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The Community Consultation Panel
Mental Health Act Review
Mental Health and Drugs Division
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Dear Panel,

St Vincent's (STV) welcomes the opportunity to provide a submission to the Department of Human Services *Review of the Mental Health Act 1986 Consultation Paper*. This submission provides the perspective of clinical services that rely on the Act in every day practice, inclusive of the viewpoint of adult and aged clinical mental health services, that of state-wide dual-disability, trans-cultural and dual diagnosis mental health services.

STV considers that the new Act should be written with the aspiration of achieving the highest possible level of rights and support for patients of mental health services. While there are associated resource implications, STV believes this should be considered in the context of providing the best available care, protection of rights and safeguards of patients for many years to come.

Comments have been structured consistent with the Consultation Paper.

We hope our submission assists in deliberations on this critical part of the service system.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Patricia O'Rourke', written in a cursive style.

Patricia O'Rourke
Acting Chief Executive Officer
St. Vincent's Hospital (Melbourne) Ltd



St Vincent's

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Chapter 2 Background and framework for reform

Question 2: What principles, departmental objectives and functions should the new Act include?

In terms of principles, the new Act should reflect the principle of upholding human rights at the same time as providing for those in need of treatment and care and protecting those in the community who are most vulnerable.

In recognition of the principle of protection, one of the key objectives of the Act should be to reflect the different types of rights that exist, such as the right to freedom, right to treatment and right to refuse treatment. The existing Act does effectively differentiate between overriding the right to freedom (i.e. by involuntary admission / assessment) and the right to refuse treatment (i.e. coerced treatment with medications), as does legislation in other jurisdictions and countries such as the United States and United Kingdom. The review of the Act provides an opportunity to ensure that as many rights as possible are protected, and where it is appropriate to override those rights. The new Act should consider these aspects and the mechanics provided when these rights are upheld and when they should be limited.

When a person with a permanent impairment requires psychiatric care, the new Act must effectively provide legislation for patients to exercise their rights. As the existing Act does not effectively protect this group, patients may receive inappropriate treatment as they are presumed to have provided informed consent, despite being incapable of so doing. For this reason the new Act should protect those who have a permanent impairment who are unable to express their views and wishes when receiving psychiatric treatment and recognise that they may require special assistance to exercise their rights and greater opportunities for accessing a second opinion.

Chapter 3 Involuntary orders

Question 3: How should mental illness be defined in the new Act?

The definition of mental illness is a complex issue. A major difficulty is the differentiation between a mental illness, neuro-developmental disorders and medical or neurological disorders. A mental illness is characterised by onset and possible recovery (ie schizophrenia, mood disorders), while neuro-developmental disorders may be evident early in life and are generally lifelong impairments (ie intellectual disability, autism spectrum disorders, personality disorders etc.) and are distinct from medical or neurological disorders (ie epilepsy, dementia or acquired brain injury). Further to this, additional complexities arise in the presence of co-morbidities, such as the impact of substance use with mental disorders.

The reality is that all three different groupings of mental disorders outlined may result in a patient presenting with significant risks, be associated with lack of capacity and may require treatment. These disorders often co-exist and are difficult to differentiate between.

For this reason it may be more appropriate to adopt a broad definition and use the term mental disorders, rather than mental illness. A mental disorder is best defined with reference to 'patterns of psychological and behavioural signs and symptoms that can be recognised and classified using operationalised criteria by appropriately trained professionals'. These are characterised by significant disturbances of thought, emotion, cognition, memory, judgement, perception and volition and are assumed to arise from an underlying dysfunction in the patient.

Question 4: What conditions should be excluded from the definition of mental illness or Act?

If the new Act serves to preserve the rights of a patient, then there should be no reason to exclude any mental disorder from definitions in the new Act. It should, however, be specified that personal beliefs concerning religious, political and sexual preference do not in themselves constitute mental disorders.

Question 5: If separating the involuntary process into three stages is supported:

- a) *What should be the grounds for each order?*
- b) *What should be the duration of the order?*
- c) *Should there be any restrictions on the kinds of treatment that can be given under each order?*

The separation of the involuntary treatment process into three stages is supported, to ensure that there is an assessment phase before an involuntary order is made.

A 72 hour assessment period would be appropriate to balance the need for a thorough clinical assessment with the need to commence treatment planning. (An assessment period such as that used in England and Wales of 28 days is considered too long.)

During an assessment period, a restriction on the types of psychiatric treatment that can be used without consent would be reasonable. As treatment is frequently required in an emergency situation (e.g. re-hydration, short-term sedation), Clinical Guidelines describing appropriate treatment options during this stage would need to be developed and regularly updated to supplement the Act.

Question 6: How should the new Act address the issue of a person's capacity to consent to treatment in the grounds for an involuntary order?

The issue of a person's capacity to consent to treatment should remain as one of the grounds for an involuntary order, but there needs to be a clear definition of 'capacity to consent'. In

many cases of mental disorder, a patient's capacity to consent will fluctuate and need to be clinically reassessed at relevant points in time and in an ongoing manner. In contrast, for some patients, capacity may not be achievable (young children, people with intellectual disability or dementia). Ideally the person should be free to make decisions without adverse consequences but this is impossible to achieve if refusal will lead to involuntary treatment.

Question 7: How, if at all, should the new Act define what constitutes capacity to consent to treatment?

STV is not proposing a definition of capacity to consent, but notes that in defining capacity the following issues need to be considered:

- Consent must be specific to an individual person (i.e. a person may have capacity to spend their money but not to agree to treatment)
- Patients must be suitably informed to provide consent to treatment
- Patients must have the ability to make the decision (are able to understand the issues, appreciate the personal significance, demonstrate appropriate reasoning and able to express their opinion)
- A patient's ability to act on their decisions (i.e. the person may then act impulsively or may deliberately mislead professionals to their own advantage).

Question 8: What requirements, if any, should the new Act contain for deciding whether or not a person has the capacity to consent to treatment?

STV believes that it should not matter why a patient cannot consent (i.e. due to the mental illness or another condition) as this can be impossible to determine. If patients are not able to consent then it is not possible to provide them with voluntary treatment and they should be treated as involuntary patients.

Question 9: In what circumstances, if any, should the new Act permit a person to be placed on an involuntary order where the person has capacity to consent and is refusing treatment?

There are occasions where a patient may have the capacity to give consent but through their psychopathology they may make very poor decisions (such as to inflict extreme violence on a family member). In such instances, there is a need to be able to apply involuntary treatment despite the patient's capacity to consent. This is in consideration of the fact that mental disorders are not the only predictors of extreme behaviour, social context can also be a strong influence on patient behaviour, and in such instances patients may require involuntary treatment.

The Act should also specify that the patient's capacity has been assessed by an appropriately trained professional. The basis for this should be independently reviewed by the external review body. It should distinguish between assent (will accept treatment without understanding the implications) and consent. Assent is insufficient grounds for the provision of treatment.

Question 10: How should the new Act address the issue of the seriousness and immediacy of risk in the grounds for an involuntary order as they apply to:

- a) a person?
- b) Others?

Where a patient has the capacity to consent, is refusing treatment and is a significant risk to themselves or others, the Act should permit an involuntary order to be placed on this patient.

In addition, it is important to note that immediacy of risk is not the only important factor in

determining an involuntary order. Mental health services need to maintain the ability to use an involuntary order to treat people who would otherwise refuse treatment, and for whom the consequence of this would be a deterioration in health that impacts severely on their daily living and social and vocational functioning (including alienation of family / friends, reduced work capacity leading to loss of employment and / or loss of stable accommodation).

If the serious or immediate risk is to others, the new Act should permit service personnel to disclose relevant information to those others.

Question 11: How should the new Act address the issue of 'immediate treatment' in the grounds for an involuntary order?

Provisions in the Act should allow for services to apply immediate treatment in such cases of serious and immediate risk.

Question 12: How should the new Act address the issue of the 'least restrictive manner' in the grounds for an involuntary order?

The issue of the 'least restrictive manner' in the grounds for an involuntary order needs to remain paramount. There should be a compulsion to consider the client's long term recovery goals as well as their immediate treatment needs when making an involuntary order. The documentation of this in the treatment plan should create greater transparency of decision making processes and consideration of the patient's needs and rights.

Question 13: What requirements, if any, should the new Act contain to enable involuntary patients to provide informed consent to a wider range of psychiatric treatment?

The new Act should enable involuntary patients to provide informed consent to a range of psychiatric treatments wherever possible. Ok to remove

Question 14: If a second psychiatric opinion scheme is considered necessary, in what circumstances should the new Act require a second opinion?

A second psychiatric opinion scheme is considered necessary and needs to be enhanced from the existing provisions in the Act. The current process for seeking second opinions is inadequate as the authorised psychiatrist is not obliged to follow the second opinion. There should be a requirement that the second opinion is from a practitioner external to the treating service and it is given due consideration by the treating team. In the experience of STV, it is uncommon for patients to identify and locate a psychiatrist they wish to access for a second opinion. On the occasion that they do, however, there should be some identified resource mechanism within the system to support this, to ensure second opinions are not reliant on the capacity to pay.

Where there is a second opinion, the Act should require that a discussion between the treating psychiatrist and the psychiatrist providing the second opinion be held, and the second opinion should also be available to the external review body.

The new Act should also consider the particular circumstances where a second opinion should be required, such as patients with more complex or rare disorders ie dual disability. There should be an expectation that where there is a recognised state-wide specialist service for the needs of particular clinical groups, this service should be used to provide the second opinion, and the treating team should be required to follow the recommendations made by that recognised specialist service. For example, it should be mandatory that patients with a dual disability who are placed under involuntary treatment orders should have the involvement of the Victorian Dual Disability Service (VDDS) in a review and treatment plan for that patient. For such patients, the recommendations of the second opinion should also be provided to the patient and/or to the nominated person (carer or advocate). This would ensure that teams treating a patient with significant complex needs are required to involve an expert opinion and

appropriate care. This provision could be extended to other areas such as eating disorders, acquired brain injury, neuro-psychiatric disorders and personality disorders.

Question 15: What additional safeguards, if any, in relation to treatment decisions made by the authorised psychiatrist should the new Act include?

STV believes the new Act should specifically consider the provisions regarding consent to non-psychiatric treatment. The current provisions provide that if a patient is incapable of giving informed consent for non-psychiatric treatment, the treatment may be performed with the consent of (amongst others), the authorised psychiatrist. Psychiatrists are often called upon to provide this consent in circumstances where the patient does not have a guardian.

In clinical practice the approach to determining consent to non-psychiatric treatment generally involves two steps:

1. Establishing incapacity to give informed consent and the need for a substitute decision maker; and
2. Making the decision whether to proceed with the non-psychiatric treatment.

Psychiatrists are the appropriate specialists to address the first step, but the second step involves balancing the risks and benefits of the non-psychiatric treatment as well as consideration of the patient's personal circumstances. The difficulty is that by definition non-psychiatric treatments lie outside of the main area of a psychiatrist's expertise. The psychiatrist may have no expert knowledge regarding the procedure and the risks and benefits, beyond the general knowledge of any medical practitioner. The medical specialists providing the non-psychiatric treatment will have expert knowledge in the relevant area, and may be better situated to decide this second step.

It should also be noted that in cases where patients lack capacity to consent due to illnesses not subject to the Mental Health Act, this second step should be undertaken by an independent party (guardian) under the *Guardianship and Administration Act 1986*.

There may also be other advantages in separating the two roles of assessor and decision maker. We suggest that in regard to consent to non-psychiatric treatment, the Act be amended to provide that where a guardian has not already been appointed then the authorised psychiatrist can assess incapacity and the need for a substitute decision maker, but another person act as the substitute decision maker. This role could be filled by either the medical specialist who will carry out the treatment or a guardian appointed under the *Guardianship and Administration Act*.

Question 16: Should the Act include a best interests requirement in relation to treatment decisions made by the authorised psychiatrist?

A best interests requirement for treatment decisions should not be included in the new Act. This has proven to be hard to implement in other jurisdictions, as the definition of best interests is too broad and difficult to predict in relation to the future.

Question 18: What requirements, if any, should the new Act contain for clinical reviews of involuntary patients subject to:

- a) An involuntary order?
- b) A community treatment order?

The new Act should require that clinical reviews of patients admitted to an inpatient

psychiatric service on an involuntary order be:

- Conducted daily.
- Multidisciplinary team discussions should be held at least weekly.
- Patients should be discharged from an involuntary order as soon as it is no longer required.

For those on a community treatment order, clinical review requirements should be consistent with the National Standards for Mental Health Services.

Question 19: In what circumstances, if any, should the authorised psychiatrist consent to the annual examination of an involuntary patient?

Due to the high level of physical morbidity in people with mental illness, physical health needs should be one of the priorities of assessment and treatment. To ensure that this is done, the new Act should provide for the authorised psychiatrist to consent to the annual examination of an involuntary patient where necessary.

Question 20: What obligations, if any, should the new Act impose in relation to reporting results of annual examinations?

The new Act should impose the same expectations in relation to reporting results of annual examinations as the current Act.

Question 21: If separate grounds for a community treatment order are considered necessary, how should they differ from the grounds for making an involuntary treatment order?

The grounds for making a community treatment order should not differ from those for an involuntary treatment order, but there should be a requirement that a community treatment order can only be made if the treatment is available and able to be delivered in the community. For example, STV has had contact with people who have not responded to any form of compulsion to engage with treatment. Where there is no hope of ongoing contact with such people, community treatment orders are not appropriate.

Question 22: What should be the duration of a community treatment order in the new Act?

The duration of a community treatment order in the new Act should be for less than 12 months; a more reasonable time would be 6 months. It should be recognised that this will involve an additional workload for both mental health services and the external review body.

Question 23: Should there be any restrictions on the type of treatment that can be given under a community treatment order in the new Act?

STV has not detailed any specific restrictions, however there should be acknowledgement that a community treatment order needs to involve more than ensuring adherence to medication, and that treatment plans should consider all factors including concurrent substance use.

Chapter 4 Patient participation in treatment and care

Question 24: What obligations, if any, should the new Act impose in relation to informing a patient's family, carer or nominated person of a patient's rights?

The Act should ideally impose obligations on services providing involuntary treatment to inform a patient's family, carer or nominated person of a patient's rights.

Question 25: If a nominated person scheme is considered necessary, how should the Act address this?

A nominated person scheme would require considerable thought in describing the relevant roles and responsibilities. The scheme could involve encouraging patients to identify at least one person (family member or carer) who will be informed of their status under the Mental Health Act, though this would need to be someone who is capable of understanding these rights. There should be an external body (such as under the Public Advocate) to provide an advocate for those who do not have an available or appropriate family member or carer to nominate.

Question 26: What requirements should the new Act contain to assist patients to understand and exercise their rights throughout the involuntary treatment process?

Mental Health Services providing treatment to patients on an involuntary basis should be required to advise patients of their rights and ensure that over time these rights are understood. This is required by the National Standards for Mental Health Services. An additional safeguard would be to recommend that the nominated person also follows up that people understand their rights.

Question 28: What requirements, if any, should the new Act contain to address issues of:

a) Patient involvement in treatment planning?

The Act should clearly state that treatment planning needs to involve the input of the patient and the carer / family.

Question 29: What additional requirements, if any, should the new Act contain to ensure the effectiveness of treatment plans?

The directions for treatment plans should emphasise:

1. The patient's recovery goals and the role that clinical treatment plays in contributing to these
2. Cultural issues relevant to the patient, and
3. The need to respond to the high incidence of people with concurrent substance use.

Question 30: If an advance statement scheme is considered necessary:

- a) What requirements should the new Act contain to ensure their effectiveness?*
- b) In what circumstances, if any, should the new Act allow an advance statement to be overridden?*

The Service supports the principle of an advance statement scheme in the Act. Considerable thought would be required in the drafting of an advance statement scheme particularly concerning the expression of consumer preferences rather than requirements which would need to be overridden on occasions. Furthermore, as it is rare for Advance Care Plans to cover every possible clinical scenario, patients are encouraged to have conversations with their

nominated person, family member, clinician and/or GP to make their wishes known. This facilitates the clinical team working with the patient's representative in determining the best course of action also being mindful of the patient's preferences, in cases of temporary or permanent incapacity.

Chapter 5 Electroconvulsive therapy (ECT)

Question 31: How should the new Act regulate and monitor:

- a) Premises on which ECT is provided?*
- b) Persons who administer ECT?*

The current licensing requirements for ECT (for both premises and personnel) are rigorous and should be maintained.

Question 33: If oversight of consent to ECT is considered necessary, what type of scheme should the new Act contain?

The new Act should require that a second opinion for using ECT without a patient's consent is mandatory. There will also need to be mechanisms for rural / remote areas to use ECT when there is no-one available to provide a second opinion.

Where ECT is authorised, it should be for a period of up to 12 treatments of ECT. The time-lapse after which new authorisation for ECT is required should be extended to one month, to allow for people to be prescribed maintenance ECT.

Question 34: How, if at all, should the new Act regulate provision of ECT in an emergency?

The provision of ECT in an emergency should be deleted from the new Act as this provision is neither used nor clinically sound.

Question 36: What additional safeguards, if any, should the new Act contain where ECT is proposed for a young person?

In general, ECT should not be used in children less than 16 years. In any event that it is considered, there should be a requirement to have a second and third opinion.

Chapter 6 Restraint and seclusion

Question 37: How, if at all, should the new Act regulate physical restraint?

The new Act should regulate physical restraint. Certain restraints should be approved, and clinicians should be required to receive adequate training in these.

Question 38: How should the new Act address the grounds of mechanical restraint and seclusion?

The new Act should require that mechanical restraint and seclusion of involuntary patients only occurs in instances of serious or immediate risk to the patient or another person. The risk of absconding should not be grounds for the use of restraint or seclusion.

Question 39: What obligations should the new Act impose on the authorised psychiatrist in relation to authorisation of mechanical restraint and seclusion?

When an involuntary patient requires mechanical restraint, the care requirements are clearly set out in the Act and are adequate. These requirements are quite specific and reflect the seriousness of the intervention. The patient is to be monitored under 1:1 observation by a registered nurse Division 1 or 3 or a registered medical practitioner (the latter is probably unrealistic in practice). It would be helpful if guidance was given regarding the appropriate response if that level of staff is not immediately available, because often the restraint is applied in an emergency. Issues relating to compliance with these requirements are more to do with lack of knowledge, and culture and practice issues, than inadequacies of the legislation.

The authorised psychiatrist should be required to authorise all use of restraint and seclusion in the mental health service. Where psychiatrists are not available in an emergency where restraint needs to be used, they should be required to review the patient at the earliest possible time.

Question 40: What obligations should the new Act impose in relation to the clinical monitoring of secluded or mechanically restrained patients?

The new Act should require that where a patient is isolated in an outdoor area, this is a form of seclusion, and should require the same level of monitoring.

The new Act should require observation of someone in seclusion to be continuous, as is required for someone who is mechanically restrained. Medical review of someone in seclusion / restraint should be at three hourly intervals. Email sent to check this one re overnight, weekends

Question 41: Should the new Act require mechanical restraint or seclusion to end 'immediately' when the grounds for their use are no longer met?

The new Act should require mechanical restraint or seclusion to end 'immediately' when the grounds for their use are no longer met.

Question 43: If the physical restraint, mechanical restraint and seclusion of voluntary patients is considered necessary in the new Act:

- a) *On what grounds?*
- b) *For what duration?*
- c) *Subject to what safeguards?*

The physical restraint, mechanical restraint and seclusion of voluntary patients are considered necessary for the new Act only on the occasion of serious or imminent risk. Patients should not

be secluded on the grounds that due to a communication disorder they are unable to express their needs. The use of ongoing seclusion for a patient with an intellectual disability should require an expert second opinion, as seclusion could lead to further problems. Absconding risk should not be used as grounds for seclusion / restraint.

The duration should be the least time until they can be reviewed by a doctor.

The use of seclusion or restraint repeatedly on one patient should prompt the requirement of a second opinion. Management plans for people who have had several seclusion events should be required.

The environmental requirements of seclusion areas also need to be regulated.

Question 44: What additional safeguards should the new Act contain for the effective regulation of restraint and seclusion?

There is sometimes a tension involved in keeping both the patient and the staff members safe, and currently there do not appear to be adequate solutions to this issue. There needs to be acknowledgement that constant visual monitoring through a window may not ensure the safety of the patient in seclusion. If there was an adequate form of electronic monitoring to use in addition, this may be preferable to visual monitoring alone.

Additional comments in relation to restraint and seclusion

An issue that contributes to confusion within the sector is that the requirements of restraint care under the Mental Health Act are not always the same as those for general hospital voluntary patients. The principle of gazetting the premises of an entire health service as an approved mental health service, (not just the mental health wards) creates uncertainty for staff within the general hospital and within the psychiatry teams that consult to the emergency departments and the general wards. The general wards and emergency department operate under a duty of care imperative and the restraint policies within these areas reflect this focus. When a general hospital voluntary patient is restrained, the policies and legislation of the general hospital apply. This matter requires further clarification and it is recommended that in the interim, the 'Early Response Teams' are established to oversee physical restraint within hospitals, to ensure consistency and best practice in the application of restraint.

Chapter 7 Review and appeals

Question 45: How soon after the making of an involuntary order should the new Act require an external review?

External review after the making of an involuntary order under the new Act should ideally be at two weeks, but limitations on resources may require that the time-frame be four weeks.

Thereafter the new Act should require external reviews of involuntary patients in hospital settings to be done at least monthly, and for those in the community it should be at every six months.

Question 46: What type of external body, what kind of proceeding, and what powers should the new Act contain for:

- a) *External review soon after the making of involuntary orders?*
- b) *Subsequent external reviews of involuntary orders?*

An external review body similar to the current Mental Health Review Board is recommended. The selection of psychiatrists on the external review board panels need to include some members with experience in dual diagnosis. The new Act should include provision for the reviewing authority to accept responsibility for any adverse consequences that occur in the event that they cease an involuntary order made by a treating psychiatrist.

Question 47: How should the new Act address issues of patient participation in external review?

The new Act should ensure that the external review panel require patients have an opportunity to express themselves to the external review body independently, without the presence of members of the treating team.

Question 48: How should the new Act address issues of participation of families, carers or nominated persons in external review?

With a similar intention, external review bodies should enable families / carers to speak with them without the patient being present, as some families and /or carers may feel compromised in their role / relationship with the patient if they have to speak in the patient's presence.

Question 49: How should the new Act address issues of participation by members of the treating team in external review?

All members of the treating team should be required to provide information to the external review panel. It should not require that every person involved in the treatment writes a separate report, they should contribute to one treating team report.

The new Act should require that where the external review panel makes a finding contrary to that of the treating team, a statement of reasons is given to the treating team within a stated time frame.

Question 50: Should the new Act incorporate the functions of the existing Psychosurgery Review Board within the functions of the external body that reviews involuntary orders?

The new Act should incorporate the functions of the existing Psychosurgery Review Board within the functions of the external body that reviews involuntary orders.

Chapter 8 Monitoring patient wellbeing

Question 51: What monitoring functions and powers should the new Act contain?

The current monitoring functions and powers of the Chief Psychiatrist are considered appropriate, given that services are also monitored through accreditation processes such as The Australian Council for Healthcare Standards (ACHS) and Department of Human Services reporting requirements.

Question 52: If publishing of information

The publishing of information obtained through monitoring functions of the Chief Psychiatrist is considered appropriate for the purposes of transparency of service provision by mental health services.

Chapter 9 Complaints

Question 56: What requirements, if any, should the new Act contain in relation to local complaint systems?

STV believes that initially complaints should always be addressed at the local level. Mental Health Services are required to maintain effective complaints systems that comply with the Australian Standards for Healthcare Services (ACHS) guidelines for accreditation.

The report from the Ministerial Advisory Committee will inform changes to practice within local complaints systems, but it will need to take into account that clinical mental health services are part of a larger health service. It should contain recommendations not only on dealing effectively with complaints but also support to mental health services in this process.

Question 57: a) What complaints functions and powers should the new Act contain?

b) What type of body would be most effective in performing these complaint functions and powers?

A central location for receiving complaints about mental health services supported by staff with clinical mental health expertise, would streamline complaints management and provide an independent system for resolving patient / consumer complaints. This body would need to have sufficient powers to investigate, conciliate and make recommendations to the service regarding treatment and rights.

As outlined in the Consultation Paper, it is not ideal to have this function located as part of the Office of the Chief Psychiatrist, as it currently has “a dual role of advising the sector and dealing with complaints from patients”. By contrast while the Health Services Commission (HSC) has powers to investigate and conciliate, it does not have the authority to make treatment decisions. In general, HSC personnel do not have the appropriate clinical mental health expertise or experience to deal with mental health consumers and the type of issues raised about their treatment.

One possibility would be for the body to be part of the Office of the Public Advocate, as the Public Advocate already oversees the community visitors scheme. It would require staff to have appropriate mental health expertise, the capacity to investigate and make recommendations.

Question 58: What requirements, if any, should the new Act contain to support patients to make complaints?

As it is standard practice to request that formal complaints be put in writing, there needs to be support available to assist patients with this task. Not only is this support important for patients from CALD backgrounds, but also allows sensitivity to a patient’s level of literacy and ability to navigate what can be a complex system.

It is not always appropriate or acceptable to the patient to have a clinician involved in their treatment assist them to make a complaint. It is often left up to carers or family members. The appointment of external consumer advocates also employed by the Office of the Public Advocate could be considered. Importantly, as a number of complaints can lead to the possibility of litigation against services, consumer advocates would require access to legal advice from the Office of the Public Advocate.

Question 59: What requirements, if any, should the new Act contain to ensure that information learned from complaints is used to promote service improvement?

As with the ‘Coronial Findings - Summaries’ published by the Office of the Chief Psychiatrist

which provides information and learning for mental health services regarding adverse events, a similar summary would be of value for complaints issues. This should focus not on the number of complaints (which has a number of variables depending on the service and its demographics) but the type of issues, how they were resolved and improvements made. Furthermore, Mental Health Services need to be more transparent about reporting complaints as with the many other clinical indicators / key performance indicators. This will not only promote best practice and benchmarking but encourages services to analyse data and initiate change.

Chapter 10 Confidentiality and information sharing

Question 60: In what circumstances should the new Act permit disclosure of information to families and carers without patient consent?

General disclosure as exists in the provisions of the current Act (listed on page 73-74 of the consultation paper) is reasonable. Further disclosure of information is often a complex problem of balancing the needs and rights of the family / carer with the needs and rights of the patient. When family / carers are the providers of care in the community for the patient, it is understood that they require information to provide that care. The new Act should emphasise that mental health services need to provide family members with information about a patient's diagnosis and the potential demands this may require of them as a carer. When a patient lives with and receives care from a family member / friend and does not give consent for the disclosure of information to that carer, the Act should permit disclosure of key information from the treatment plan to the carer.

There should be a clear system whereby patients identify at least one particular person who is their 'nominated carer' and this name needs to be clearly recorded on the documentation relevant to their involuntary status so that it is understood by whom information may be required.

Question 61: What key events should the new Act require to be disclosed to a patient's family, carer and any nominated person without patient consent?

The new Act should require the disclosure of the following key events to the patient's family / carer and / or nominated person: admission to hospital and planning for discharge. Families and/or carers (where appropriate) should also be invited to participate in discussions about treatment planning and discharge planning.

Question 64: a) What service providers, if any, should receive identified information without a patient's consent?

b) If so, in what circumstances should they receive identified information without a patient's consent?

Other Service providers who are directly involved in providing treatment for a person should be clearly informed about what treatment is being provided by the gazetted mental health service, and how they can contribute to the treatment plan. (This may include psychiatric disability rehabilitation and support services (PDRSS), GPs, other medical specialists and other allied health providers). There should be clear direction regarding relevant information to be provided to protect the privacy of the patient, outlining that only essential information that specifically pertains to the patient's ongoing care.

If one of the above providers is a partner in the provision of care for the patient, they should be advised of the patient's admission to hospital and treatment planning issues involving their knowledge and participation, and they should be invited to participate in discharge planning. The transfer of this basic information would still be necessary if the patient does not give consent.

Additional comments on the development of a new Mental Health Act.

The system for the management of a patient's funds required by the current Act requires that there is a Senior Officer appointed for dealing with patient money, and that a patients' trust account is maintained. STV recommends that these requirements be deleted from the new Act as they are impractical and not complied with by most clinical services. Policies at local service levels which meet the standards of the Australian Council of Health Service (ACHS) guidelines for accreditation are adequate for the management of patients' funds.