

INFORMATION HANDOUT

MENTAL HEALTH ACT 1996 **Progress on the Review and the Government Response**

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The 1996 Mental Health Act

Part of the Act specific to Patient's Rights

Introduced the Mental Health Review Board

Introduced Community Treatment Orders

Made the Board of Visitors the Council of Official Visitors

Gave a determination of mental illness and criteria for involuntary status

Gave specific powers to the police

Prohibited certain treatments and regulated others

Stated there had to be a review of the Act after 5 years of the Act being in force

The Review was conducted over an 18-month period and included:

1. Over 300 public submissions.
2. A widely representative stakeholder group.
3. Working Parties to examine specific issues relating to the: Council of Official Visitors, Mental Health Review Board, Involuntary Status & Community Treatment Orders, Part 5 - Treatment of Patients, Part 7 – Protection of Patients' Rights, Criminal Law (Mentally Impaired Defendants) Act.
4. Circulation of a Draft Report in October 2003.
5. Feedback from the public about the Draft Report.
6. A series of regional consultations in rural and remote areas of WA.
7. Presentation of a Final Report 'The Way Forward' to the Minister and Attorney General in December 2003.

Recommendations which are accepted and advance the human rights of persons with mental illness include-

- That the definition of 'mental illness' be revised to accord with internationally accepted standards
- That the objects of the Act are replaced and expanded to include principles relating to Aboriginal and Torres Strait Islanders, the rights of carers and access to health care and support services for carers
- That the role of the Chief Psychiatrist be enlarged to include the care and welfare of voluntary patients as well as involuntary patients
- That the Chief Psychiatrist give approval to guidelines to improve treatment and care
- That the criteria for involuntary status be amended to include that '*the person has unreasonably refused treatment*' accepting that persons may quite reasonably refuse treatment and should not be made subject to involuntary status
- The requirement of the referrer be changed from '*personally examine*' to '*personally assess*', thereby implying a wider range of inquiry before referral
- That a Form is provided to the referred person to inform them as to why the referral is occurring and what the expectations of the referral are
- That a psychiatrist may be able to examine the person by audiovisual means thereby ensuring that persons are not unnecessarily transferred from a rural to a metropolitan hospital
- That there is a reduction in the maximum time a person is maintained as an involuntary detained patient from 28 to 21 days and in relation to extension of the order from 6 months to 3 months
- That the definition of treatment be expanded to allow a wider range of therapeutic intervention

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- That the statement regarding informed consent is expanded placing expectations on services to obtain informed consent
- That a carer's involvement in treatment be expanded leading towards a partnership model of care
- That the Chief Psychiatrist publish guidelines to ensure that a second opinion provided by a psychiatrist is 'independent'
- That emergency psychiatric treatment is not to include electroconvulsive therapy (ECT)
- That all persons admitted to an authorised hospital receive a complete medical as well as mental health assessment
- That a mandatory review by the Mental Health Review Board will be conducted within 35 days rather than 56 days as under present legislation.
- That, with appropriate restrictions, legal representatives may have access to a patient's records for the MHRB review
- That in the part of the Act dealing with community support services, prominence is given to the importance of discharge planning
- That the duties and powers of the Council of Official Visitors (COV) be extended to include the referring of environmental matters to the Licensing Standards and Review Unit and the Chief Psychiatrist
- That the meaning of 'affected person' be extended to persons referred to an authorised hospital for examination, voluntary patients and those patients subject to the *Criminal Law (Mentally Impaired Defendants) Act 1996* therefore allowing the COV to become involved
- That any restrictions on the capacity to vote be removed
- That there is a further Review of the legislation after five years

It is recommended the Act has a specific part for dealing with Minors

- That the concept of the Mature Minor be introduced into mental health legislation
- That there are shorter time frames for the MHRB review of minors as well as shorter time frames for involuntary detention
- That ECT be prohibited for children under 12 and with special restrictions for its use in minors under the age of 18
- That the concept of the Youth Advocate be introduced
- A section listing the rights of parents or a guardian with respect to a child or adolescent

A new part of the Act dealing with complaints

- Set out who can make a complaint such as a patient, former patient, carer, practitioner, official or member of the public
- Development of local complaints procedures
- Complaints which do not concern the administration of the Act should go to the Office of Health Review
- Complaints about the administration of the Act should go to either the MHRB or the Chief Psychiatrist
- Complaints will be monitored by the Chief Psychiatrist

Recommendations accepted that clarify the Act include

- That there is a new Act with contemporaneous repeal of the 1996 Act
- That the criteria of a mental health practitioner be changed to allow an Enrolled Nurse to become a mental health practitioner and the length of service requirement be removed.

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- That a medical practitioner or an authorised mental health practitioner be enabled to detain, if necessary a referred person for up to 6 hours
- That the process of detaining a voluntary patient who requires involuntary status while an in-patient in an authorised hospital be changed to make the process more in line with referrals from the community
- That the Criminal Code be changed so that a person who exercises a duty of care to a person with degenerative brain disease will not be liable to section 337 of that Act. This will give clarity to staff working with the elderly who because of wandering present as a safety risk
- That the referral of persons on CTOs to authorised hospitals be changed so that the CTO is suspended
- That the issue of Interstate Movements be changed to give legislative backing to Interstate agreements
- That the administration of seclusion and mechanical bodily restraint be changed to clarify who may be subject to this intervention and who may not, as well as the keeping of statistical information
- That the Minister for Health have the ability to declare areas in the state where longer time-frames may be allowed for detention which will lead to greater safety for patients and clarity for clinicians
- That the role of rural nurses be changed to enable medication to be administered in rural settings
- That there is a new section to the Act allowing the use of reasonable force by mental health or medical practitioners in relation to disturbed patients
- That there is mandatory reporting to the Chief Psychiatrist of 'notifiable incidents' to allow monitoring of critical incidents

Recommendations not accepted include

- Changes to the criteria under section 26(b)(i) of the Act from '*to protect the health and safety*' to '*serious likelihood of immediate or imminent harm*' is not accepted.
- The present criterion '*to protect the health and safety*' better reflects the need for involuntary status.
- Adding '*serious likelihood of immediate or imminent harm*' may lead to the exclusion of persons, who while not being in danger of '*immediate or imminent*' harm, may require treatment for their mental illness and if the treatment is not provided may deteriorate to a degree causing significant harm to their health.
- The Act is about providing safety and this must be recognised in the criteria

Community Treatment Orders

- Changes to the confirming of a CTO, which allows in certain circumstances that this function may be omitted, is not accepted
- In effect it is a reduction in the rights of persons placed on CTOs
- A CTO is still an involuntary order and it is important that a second psychiatrist or medical practitioner confirm the order
- It would be appropriate for the confirming practitioner to be extended to include a mental health practitioner in addition to the other categories of psychiatrist or medical practitioner

Separation of treatment from detention

- The separation of treatment from detention so that before treatment can commence a body such as the MHRB must review the matter is not accepted
- The purpose of involuntary status is to provide treatment

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- Separating the detention and the treatment process is contrary to the fundamental purpose of involuntary status
- If a person is able to give informed consent to treatment they should not be made subject to involuntary status
- If they unreasonably refuse or due to their mental illness are unable to consent then they are made involuntary patients in order to receive treatment
- The psychiatrist and treating team is in the best position to decide what treatment the patient requires

Confidentiality

- That carers have a right to information, which may overrule issues of confidentiality, is not accepted.
- Although the intention of this recommendation is commendable the issues regarding a patient's right to confidentiality need to be maintained.
- If a patient is unable to give consent the recommendation as outlined may have merit.
- However, if a patient is adamant that certain information should not be disclosed to a relative that right needs to be upheld

Concluding statements of the report

- This report, founded on the review recently conducted, gives recognition as to what is required in amending mental health legislation
- The recommendations that have been accepted will strengthen the human rights of persons with mental illness and their carers
- A number of the recommendations, which are accepted, will clarify the intent of the legislation and make the Act more practical in its implementation
- The final result will be an Act, which advances human rights while emphasising the need for treatment of persons with a mental illness

Caveat to the report

The report is subject to further discussions between the Police Service and the Department of Health.

Meetings between the Police Service and the Department of Health have commenced to resolve issues of police assistance in transportation.

Once those matters have been resolved they will become part of the information provided to legal services who are preparing drafting instructions.

Process from here- hopefully

- Legal and legislative services will prepare drafting instructions by September 2005
- Parliamentary drafters will prepare a Mental Health Bill by March 2006
- There will then be an opportunity for community consultation
- A new Mental Health Act will be presented to Parliament in Spring 2006

The Government Response report can be accessed on the features page of Mr McGinty's website-

<http://www.ministers.wa.gov.au/mcginty/index.cfm>

And also the review website-

<http://www.health.wa.gov.au/mhareview/index.html>