Review of Mental Health Act 1986

Submission

from Mark Lacey,

Consumer Consultant

Ballarat Health Services – Psychiatric Services

Q1. What, if any, additional reform objectives should be reflected in the new Act?

The list given in the discussion paper seems okay. There are no glaring omissions that I can see,

Q2. What principles. departmental objectives and functions should the new Act include?

Again, the three principles given in the discussion paper list given seems okay to me and there are no items I would add.

Q3. How should mental illness be defined in the new Act?

If I have understood them right, "volition" and "orientation" seem possible additions. People's will to live and ability to make decisions in their own and others' best interests, often seems impaired by mental illness, if that is what is meant by "volition". Equally, "orientation" seems affected – people seem to lose sense of time, place and date, when acutely unwell. These two measures shouldn't be the only ones though. It would seem best to add them to the 4 items already used - thought, perception, mood and memory.

Q4. What conditions should be excluded from the definition of mental illness in the new Act?

Could/should the mention that "the person has an acquired brain injury" be added to the list of exclusions? ABI is not a mental illness, so it would seem to be good to make the same delineation as with intellectual disability and the others mentioned – religious belief, political belief, etc.

Q5. If separating the involuntary treatment process into three stages is supported, a) What should be the grounds for each order?, b) What should be the duration of each order?, c) Should there be any restrictions on the kinds of treatment given for each order?

The separation into three orders seems a good one/

a) Appears to have a mental illness for stage 1. Has a mental illness for stages 2. and 3. It would seem good to include a period of assessment before treatment. This would seem to be involve creating a gentler period of introduction to those using mental health services for the first time.
b) I think the Queensland model of 24 hours duration, with the option of extending this to 72 hours, seems the best.
c) I like the Queensland model saying that there is no involuntary treatment in this time. That allows the service some time to figure out if the person really is unwell. But it also extends consumer rights, in that no treatment is given until it is clear that the person is unwell. By making it 72 hours, it also means that someone who really needs treatment, does not have too long untreated before treatment is brought in. That will mean they will suffer with untreated illness for a shorter time.

Q6. How should the new Act address the issue of a person's capacity to consent to treatment in the grounds for an involuntary order?

I like the idea of a person's "ability to make decisions about treatment being significantly impaired" being the basis for measuring a capacity to consent, or its absence. This seems to me to be a more direct reflection on insight or the lack of it.

Q7. How, if at all, should the new Act define what constitutes capacity to consent to treatment?

See answer to Q, 6/

Q8. What requirements, if any, should the new Act contain for deciding whether or not a person has the capacity for consent?

There should be some report written each time a person is adjudged to have “an ability to make treatment decisions that is significantly impaired”. That is, the decision should only be made when it is clear to the clinician and by extension to any other reasonable person that there is a lack of insight that is interfering in the decision-making process.

Q9. 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?

No circumstances. If a person has capacity to decide and their ability to decide is not impaired, but they don’t want treatment, this should be respected and they should be free to make their own decisions. While it might be wise in such a situation for the person to accept treatment, the law should not require it.

Q10. 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) the person; b) others?

a) and b) I agree with the suggestion in the discussion paper that our Act should mention “serious, imminent or serious risk”. It seems involuntary treatment is overused. This would be one way of attempting to make sure that it is only used when clearly needed.

Q11. How should the new Act address the issue of “immediate treatment” in the grounds for an involuntary order?

I like the MHRB’s framework for deciding immediacy – chance of relapse, severity of relapse and degree of disruption. Why not specify this framework in the new Act? Define the need to assess a high likelihood of relapse – maybe 50%, that the relapse would be likely to further disable the person, and that it would lessen the chance of recovery for the person. The research has shown for years that people’s chance at full recovery diminishes with each relapse. We need to intervene sometimes to protect people from further deterioration and the reality of a lessened chance of recovery.

Q12. How should the new Act address the issue of "least restrictive manner" in the grounds for an involuntary order?

It would be good, if as suggested in the review document text, and as with Qn. 11, there was some explicit framework in the new Act that gave some guidance as to what needs to be considered in making a decision that a person can or can't make a go of a life in the community; or alternatively does or doesn't need hospitalisation. Issues that should/ could be considered include:

- an assessment of the severity of the illness;
- the availability of good community mental health services/PDRSS's/other services to treat the person's illness;
- the presence of an educated (about mental illness), informed and committed family and friends to guide the treatment in the community.

It seems worth noting that treatment in a "less restrictive environment" should not be used as an excuse not to give a person the maximum chance at recovery. Sometimes it may be necessary to give the "most helpful environment" to treat a person. That is, a brief period of hospitalisation for someone who requests it may be slightly more restrictive than treatment in the community. It may however be really useful at a time a consumer needs to have respite from his/her illness and needs for the burden of daily life to be eased for a while.

Q13. What requirements, if any, should the new Act contain to enable involuntary patients to provider informed consent to a wider range of psychiatric treatment?

The law quoted in the discussion paper from Scotland sounds good. That is, some law that maximises the consumer's freedom of choice and provides a range of treatment options. The law stating that when a clinician is providing involuntary treatment, he/.she needs to write the reasons for providing that involuntary treatment, and that it must always be in the person's best interests seems a very good one.

Q14. If a second psychiatric opinion is considered necessary, in what circumstances should the new Act require a second opinion?

The second opinion scheme mentioned in the discussion paper sounds good – that is, the one mentioned from Scotland. It would allow for people to have a second opinion when two months of involuntary treatment has elapsed. Diagnoses on the presence or absence of a serious mental illness are very serious decisions and people deserve and need a second opinion here.

Q15. What additional safeguards, if any, in relation to treatment decisions made by the authorised psychiatrist, should the new Act include?

The idea of a 2nd opinion given by a panel of psychiatrists, as mentioned in the discussion paper, seems a good one. Consumers often feel that a second opinion isn't independent enough, so the option of an independent panel seems a good one. It also allows for the service ethos to be critiqued from an independent perspective.

Q16. Should the new Act include a best interests requirement in relation to treatment decisions by the authorised psychiatrist?

Yes. All mental health treatment should be in the person's best interests, and that of those around them. And the legislation should make this principle explicit, so that there is clear recourse when poor practice loses sight of this.

Q17. How should the new Act address the issue of children and young people who do not have the capacity to consent to treatment due to their mental illness?

The parents of those under 18 should have permission to consent to treatment on the grounds of the teenager or child's mental illness, not due to the consumer's level of maturity. This then gives the child or adolescent the right to appeal that decision and so gives them the same rights as adults. Teenagers are often finding their own independence and undergoing a period of differentiation from their parents, when those teenagers are recovering from their illness. So law that allows them the right of appeal, and the same rights as adults, would seem to make sense.

Q18. What requirements, if any, should the new Act contain for clinical reviews of involuntary patients subject to: a) an involuntary treatment order; b) a community treatment order?

a) As in NSW, 3 monthly reviews should be required, followed by 6 monthly reviews after a year of treatment. This would allow for regular statutory review. Removal of the right to freedom of movement is a serious decision, and consumers should be able to have these serious decisions reviewed,

b) The same as in a), The removal of the right to consent to treatment is a very serious one, and it seems necessary to review treatment and see that it is working and that the provision of it at an involuntary level is still necessary.

Q19. In what circumstances, if any, should the authorised psychiatrist consent to the annual examination of an involuntary patient?

If the person is involuntary, an annual examination should be given regardless of the person's consent or failure to consent. If the person meets the criteria for involuntary treatment and so is involuntarily treated, he/she should not be expected to have the capacity to consent or not consent to the examination. Yet for his/ her health and safety, it is clearly needed.

Q20. What obligations, if any, should the new Act impose in relation to reporting results of annual examinations?

There should be both local and statewide reporting. The reports to the Chief Psychiatrist, or other similar body should be used as evidence in Coroner's reports when there is a death of an involuntary patient, which may be because of physical illness. suicide or as a result of the side effects of medications. If kept at a local level, the reports must be accessible by the Coroner, if needed. To stop the potential for dishonest cover-ups by services at the time of a Coroner's inquiry, it would seem better for all reports to go immediately to the Chief Psychiatrist or other relevant authority.

Q21. If separate grounds for a community treatment order are considered necessary, how should they differ from the grounds for making an involuntary treatment order?

As in NSW. That is, it would seem wise to follow a jurisdiction in which the system works better than here in that it provides more individualised care. Inpatient involuntary care often seems to be about safety, while CTO care seems to mostly revolve around compliance. So it would seem to make sense to use two different sets of guidelines here.

Q22. What should be the duration of a community treatment order in the new Act?

3 to 6 months, preferably 3 months. If the review is every 3 months, it may act as something of a disincentive for service providers to keep using CTO's. This might mean that they may be forced to continue a set of treatments that the consumer consents to, and so have a greater chance of getting the consumer to recovery.

Q23. Should there be any restrictions on the type of treatment that can be given under a community treatment order in the new Act?

CTO's should require that treatments other than medications are given. That is, there is a strong evidence base for psychosocial treatments, and it would appear necessary, somewhere in the Act, to require that these treatments be given by services, as well as the medication-based treatments. That is, if services are only required to give medications in the terms of a CTO, it is almost certain that the service will lapse into being a custodial service in which little recovery is delivered to the consumers it claims to treat.

Q24. 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?

There should be a method of reporting to the MHRB, Chief Psychiatrist, or other external body, the number of consumers who have had their rights explained to them. This should also be the subject of an external audit. There seems currently a big gap between consumer reports of being informed of their rights (10 – 15 % in my experience) and staff reports of the same proportion (staff usually claim 80 – 90%). An external audit, or the existence of consumer advocates, as mentioned elsewhere, should help address this.

When a person is made involuntary, it would seem important that the Act also give guidance on informing a family member of the person's rights. Family are often the ones who make sure the person gets a high level of care, when the person is unable to do so him/herself.

Q25. If a nominated person scheme is considered necessary, how should the new Act address this?

The Act should set up guidelines and a framework for the fulfillment of this role. The role could be under the auspice of an external body like the VMIAC, MHLC or other service. The role could be given powers under the new Act, to have entry to any Mental Health Service Area (MHSA). It should also give guidelines concerning where and when those visits could/ should and could not/ should not happen. For instance, it might be stated that visits cannot happen when a person is in seclusion, but that the nominated person should be informed that the person can see them as soon as the person is released from seclusion. The nominated person scheme could be an excellent way of giving greater priority to the informing of rights for people.

It also could be a role that those who have first hand experience of the mental health system/ consumers would fill very ably. Though perhaps it would be wise not to make first hand/consumer experience a condition of employment, as it is of the consumer consultant role. Giving some place to consumer workers, among other employees who haven't experienced a mental illness, would seem to create a parallel to the case of drug and alcohol workers in that sector, where there is a mix of workers who both have and don't have first hand experience of drug and alcohol abuse/misuse. This system in alcohol and drug services seems to work well with each group keeping the other honest, and might have some relevance in this instance.

Q26. What requirements should the new Act contain to assist patients to understand and exercise their rights throughout the involuntary treatment process?

The idea of the appointment of patient advocates seems an excellent one. Some definitions of the consumer consultant role and the existence of advocates at the VMIAC

allow for this. But I think there is a clear argument for this role to be extended to other workers, in each MHSA (though not necessarily employed by them) and for giving these advocates some powers to request systemic change in services, in combination with the reports on complaints mentioned in Q56 below. These advocates could then have a role in critiquing poor service delivery and could also have a mandate to require services to make systemic changes when this appears necessary. As mentioned in Q26, they should be employed by the VMIAC, or by the MHLC, or some external body, to guard against the conflict of interest entailed in employing them in the MHSA. And their reports should go to the state government so that the parliament becomes aware of the situation of quality of service in MHSA's and can act to require changes where this is necessary.

Q27. What requirements, if any, should the new Act contain to assist voluntary patients to understand and exercise their rights?

The Act should require services to provide the rights mentioned in the discussion paper. In my experience, voluntary patients ask most often ask that they be informed of their rights. The general feeling seems to be that provision to voluntary patients of the rights concerning involuntary treatment allows consumers to prepare for the possibility of becoming involuntary patients. One belief is that being told of involuntary rights might make consumers anxious about becoming an involuntary patient. But this seems to be outweighed by the anxiety of not knowing what the law is, so that it would appear the lesser of two evils is to inform voluntary consumers of involuntary rights.

Q28. What requirements, if any, should the new Act contain to address issues of: a) Patient involvement in treatment planning? b) The content of treatment plans?

a) and b) The Act should make a decision about the best format for a treatment plan and mandate that this format be followed, with some modifications allowed for by the individual service. For instance, it would seem clear that a treatment plan that incorporates work with the person's family as allies in the recovery process, that allows that the central goal setting in the process be done by the consumer, that incorporates psycho-social therapies, insight-building, problem-solving and development of an understanding of early warning signs for relapse provides a

much better chance of recovery plan than a more basic individual service plan that addresses very few of these issues. If the Act mandates such a format, then the MHRB can have a more useful role in requiring services to act on these plans.

It might even be considered that, if a service is consistently reviewed by the MHRB as falling short of standards in this process, a request be made to the Chief Psychiatrist or other service to investigate the service. If the Chief Psychiatrist then found that the service fell well short of giving consumers a real chance at recovery, the Chief Psychiatrist could be given powers to dismiss the Executive Director or Manager of the service. The lead position could then be advertised to be filled by someone who was committed to service reform and high quality service provision. While this would seem a drastic measure, it would perhaps address the apparent reality that some services seem to languish in poor service delivery, with no-one prepared to or empowered to hold them to account for this. This seems to invariably mean that poor quality service is consistently provided.

Q29. What additional requirements, if any, should the new Act contain to ensure the effectiveness of treatment plans?

As mentioned, some method of holding services to account for poor service provision.

Q30. If an advance statement 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?

Advance statements do seem necessary as part of good service provision.

a) As mentioned in the discussion paper, legislation requiring that advance statements be used as evidence in making treatment decisions would seem necessary.

b) It would seem fair to override the request of an advance statement when it was clear that carrying out the statement would mean acting against the best interests of a consumer and/or their family. In these circumstances, it would be good if, the psychiatrist or clinician making the treatment decision were required to write a

report stating why the advance statement was to be overridden. This report should go to the person who wrote the statement and to some external authority. This would increase the chance of stopping abusive neglect of the advance statement. There could also perhaps be some kind of appeal board so that, if a consumer or family felt that the statement had been either unjustly used or ignored, they could appeal to the board as a way of seeking redress.

Q31. How should the new Act regulate and monitor: a) premises on which ECT is provided? b) Persons who administer ECT?

a) Continue licensing and accreditation. ECT is a serious treatment and requires strong safeguards to be in place.

b) Whoever administers ECT must be suitably qualified and trained, with all of the supports in place and able to be used which protect life and health in the event of the treatment going wrong.

Q32. How should the new Act address the issue of a person's capacity to consent to ECT?

A second opinion should be mandatory. ECT is a very serious treatment and requires strict oversight.

Q33. If oversight of consent to ECT is considered necessary, what type of scheme should the new Act contain?

As mentioned in Q32, a second opinion should be mandatory and should always be completed before commencement of ECT.

Q34. How, if at all, should the new Act regulate provision of ECT in an emergency?

ECT should not be given if a person is capable of consent and refuses. This seems a breach of human rights.

Q35. How should the new Act address patient participation where ECT is proposed?

As mentioned in the discussion paper, a person nominated by the consumer should be informed of the plan to provide ECT. This would seem to allow the consumer to feel that there was someone in his/her resource group of friends and family that was included in the discussions about ECT and so that the consumer had some support in the decision to receive ECT.

Q36. What additional safeguards, if any, should the new Act contain where ECT is proposed for a young person?

Family.carer/ resource person should be informed. Second opinion should be mandatory before starting the ECT treatment.

Q37. How, if at all, should the new Act regulate physical restraint?

There should be some part of the legislation that defines the respectful, as against the unduly rough and disrespectful, use of physical restraint. There should also be penalties against those who use restraint roughly and disrespectfully. It would seem to be a regular theme among consumers that staff members, particularly unqualified staff members, abuse physical restraint. And at least some times, this appears to be the case.

Q38. How should the new Act address the grounds for mechanical restraint and seclusion?

I agree that the "serious harm" phrase needs to be included, as suggested in the discussion paper. It would seem an abuse of someone's rights to use seclusion to prevent absconding, and even possibly to prevent destruction of property. It would seem that detention in a good PICA/ HDU area should be adequate to stop absconding.

Q39. What obligations should the new Act impose on the authorised psychiatrist in relation to authorisation of mechanical restraint and seclusion?

It would seem advisable that the Act state that either of these treatments be authorised by the authorised psychiatrist in all cases, and it not be sometimes left to the nurse/ shift manager.

Q40. What obligations should the new Act impose in relation to clinical monitoring of secluded or mechanically restrained patients?

It would seem good to include the two resolutions suggested in the discussion paper. That is, that a constant review of seclusion be required unless the medical officer authorising the seclusion has stated that this need not happen. It would also seem advisable that the Act state that the review by the medical practitioner happen "as soon as practicable" after its instigation.

Q41. Should the new Act require mechanical restraint or seclusion to end "immediately" when the grounds for their use are no longer met?

Yes. Both are serious restrictions on a person and serious treatments and so should be ended as soon as possible when the conditions that gave rise to them are resolved.

Q42. If regulation of physical restraint is considered necessary, should the new Act: a) Authorise persons to exercise these powers? b) If so, who should be authorised?

I would like to see physical restraint regulated. a) and b) I do think some people should be authorised to exercise restraint, and not others. It often seems that unthinking security guards use physical restraint falsely and unnecessarily roughly. So I would suggest that the new Act might allow restraint to only be allowed under the supervision of a professional mental health worker, and with their oversight.

Q43. 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?

I don't think any of these procedures should be necessary for voluntary patients and I believe the new Act should make this clear.

Q44. What additional safeguards should the new Act contain for the effective regulation of restraint and seclusion?

Family should be informed and/or a person nominated by the consumer. Advance statements on the informing of a family member or friend should always be acted on.

Informing a monitoring body would allow for another level of review. It would seem preferable that a family member be informed, or where contact with family had been effectively broken and lost, the person nominated by the consumer as effectively family.

Q45. a) How soon after the making of an involuntary order should the new Act require external review? b) How frequently thereafter should the new Act require external reviews of involuntary orders?

a) Approximately 4 weeks. The current legislation, as mentioned in the discussion paper, means that review often is denied. This is because it seems psychiatrists, either as a matter of course during fair treatment, or as part of an unfair treatment system in which external review is avoided, discharge people before the hearing time of 8 weeks is completed. Given also that the average length of stay is about 12 days, 4 weeks would seem a reasonable option.

b) Every 6 months might be reasonable. The current legislation seems to lead to a system in which the MHRB is seen as a disinterested observer by many consumers. Making the reviews more regular might give consumers the sense that the MHRB is sufficiently interested in them to keep reviewing developments in their care every six months, and this might help the recovery process by instilling in the consumer a sense that someone outside the local system cares about them and wants to assist them in their path to recovery, besides the tangible benefit provided of reviewing the system.

Q47. How should the new Act address issues of patient participation in external review?

Consumers may well attend at a higher rate than currently is the case if, as suggested in the discussion paper, they had mandated representatives at the hearings. Lawyers, mental health advocates are both worth considering.

Q48. How should the new Act address issues of participation by families, carers or nominated persons in external review?

With the consumer's consent, and in situations in which there is a carer or family member who has stayed in touch with the consumer throughout the course of the illness, it should be mandated that the family member is informed of the MHRB. Family members who have not kept in touch shouldn't be included in the treatment process or therefore review. If they had cared enough about the consumer to keep in touch, it would seem reasonable that they be included and informed. If they haven't cared enough to keep in touch, I can't see why they should be notified when an MHRB hearing comes up. But with that caveat, it would seem logical that, if the family is already involved, they should certainly be notified. Especially as, if the consumer is to be discharged and allowed to come home from an acute unit, the family should be allowed to consent to this and be prepared to be involved.

Q49. How should the new Act address issues of participation by members of the treating team in external review?

This should be mandated. MHRB's are serious reviews and the clinicians should always be present. If nothing else, they should be there to provide the consumer with support in the often likely event that the consumer's involuntary status is upheld.

Q50. Should the new Act incorporate the functions of the existing Psychosurgery Review Board within the functions of the external body that reviews involuntary orders?

Yes. The Board seems so rarely used that it could be disbanded and subsumed into the MHRB's functions. Doing so might also dispel some of the mystique around psychosurgery, which seems to me to be largely misplaced and unhelpful.

Q51. a) What monitoring functions and powers should the new Act contain? b) What type of body would be most effective in performing these monitoring functions and powers?

a) A commission, as in NZ, would seem a good idea. It would give formal authority to a proactive mental health body. If the Office of the Chief Psychiatrist is to be maintained, it would seem advisable that the office become an independent,

statutory body that is independent from the Department of Human Services. There seems to be a clear conflict of interest in the current status quo.

b) Either or both of, the two mentioned – that is, either or both of a commission, and a truly independent Office of the Chief Psychiatrist.

Q52. If publishing of information obtained through monitoring functions is considered necessary: a) What publishing requirements should the new Act contain?; b) In what other ways should the new Act require that information obtained through monitoring is used to improve patients wellbeing and achieve service improvement?

a) It would be really good if, as suggested by Ballarat Health Services at the consultation on the "Because Mental Health Matters" green paper, services were held to account in domains that evidence shows is indicative of high quality service. That is, such measures as low AAU occupancy (as people are treated in the community), low recommencement of treatment rates (as people get better and stay well) and other such measures. The Act could then require the publishing of these statistics.

b) The statistics mentioned could be used to rate services. Good services could get extra funding for initiatives like research and quality improvement. Services that did poorly would be likely to invite consumer and family condemnation which in turn might drive system change and reform. These statistics would be gathered by the commission or the remodeled Office of the Chief Psychiatrist.

Q53. a) What death review functions and powers should the new Act contain? b) What type of body would be the most effective in performing these death review functions and powers?

a) As mentioned in the discussion paper, the review of all involuntary deaths would seem a necessary idea. Deaths are sometimes preventable, and all deaths of involuntary patients, if investigated, might give a good indicator of really poor services that would need reform.

b) Either the newly established commissioner, the remodeled Office of the Chief Psychiatrist, or a Mental Health Safety Commissioner, as mentioned in the discussion paper. In fact, it might make sense to subsume the current Office of the Chief Psychiatrist into a commission that dealt with clinical standards and with safety and had real teeth to monitor practice, promote good practice and reform poor practice.

Q54. If the establishment of a clinical leadership role is considered necessary, what functions should the clinical leader perform?

Possibly either or both of two actions – firstly, creating a more independent and effective Office of the Chief Psychiatrist, and/or secondly, the institution of a Senior Practitioner might be advisable. It would seem most effective to do both, with the Chief Psychiatrist as the senior role, and the Senior Practitioner as the leader of practice for those clinicians without a medical qualification.

Q55. If giving legal force to clinical guidelines or codes of practice is considered necessary, what should be the implications of non-compliance?

As mentioned in Q28 above, it would seem a good idea to enshrine treatments beyond the biological/ medication-based treatments in the clinical guidelines – that is, the range of psychosocial treatments. If services are consistently non-compliant in this, and also fail to therefore provide an adequate level of care as mentioned in Q. 52 above, severe sanctions could be imposed to change leadership or restrict funding.

Q56. What requirements, if any, should the new Act contain in relation to local complaint systems?

It might be advisable to build a system like the one mentioned in the NT, where services are required to publish a list of actions taken to address systemic issues pointed to by the complaints process.

Q57. 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) As mentioned in the discussion paper, it would seem advisable to have one complaint body with accountability to the complainants, independence as separate from the department and with powers to take matters to a tribunal.
b) One that is separate to the department and accountable to the complainants.

Q58. What requirements, if any, should the new Act contain to support patients to make complaints?

It would seem advisable to legislate that, as suggested in the discussion paper, people other than the consumer could make a complaint on behalf of the consumer. This should allow for advocacy being more adequately provided by staff, by family members or by supportive community members when a consumer is unable to do so.

Q59. What requirements, if any, should the new Act contain to ensure that information learned from complaints is used to promote service improvement?

As mentioned in the discussion paper, it would seem advisable to make complaints and responses from services public and to allow complaints services to conduct random visits to services. That might mean that services are required to respond to systemic problems in an effort to address the concerns raised. This should move from the current system where complaints are responded to at an individual way, to one in which systemic responses are required and elicited.

Q60. In what circumstances should the new Act permit disclosure of information to families and carers without patient consent?

When, firstly, it is judged by the clinician to be in the best interests of the consumer to inform the family, and secondly, when the family has been involved in the care for the consumer in the long term. And thirdly, when requests for specific parts of information to be kept confidential made by the consumer are respected unless they endanger the lives of the family, the consumer or other members of the public. This third clause would

seem to allow that, if a consumer wants to keep material confidential from the carer/family and there is no safety concern in doing so, that request by the consumer should be respected.

Q61. What key events should the new Act require be disclosed to a patient's family, carer and any nominated person without patient consent?

As mentioned in the discussion paper, it would seem reasonable and advisable to provide information about all the key events mentioned – when a consumer is admitted to, or discharged from, a mental health service as an involuntary patient, when a consumer is placed on a community treatment order or when a hearing is listed before the MHRB. In all of these it would seem that the family has some right to know that the service is taking any one of the serious actions mentioned.

Q62. In what additional circumstances, if any, should the new Act require disclosure of information to guardians?

It would seem advisable that all information given to the patient be given to the guardian, as mentioned in the discussion paper. Otherwise there seems a risk that the guardian may not be properly qualified to act on behalf of the consumer. But it would also seem necessary to have a tribunal in which the consumer can challenge the appointment of a particular person as guardian and secure full legal representation to do so. Without this safeguard, it may be that a guardian is appointed that does not have the consumer's interests at heart.

Q63. In what circumstances, if any, should the new Act allow a guardian to consent to the disclosure of information about a patient?

Again, as mentioned in the discussion paper, it may be advisable that the guardian be given powers to be able to disclose information about the consumer to other people or organisations, when that guardian judges it to be in the consumer's best interests to do so. As with Q. 62 above, it would seem necessary that the consumer be able to appeal against the appointment of a particular guardian, and be allowed full legal representation to do

so, in order that the person appointed to uphold the consumer's interests does not become the person who acts to denigrate those interests.

Q64. 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?

While it is acknowledged that an integrated approach between services may achieve better outcomes than when services are working in isolation, it would still seem that people with mental illness should be able to be given freedom of choice about whether drug and alcohol services are informed about the presence of mental illness, or vice versa. While a trusted worker might be a useful advocate for a better set of outcomes for a consumer, that will be found by the worker doing his or her job. If the worker gains the trust of a consumer, the leverage found in this exchange can then be used to ask the consumer if it is okay or not to pass the information on. That is, good practice will engender the trust that might increase the chances of meaningful collaboration. It would seem wrong to me to presume that this transfer of information can be made without the consumer's consent. And, in most cases, if the consumer genuinely wants to work on both issues, he or she will be happy regardless of legislation, with information being passed between two trusted workers.