

## 3.9 Strategic governance and legislation

### 3.9.1 Mental Health Bill 2011

Time constraints prevented a full review of the Mental Health Bill 2011. However, the Reviewer makes the following interim comments.

The Bill reflects many of the recommendations put forward by the Holman et al. report (2003) and omits a number of recommendations that were accepted by the Government (Holman 2003).

The Reviewer is of the opinion that the Bill is intended to protect the human rights of persons with mental illness, and contains specific schedules that empower consumers and involves carers in decision making about admission, treatment and discharge planning.

Many of the issues in need of improvement in the mental health system that have come to the attention of this Review are addressed in the Bill, including:

- Consent to and involvement of the patient with treatment. It is commendable that the Bill requires that patients are involved in the development of treatment plans and have the right to a second opinion; as well as the right to withdraw consent (Pt 13 and Pt 14 Div 3 s 252). The power of the Chief Psychiatrist is appropriate in ensuring that patient's rights are appropriately explained.
- Physical health of patients.
- Aspects of the Carer Recognition Act 2010, especially involvement of the carer with treatment and discharge planning.
- Aspects of Aboriginal ethnic requirements such as being accompanied by a nominated person or medicine Elder throughout treatment. Sections 142 and 143 and more generally Pt 4 Div 1 enable Aboriginal culturally appropriate care.
- The need for a nominated person to 'walk' or be with the patient through mental health services.
- Acknowledgement and inclusion of advanced care statements.
- Reporting of sentinel /incidents events [rare events that lead to catastrophic patient outcomes]to the Chief Psychiatrist.
- Special consideration in the care of children.
- Authorised professionals other than police officers needed to transport mentally ill patients.

This Review is concerned with some aspects of the Mental Health Bill as follows:

- The Office of the Chief Psychiatrist (OCP) would benefit by being external to the Mental Health Commission and the Department of Health, acting independently and reporting directly to the Minister for Mental Health and the Minister for Health. This would empower the OCP to carry out the duties specified in the Bill without any conflicts of interest.
- Such independence would enable the OCP to develop guidelines, monitor continuous quality improvement (particularly investigations of deaths and other incidents), patient advocacy and support to mental health staff from purchaser and provider associations. It is the Reviewer's opinion that for the Chief Psychiatrist to report alone to the Mental Health Commission or to the Department of Health raises major issues of conflicts of interest.

- It is commendable that the Bill acknowledges the differing needs of children with mental illness (Pt 15). However, there is no specific acknowledgement of the needs of youth aged 16–25 and the requirement for secure care environments for children and youth. Youth should be cared for in a separate environment to young children and adults.

The definition of mental illness needs re-examination or further description to remove the dementia of the ageing population or of some specific diseases, which are best cared for in the geriatric or other special medical environments.

The time frames that have been put forward concerning the involuntary patients and their review is very short and this Reviewer does not believe those requirements can be achieved, especially with current workforce issues.

### 3.9.2 Office of the Chief Psychiatrist

Before the Health Administration Review Committee (HARC) Report released in 2001, the Office of the Chief Psychiatrist (OCP) was both the funder and provider of mental health services in WA. This included responsibilities for operations, planning, policy and legislation. HARC recommended that the OCP separate from the Mental Health Division (Recommendation 13: The role of the Chief Psychiatrist be developed as a discrete function within the health care division) and the *Mental Health Act 1996* defined the statutory responsibilities in legislation.

The OCP became responsible for the medical care and welfare of all involuntary patients, and the monitoring of standards of psychiatric care throughout the State (s 9 of the *Mental Health Act 1996*). Other functions include keeping a register of authorised hospitals and practitioners and the maintenance of satisfactory standards in relation to medication use in psychiatry. The OCP introduced clinical governance reviews to discharge the Office's responsibilities with regard to the care and welfare of involuntary patients and standards of care in services.

The separate and independent office was established on 1 July 2002.

The OCP is directly accountable to the Director General of Health and the Minister for Mental Health and ultimately to the community and particularly those people with a mental illness, their carers and family.

In the new (services) purchasing environment, the roles and responsibilities of the Mental Health Commission, Department of Health and the OCP are unclear. The OCP informed the Review that they have been requested to inform the Mental Health Commission of the quality and safety of the services the Commission are purchasing. A concern in supplying data is that it be high level and generic and not at individual patient level. At the same time, the Chief Psychiatrist needs to inform the Department of Health of similar issues in the provision of services.

The mental health reforms and maintenance of the current level of service highlights that a purchaser cannot operate without close collaborative work with the providers.

*See Recommendation 6: Office of the Chief Psychiatrist.*

### 3.9.3 Mental Health Commission

Reporting to the Minister for Mental Health, the Mental Health Commission of WA has responsibility for the strategic planning and purchasing of WA mental health services. The Commission obtains strategic advice from the Mental Health Advisory Council. The establishment of this commission in March 2010 occurred as the first stage of system reform; the second stage will occur under the anticipated new mental health legislation in 2012. This reform aims to embed a stronger focus on the rights and protection for patients and carers.

In October 2011 the Hon. Colin Barnett, Premier and Minister for State Development, and the Hon. Helen Morton, Minister for Mental Health and Disability Services, launched the 10-year strategic plan *Mental Health 2020: making it personal and everybody's business* (MHC 2011). This Plan has five key principles:

#### Respect and participation

People with mental health problems or mental illness, their families and carers are treated with dignity and respect, and their participation across all aspects of life is acknowledged and encouraged as fundamental to building good mental health and to enriching community life.

#### Engagement

People with mental health problems or mental illness, their families and carers are engaged as genuine partners in advising and leading mental health developments at individual, community and service system levels across WA.

#### Diversity

The unique needs and circumstances of people from diverse backgrounds are acknowledged, including people from Aboriginal or culturally and linguistically diverse (CALD) backgrounds, people with disability and people of diverse sexual and gender orientation, and responsive approaches developed to meet their needs.

#### Quality of life

By developing personal resilience and optimism, maintaining meaningful relationships, having access to housing and employment, opportunities to contribute and engage within the community and access to high-quality mental health services when needed, individuals can build a good and satisfying life despite experiencing mental health problems or mental illness.

#### Quality and best practice

Mental health programs and services are statewide, based on contemporary best practice, easily accessed and delivered in a timely and collaborative way.

This Plan drives the objectives of the Mental Health Commission. The Commission aims to promote public awareness of mental wellbeing and address stigma and discrimination affecting people with mental illness. The Commission:

- acts as steward of the public investment in mental health and has a duty to direct funding towards those services and supports that best meet the needs of patients, their families and carers
- engages with people in the public and private mental health services and the non-government sector to ensure people are at the centre of thinking and planning
- raises awareness of the capacity of self-directed support programs to give vulnerable people greater control over their lives
- appreciates and supports the many established service providers who are dedicated to improving the wellbeing of Western Australians who experience mental health problems or mental illness.

The Mental Health Commission must work closely with the Department of Health as the largest provider of clinical mental health care and ensure there is adequate funding for acute and ongoing clinical services.

The Mental Health Commission favours the disability model of funding, where funding is attached to a person and gained via funding rounds. The funding enables choice and control of care by the individual's purchase of services to meet their needs. Not all persons qualify for such funding. While this funding may be suitable for persons with chronic disability, it may not meet the needs of persons with mental illness because of the often-fluctuating pathway that occurs in many patients between stabilisation and acute relapse.

The complexity of mental health needs confounds such a disability funding model. Clinicians support the disability funding model for community patients who have a chronic but stable condition. However, they do not agree that this model fits well with patients with acute illness.

People with mental illness often present with acute episodes of illness, some requiring an intensive level of care (e.g. involuntary secure environments with 1:1 care). Many have intermittent illness requiring acute inpatient followed by long-term acute community care. However, a number of people require rehabilitation and long-term support and could benefit from the disability services funding model (personal communication Chief Medical Officer 2012).

Applying the disability funding model alone will severely affect the ability of acute and rehabilitative specialised mental health services to respond to patients in need.

Clinicians commented that the Mental Health Commission requires a communication strategy that includes engaging clinicians 'on the ground'. They perceived that the Commission has been focused on non-government organisations (NGOs) when a collaborative model is required to address the needs of patients with mental illness. They feared this funding model would deplete mainstream services to the point of collapse.

Effective integration between hospital, community and NGOs was described as vital by the community mental health services. The ability to maintain relationships and perform in an integrated manner as suggested requires funded support.

Staff in the Great Southern wished for better understanding of Mental Health Commission plans and requirements to assist local service planning and designs, particularly in terms of Better Access and Better Outcomes for remote communities.

Mental health directors informed the Review that they had requested resources to implement innovation in services by submitting business cases. However, during the past four years, no case had been successful. The reallocation of existing resources and obtaining external funding from service club donations and research grants had been necessary strategies to fund innovations in some situations.

The Mental Health Commission needs to develop a Clinical Services Plan with the Department of Health that clearly demonstrates the hospital and community services required in WA over the coming decade.

*See Recommendation 1: Governance (1.1.1; 1.1.8); Recommendation 5: Beds and Clinical Services Plan (5.4); and Recommendation 8: Children and youth (8.10.1; 8.10.2).*

### **3.9.4 Mental Health Advisory Council**

The Mental Health Advisory Council advises the Mental Health Commissioner and Minister for Mental Health about major issues affecting Western Australians with mental health problems, their carers and services providers (Mental Health Advisory Council, terms of reference).

The Chair and Deputy Chair are appointed by the Minister for Mental Health and the committee consists of members from a range of backgrounds including teaching, psychiatry, refugee settlement, mental health nursing, non-government mental health agencies and general practice as well as consumers and carers (media release, Minister Morton 2011).

### **3.9.5 Mental Health Review Board**

The Mental Health Review Board ('the Board') is currently funded by and colocated with the State Administrative Tribunal as part of the Department of the Attorney General. As of 1 July 2012, the Board will operate independently of the Tribunal and be funded by the Mental Health Commission.

The Board undertakes periodic reviews of involuntary patient status in addition to reviewing patients on request. The Board uses a computerised patient management system wherein records of all involuntary patients are maintained and appointments scheduled. The Board has the power to reverse the involuntary status of patients.

Reviews of patients occur in the hospital or clinic providing care for the patient within the metropolitan area or by video-conferencing in regional areas.

The Chair of the Mental Health Review Board informed this Review that patient medical records often reflect that the patient's discharge planning commenced on admission. However, a lack of supported accommodation has been an obstacle to discharge of patients for many years. There is difficulty in supporting patients of no fixed address in community mental health services.

The Board has also observed that medical records often reflect the plan to make contact with a family member. However, engaging family or successful contacts are rarely recorded. It is unclear to the Board why it is that they have difficulty contacting the family.

Family members rarely attend the patient's Mental Health Review Board meetings. The Board writes to the patient encouraging them to bring along supportive family and friends and to the psychiatrist encouraging the family to be informed of the review. The Board is not empowered to invite family members directly.

When family members attend the review meetings, they are welcomed, often provide crucial information on the circumstances of hospitalisation, and assist with discharge planning. At times, the discussions at the Board with the family appear to be the first occasion of family engagement with the psychiatric care for the patient.

The Chair informed the Review that the quality of clinical notes has vastly improved over the years. However, reports for hearings are difficult to obtain. In part, this is related to a stretched workforce, and a Board member suggested that psychiatrists should have secretarial services as well as training to use them effectively.

The Mental Health Bill 2011 provides for the Board to be re-established as the Mental Health Tribunal (Pt 18) and required to review the involuntary status of patients more frequently:

- after 35 days for involuntary patients 18 years and older and three monthly thereafter
- 10 days after the order is made for children and three monthly thereafter
- six monthly for patients on community treatment orders for more than 12 months
- voluntary patients who have been hospitalised for more than 12 months (Div 4).

The impact of increasing frequency from the current *Mental Health Act 1996*, which stipulated eight weeks from the initial order along with six monthly periodic reviews, will extend to the treating psychiatrist who will be required to prepare patient reports. In addition, the Mental Health Tribunal may be legislated to authorise electroconvulsive therapy (ECT) (Div 5) and psychosurgery (Div 6) and review the appropriateness of transfer orders.

*See Recommendation 3: Carers and families (3.4).*

### 3.9.6 Council of Official Visitors

The Council of Official Visitors (COOV) is empowered by the *Mental Health Act 1996* to provide advocacy for people with mental illness. Council members investigate complaints on behalf of involuntary patients and those who reside in licensed private psychiatric hostels. In addition, they regularly inspect the inpatient environment of mental health facilities and provide recommendations for improvement.

The Mental Health Bill 2011 proposes to change the title of COOV to Mental Health Advocacy Services and to extend the advocacy role to include: involuntary and voluntary patients; patients referred under the *Criminal Law (Mentally Impaired Accused) Act 1996* (the CLMIA Act); mentally impaired accused; persons released under conditions and under a release order made under the CLMIA Act; residents of psychiatric hostels; and any person who is being provided with treatment described by the regulations in Part 17 s 263. The Bill also removes the responsibility for inspecting mental health premises and this remains a right of the Chief Psychiatrist (Pt 20 Div 1 s 406).

There is an absence of council members in the north-west and north of WA.

The annual report 2010–2011 describes the issues of concern to the COOV. The issues that relate to admission, discharge, referral and transfer are:

- Patients have difficulty in accessing services (pp. 33, 35–36, 80).
- Patients held in EDs and acute public hospital wards while they wait for a place in a mental health facility and whether the Mental Health Act can or should be enacted when mental health patients are in the ED, for example, use of restraint (p. 21).

- Patients report they are told they would remain a voluntary patient if they complied with care but would otherwise become involuntary (p.19 ).
- Inappropriate placement of children in adult wards (p. 39).
- Risks associated when children on bail are admitted into the adolescent ward at Bentley (pp. 27–28).
- Lack of rehabilitation programs in acute wards (p. 23).
- Lack of information provided on patient’s discharge (p. 80).
- Insufficient number of step-down units and the need for patients to remain in hospital when they could be discharged into supported accommodation (p. 22).

In an interview with representatives of the COOV, these matters were discussed.

There has not been an ‘inspection’ by the the council focusing on admission. However, the Council undertook a statewide review of discharge planning in 2010–11. This review involved questionnaires to staff and patients. The findings include:

- Patient, family and staff have difficulty navigating the mental health services.
- Variation in patient and family involvement exists between the North and South Metropolitan Health Services.
- There is variation in computer system usage within the mental health services.
- Inpatient services are not aware of NGO contracts and therefore unclear about what they can provide.
- Accommodation liaison officers are not available to assist with housing for patients who are being discharged.
- Patients do not have their history or treatment plan provided to them at discharge.
- Receiving hostels indicated that they had inadequate notification of patient transfer, for example, less than two hours’ notice.
- The information hostels receive on transfer is inadequate to enable continuity of care.
- Some hostels have exceptional relationships with individual staff from inpatient services and this improves the quality and timeliness of information from those services.
- Medical records including care and treatment plans are not shared between services, clinics and NGOs.

The COOV also raised concern that psychiatrists sometimes discharged or made patients voluntary just before their hearing by the Mental Health Review Board. This statement has previously been investigated by the Board and found to be ill-founded. It is clear that some patients are ready for discharge before the hearing and others are well enough to be voluntary. Changes in involuntary status were not found to relate directly to the intent of avoiding a hearing.

*See Recommendation 1: Governance (1.2); Recommendation 2: Patient; Recommendation 4: Clinicians and professional development; and Recommendation 9: Judicial and criminal justice system (9.1.4).*