SUBMISSION REGARDING THE MENTAL HEALTH ACT (MHA) 1996

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Introduction

This working group felt it necessary to outline a context for the following submission.

- The Wheatbelt region consists of 92 towns, 55,000 people over 120,000 sq/km. Clinical FTE are currently 16 including 1 FTE psychiatrist. The community service runs 2 offices based in Northam and Merredin. There are no authorised beds in the region.

- Graylands Hospital provides involuntary inpatient services. This is a 10 hour return trip by road from the furthermost town in the Wheatbelt.

- The group assumed that the MHA is legislation relevant to the whole state including rural and remote areas, therefore the review of the MHA must consider the reality of limited Wheatbelt resources.

- The changes to the MHA should result in greater flexibility and support for rural and remote areas not greater restrictions.

- The MHA is for people with psychiatric Illness and should **protect** people with psychiatric illness.

- As a rural area that is not yet funded to meet the staffing benchmarks for community based care, we are concerned that we will be unable to comply if the MHA becomes more restrictive as opposed to more flexible.

- The Wheatbelt has no Psychiatric Rehabilitation program and limited capacity for intensive case management. Assertive and intensive case management of people on early discharge and Community Treatment Orders is logistically difficult.

- Other logistical issues faced include limited CDMA mobile phone coverage due to poor network infrastructure and unseasonal climatic changes. This often results in home/farm based assessments taking place in isolated circumstances, with reduced capacity to contact Metro based inpatient facilities to negotiate an inpatient bed.

- Poor resourcing of all other agencies including the Department of Community Development, Disability Services Commission, Youth Services, Wheatbelt Community Drug Service team, Domestic Violence Unit and School Support Services limits the capacity of these agencies for accessible intervention and is resulting in increased mental illness morbidity.

- The Wheatbelt volunteer driver ambulance service operates with some towns sharing ambulances and most vehicles in a poor state of repair. On 2 occasions in the past 2 years ambulances have broken down whilst transporting mental health clients to Perth. There is also issue regarding payment of ambulance fees when they are called within the community setting to transport patients on Form 1 and 3.

- The Wheatbelt has limited drug and alcohol services and no detoxification facilities.

- There are limited legal services in the Wheatbelt and no family law court.

- The Wheatbelt Police district has lost 9 officers in the past twelve months and all 1 man stations will be closing over the next 24 months. Transportation on Form 3 is difficult and often leaves up to 3 towns with no police coverage for over 10 hours at a time.

- Many police stations do not have access to police sedans and are forced to use ‘paddy wagons’ to transport people over long distances.

- Fundamentally there is a clear requirement for the Department of Health to continue to invest in peoples' mental health in tandem with this review.

- Telepsychiatry or videoconferencing has become an acceptable and useful mechanism for clinical assessment and intervention. WA has a comprehensive network that provides assessment close to peoples home. This is particularly important in Rural areas with the shortage of psychiatrists, lack of transport options and vast distances between regional centres. The use of videoconferencing must be considered as a legal means of assessment in the reviewed MHA.

- The Wheatbelt use of the term resources is inclusive of general health and general practitioner (GP's) workforce. Most afterhours emergencies are managed through the Emergency departments of the Wheatbelt hospitals with the use of an on call General Practitioner. The MHA is administered by GP's who have no requirement to attain or maintain competencies in Mental State or Risk Assessment. Currently documentation undertaken by GP's is not monitored under the MHA. Many of the smaller Wheatbelt hospitals do not have regular access to on call GP's leaving the A & E nursing staff with no options for managing the situation locally.

- The administration of emergency treatment (sedation) for transportation via Royal Flying Doctor is a requirement. This is ordered by the GP completing the Forms.

- Roles and responsibilities of General Practitioners and General Hospitals need to be explicitly included in the MHA, along with mechanisms for review, training and timely feedback.

- The Wheatbelt is predominantly a farming area, with livestock and other animals being a core part of the rural lifestlye. The current MHA makes no consideration for the responsibilities and funding for the ongoing care of the farm, livestock and pets when a person is referred for further assessment to a metropolitan facility. It should be a fundamental right of the consumer to expect their livelihood to be protected by legislation.

- The co-operation of Department of Community Development is dependent on the resources they have available and to date in the Wheatbelt this has been limited. Due to isolatory nature of farming communities and the relocation of single parent families in response to the homeless taskforce placement of children of people requiring assessment in an inpatient facility is often delayed leaving the children in high risk situations and delaying the assessment period for the person. The MHA needs to include the roles and responsibilities of other key family focussed agencies to support the administration of the MHA in under-resourced communities.

- We emplore that the MHA review identify these key roles and provide argument for appropriate support and funding to the Department of Community Development.

AREAS OF THE ACT

Definitions

The group considered the following in relation to definitions:

- The current definition of mental illness is too broad and should be refined to reflect psychiatric illness.

Definitions that should be included:

- Children and mature minors

- Risk and timeframe relating to risk ie within last 48 hours.

- Stigma

- Consent, informed, implied etc

- Emergency Psychiatric Treament

Changes to definitions:

- Authorised Mental Health Practitioners and Mental Health Practitioners must include experience in assessment not just treatment.

Objects of the ACT

- The MHA should provide a legislative base for a system that guarantees access to high quality comprehensive care. This should include access to medical assessment and care.
- The MHA should be closely aligned to the National Standards for Mental Health Services.
- The MHA should guarantee access to authorised beds for rural and remote areas through a priority or buddy system.

Office of the Chief Psychiatrist

This section should include all clients with mental illness whether voluntary or involuntary. Quality of care and service provision should be monitored by the Chief Psychiatrist in both the public and private sectors. This should also include both state and commonwealth funded programs providing mental health services and include the non government sector.

Authorised Mental Health Practitioners

Rural and remote mental health services are not funded to provide face to face afterhours services. Many rural towns have limited afterhours GP's and often hospitals cannot access a GP in the absence of an AMHP. The hospital is left with no capacity to assess the person or make a timely referral for assessment to a psychiatrist.

The development of a temporary AMHP system would assist. This could be achieved through a comprehensive training and skills maintenance program for Senior Registered General Nurses/ Director of Nursing who could apply for temporary AMHP status to undertake an assessment if a person presented to the hospital and the GP was not available. The possibility of using the Psychiatric Emergency Team for instant AMHP application and approval and support with the assessment via telepsychiatry could be considered.

Authorised Hospitals

The group identified the MHA review should consider:

- Priority for Rural and Remote areas to Authorised Hospital beds for children, adolescents, adults and psychogeriatrics
- A section on Child appropriate Authorised inpatient facilities

Referral for examination
The group identified the MHA review should consider:

- The use of videoconferencing facilities for this purpose must be considered.

Police assistance

The group identified the MHA review should consider:

- Rewording this section and expanding the definition of the role to provide a clear and concise role statement for the police.
- Replacing words like 'may' with 'will'.
- Inclusion of criterion for when police assistance can be sought
- Removing the statement " transport if no alternative'. This is being misused in this rural area by some GP's and it is clearly not a police role.

- Fundamentally the Department of Health should resource health services to be able to transport appropriately

Making a CTO

The group identified the MHA review should consider:

- Tightening the defintion of Mental Illness to ensure only appropriate people are considered for CTO's
- The use of videoconferencing facilities for this purpose.
- Extending the timeframe to 6 months for rural and remote areas due to distances travelled, reduced capacity for rapport building between consumer and clinician in out reach areas, resourcing issues in providing intensive treatment and rehabilitation services and lack of other external services to expediate recovery of the consumer.

Emergency Psychiatric Treatment

The group identified the MHA review should consider:

- Expanding the definition of emergency psychiatric treatment
- Expanding the definition to include medication administered to transport a person for assessment against their will.
- Expanding reporting requirements to explicitly include emergency medication administered without consent in Rural Hospital Emergency Departments ordered by GP's.
- Including a feedback loop to the GP and hospital from the Review Board

Children and adolescents

The group identified the MHA review should consider:

- Developing a section dedicated to children and adolescents similar to Section 26 of the Northern Territory MHA

Carers/ family and other agencies

This service regularly receives information verbally from carers, friends and other agencies reporting collateral information regarding peoples mental health. This causes contention between the person reporting the information and this agency when on assessment the person does not meet the current criteria for referral for further assessment. Typically the carer/ family are aware of the person's relapse signature and have usually identified early signs of relapse. The current MHA does not promote early intervention and treatment. Inevitably some weeks later the person is subsequently referred having caused great concern and heartache for the family.

The group identified the MHA review should consider:

- Including a formal complaint form for carers, families and other agencies to complete.
- The form be a legal document sighted by a Justice of the Peace or equivalent.
- That the form be included as collateral evidence of relapse of mental illness as part of the AMHP documentation supporting referral for assessment.

CLMIDA Section 5 Hospital Orders

In many cases seven days is insufficient time to complete a thorough assessment and the clients have to return to court after seven days. This often results in a further hospital order being made. The time frame for the order needs to be made more flexible with a maximum time frame imposed ie 21 days.

CLMIDA SECTION 28 Leave of Absence

A provision should be made in the Act regarding notification to local rural mental health services of people under Custody Orders who are going to be in the area while they are on leave. This notification should include all relevant information regarding the person so the MHS is informed and able to deal with issues as they arise.

CLMIDA Section 35 Release of Mentally Impaired Defendants

The local MHS needs to be informed of releases and included in the release planning process. The treating forensic psychiatrist should continue to hold clinical responsibility for the continuing care of the person for a specified period of time post release. This is especially needed in Rural areas such as the Wheatbelt.