Review of Mental Health Act 2009

A discussion paper to be read in conjunction with the *"Review of the Mental Health Act 1986, consultation paper – December 2008"*

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1. An objective that should be included is that the process for determining mental incompetence should be simple and the necessary paperwork streamlined and comprehensive.

2. A principle that in the absence or lack of availability of specialised mental health services that a suitably qualified general practitioner should be able to initiate the process of treatment commencement.

3. The classification of mental illness should not be disease specific it should be based on the person being a danger to themselves or the community as a result of a medical illness.

4. There should not be any exclusion – if the patient has not committed a felony – the issue of antisocial personality is a tricky area but the principle outlined in 3 should be applied.

5. The assessment phase is the major area that involves general practice – we need to be able to treat people at this stage as people frequently require some form of sedative / calmative medication to enable them to be transported safely to the medical facility where the subsequent assessments can be attended.

6. If a person's ability to make decisions about treatment is impaired by the mental illness then this should be sufficient grounds for an order and treatment to be enacted.

7. Capacity -> doesn't need to involve insight but life threatening and immediate danger to themselves or others.

8. See 7

9. A patient with capacity has the right to refuse treatment – the only area where this can be varied is in the case of a minor where the guardian is refusing reasonable treatment for the minor.

10. It should be remembered in the case of managing mental illness that people with serious mental illness can cause themselves serious harm or death as a result of chronic neglect secondary their mental illness. Therefore involuntary treatment may be required to prevent this. It is easy to manage immediate threats but it is more difficult but just as necessary to treat the chronic mental illness to prevent the consequences.

11. See 10

12. The least restrictive manner may involve the Act allowing people other than specialised mental health services supervise patients who are being treated or managed under a community treatment order. This will prove less restrictive than the current system.
13. If a patient has been deemed “incapacitated” there needs to be as much care exercised in providing medical treatments the patient’s agree with as is applied to treatments that they don’t agree with. So it would be reasonable for the treating team to be able to obtain consent for treatments needed on medical grounds from the patient.
14. A second psychiatric opinion should be required for ECT and surgical treatments.
15. That the decisions relate only to psychiatric treatments. Medical treatments much be approved or made by medically qualified practitioners.
16. Best interests for society and the patient.
17. In the same manner except the ACT should specify the order relates to the guardian or parent.
18. Review should occur as and when clinically necessary or at the time of any change of management or treatment.
19. Annual examinations of patients treated in an involuntary manner should be compulsory.
20. See 19.
21. The grounds for CTO’s should be the same as for involuntary inpatients; however the emphasis should always be on treating the patient in the community wherever possible.
22. CTO’s should have long terms - > up to five years where necessary.
23. The only restrictions to the treatments under CTO’s should be that they can be successfully undertaken in the community setting.
24. The rights of the patient’s relatives to treatment information concerning the patient need to be viewed via the privacy Act. The obligations contained in the Act need to encompass the appointment of a guardian / administrator who should have access to all information and opinions. This person should then have the right to control who else receives the information.
25. The nominated person / guardian should be appointed at the same time as an involuntary order is confirmed.
26. The act needs to appreciate that the patient cannot understand or appreciate their rights. Therefore it needs to ensure that a guardian or independent person is appointed to oversee / question these rights on their behalf.

27. Voluntary patients have the same rights as all others in the community – their rights are therefore protected by the protections that exist in the community for all people. The act does not need to go into this area.

28. Involuntary patients need their guardian involved in treatment plans etc. Others have the same rights as normal patients.

29. Patient reviews need to held against the goals and intentions of the treatment plan. These reviews were discussed in 18.

30. Advance statements are a good idea but there needs to be an assurance that they are made at a time when the patient is mentally competent to make such a statement. This point needs to be observed and certified by a medical practitioner. They should be followed wherever possible and reasonable. However; given the dynamic nature of mental illness the involuntary orders need to be able to vary the instructions contained in an advance statement where considered appropriate.

31. There needs to be no change in the rules of ECT – where / when / who.

32. See 31.

33. See 32.

34. ECT is not emergency treatment and should not be regarded as such.

35. Patient participation and ECT – the same rules as for any other form of involuntary treatment should apply.

36. A second opinion from a child and adolescent psychiatrist is appropriate. If further review is considered necessary this should only occur when or if the parent or guardian of the patient requests it.

37. Physical restraint should only be used when the immediate risk exists of the patient harming themselves or the community. It should be removed once this risk has passed.

38. See 37

39. It would be expected that the use of physical restraint would be included in the mental health plan if used on more than one occasion. See 37

40. The requirements in relation to monitoring secluded patients should be identical to those specified for prisoners in the judicial system. The monitoring should be continuous.

41. Physical restraint should be ended when it is no longer required.

42. Authorisation should be granted to appropriately qualified medical personnel.

43. See 37

44. It should be regulated that the oversight authority and appointed guardian and / or independent person is notified as soon as is practical.

45. External review should be three days and six months.

46. No change from the current.

47. There is no requirement for a greater degree of patient participation in external reviews or board appearances – artificial inducements or changes to increase this number are just that – artificial.

48. There needs to be no change.

49. There needs to be no change.

50. The current psychosurgery review process is sufficient and no changes are needed.

51. Annual reports detailing the findings of review visits are a good idea and should be adopted. The review should be conducted by an independent commission.

52. The Act should require the publication of a report annually and specify the at least annual review of all facilities.

53. The current death review requirements are sufficient. The coroner should be responsible for all investigations into the death of patients being held in an involuntary manner or on a CTO.

54. This role – clinical leader / senior practitioner – is not considered necessary. It will only add another layer of complexity to current management structures.

55. Clinical guidelines should be exactly that – guidelines not enforceable laws. There should not be any implications of non-compliance greater than those given for guidelines in any other discipline in medicine. We currently have guidelines coming out of our ears and if the mental health Act chooses to enforce its guidelines in this way it will not be long before the same attitude applies to all guidelines and medical practitioners will be unable to treat the patients according their complex individual needs.

56. I believe there are already appropriate local complaints processes in place and these should be continued. The publication of complaints and the details of their management can and would be included in the report of the body undertaking the at least annual review of all facilities.

57. The current complaints procedures are very well written and strong. There is no need for any change in this regard.

58. See 57.

59. The reporting body should review all complaints and the manner in which they have been managed. This information should be published annually.
60. The Act should allow the disclosure of information to families and carers without consent whenever it is deemed by the clinician to be in the patient's best interest.
61. There should only be a requirement of disclosure in relation to involuntary patient management and this should specify the provision of information to the guardian or specified independent person only. The detail of the information necessary to be disclosed should relate only to treatment of mental health and other medical conditions.
62. See 61
63. The guardian should have full and complete authority to disclose information in relation to the patient and their treatment to which they choose. This is their role as guardian.
64. The guardian should have the choice of who receives information in relation to provision of services to the patient. In the absence of an appointed guardian then the case manager can undertake this role when and where necessary.

Regards

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