes in the Community Treatment Order conditions should be documented in a new or varied Community Treatment Order. Specifically not minor medication changes, changed times of outpatients, etc. This is taking the interpretation of the law unnecessarily literally.
- **Sections 70+** - Revocation of a Community Treatment Order – In practice, using Forms 13 and 14 is a tedious and messy process. However, using the Breach (Form 13) can be a useful document and process. I do not believe Form 14 is necessary. Form 13 with a deadline within the conditions should be all that is needed. Practically, again, investing all authority with one Psychiatrist who may be working in various department (eg inpatient unit, community, home visits, General Practitioners) can mean logistical hurdles to deliver a Form 13 and a Form 14 are very difficult.
- The need to write Variation of Community Treatment Orders when one Consultant goes on leave naming another Consultant is ludicrous. The responsibility should be at a Service level with the capacity of named Consultants to cover for each other under the umbrella of the Mental Health Act. If this is not deemed practical, then at least state within the Act that the senior or administrative Psychiatrist has the power to name a covering responsible Psychiatrist in the absence of the treating Psychiatrist.
- Informed Consent – This section appears to be paradoxical as the clinician who decide if an individual is capable of giving informed consent is often the Psychiatrist who is the treating Psychiatrist.
- **Section 99** – Prohibited Treatments – This is not necessary. This can be dealt with in civil court like any unnecessary or poorly provided medical treatment. This should be expunged from the Mental Health Act.
- **Sections 100 – 103** – Stated penalties for breaches of the Act should not be covered within the Mental Health Act. As for all other professionals, breaches of the Health Act or unprofessional actions can be dealt with through the appropriate Act or the criminal or civil law processes. Mental health professionals should be treated equally as their colleagues in other specialities.
- **Section 105** – Describes standard clinical procedure. It is more appropriate for a clinician to refer to the College or other expert bodies guidelines than patronising directions from a static Act.
- **Section 107** – Again, criminal or civil law processes should be used for punishment for unprofessional activities and expunged from an Act which is for ensuring patients' rights. The Act gives the impression that Electroconvulsive Therapy (ECT) is a special or dangerous procedure when it clearly safe. Do other Health and Safety Acts specify specific treatments to target?
- **Section 110** – Medical Treatments – This is highly complex. Close family members should be involved in the process if at all possible and this should be incorporated into the Act. If family are satisfied (especially with a demented patient) this should be documented and given special status.

- Finding the Chief Psychiatrist in an emergency out of hours I have found impossible. The Service Head needs to be empowered, therefore, Section 110 (B) should be clear. Again, investing special responsibilities in an individual is unnecessarily rigid and does not necessarily safeguard the wellbeing of the patient.
- **Second Opinion** – Under the Act, Psychiatrists who are able to give second opinions should be approved by the Office of the Chief Psychiatrist. **The treating Psychiatrist should not in any way be involved** in the process of getting a second opinion. The issue of who is responsible for payment of external private approved Psychiatrists should be stated (Service or Office of Mental Health).
- **Requests for a Second Opinion** should at least be in writing (one line is enough) with some reason given by the patient for this. I have been in the situation where second opinions are demanded and finally provided at which time the patient does not actually remember the request.
- **Sections 117 and 118** – Criminal law, not the Mental Health Act, should decide penalties. It is the responsibility of the Service to ensure the Act is adhered to. Service and Service Managers should be liable under the Act for breaches of the Mental Health Act by that Service.
- **Mechanical Body Restraint** – The above comments are equally valid.
- **Explanation of Rights (SS156-159)** – The Service should be responsible for ensuring explanation of rights, not the Psychiatrist. The Service should have an experienced staff member designated to do this as it is a procedural process. The issue of completing a Community Treatment Order in the community (a patient's house) means that it should be mailed back to the individual by the Service. The Psychiatrist cannot be responsible for logistical difficulties unless they have the power under the Act to direct the Service.
- **Access to Records** – The Freedom of Information Act should be sufficient. All individuals in the society would then be covered by the same Act.
- **Section 162** – The Health Act or criminal law should cover this, not the Mental Health Act.
- **Section 165** – Service Managers, not the treating Psychiatrists, should be responsible.
- **Sections 167 and 168** – The Service, not the Psychiatrist.
- **Section 169** – Treating Psychiatrist may not be in hospital every day, especially if they work in integrated community based services. The Act views treating Psychiatrists as being in hospital every day. The Act promotes the Medical Model and hospital psychiatry, and should be changed.
- **Capacity to Vote** – A Psychiatrist should only confirm if a person was incapable of voting only if they did not vote. No Psychiatrist should be given the power to prevent someone voting. All people with a mental illness should have the right to vote, no matter how disabled they are.
- **Section 199 (a)** - Police Powers – Should define which Service holds the items - health or police.
- **Section 200** – If the Mental Health Act fines or imprisons others for breaches of the Act, why not Police Officers? All individuals should be held accountable under the same laws.
- **Records of Informations (Sections 204, etc)** – Why is a distinction made here between Service responsibilities and individual practitioner responsibilities in other sections?
- **Section 206** - Confidentiality – All health professionals are guided by confidentiality expectations under the Health Act. All professionals working in Mental Health Services should be treated equally with other health professionals.

Again, I thank the review process for allowing me to feedback my concerns. It would be helpful if the review process attempted to clarify responsibilities under the Act of individual professionals and Services providing that treatment. Health professionals working in the Mental Health Service are covered by other Acts for professional actions and criminal deeds. Mental health professionals should be treated equally under the law and not have specific actions and arbitrary punishments prescribed in the Mental Health Act. The Mental Health Act is an Act ostensibly to define a mental illness and ensure optimum treatment and protection for individuals requiring treatment against their will. Professional behaviour is guided by the Codes of Professional Conduct of clinicians working in Mental Health Services. The Act should abolish statements that prescribe treatment standards and view mental health professionals just like other health professionals.

Finally, the intricacies of working effective, flexible Community Treatment Orders that protect patients rights need to be thought through and documented clearly. The Act does not really support the development of the least restrictive treatment option in the community and is very 'Medical Model' and hospital focussed. I believe the emphasis should be changed.

Best of luck in the review process.

Yours sincerely

**Dr Alexander A Tait MB ChB MRC Psych, FRANZCP DCH
Senior Consultant in Adult Psychiatry
ROCKINGHAM KWINANA MENTAL HEALTH SERVICE**

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other letters/mhact review.ya