

Submission template

Response to *Review of the Mental Health Act 1986 Consultation paper*

Introduction

This template is designed to assist people in making a submission in response to the *Review of the Mental Health Act 1986 Consultation paper*. It contains a list of the questions posed in the consultation paper. Comment is welcome on any matter related to the Act, and need not be limited to the questions in the paper or the *Some key questions* paper.

Please note: Closing date for submissions is 5:00pm on Friday 27 February 2009. The use of this template is optional.

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List of questions in *Review of the Mental Health Act 1986 Consultation paper*

Chapter 2 questions: Background and framework for reform

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

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

Chapter 3 questions: Involuntary orders

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

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

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 that can be given under each order?

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?

Capacity to consent: Capacity to understand

The present Act does provide that mental health services "take into account the...religious, cultural, language and other special needs of people with a mental disorder" (p. 14) and requires "that the relevant provisions of this Act are explained to patients and other people with a mental disorder in the language, mode of communication or terms which they are most likely to understand;"(p.15). Nevertheless, a disproportionately high percentage of CALD inpatients continue to be admitted involuntarily to acute inpatients (Department of Human Services, 2006; Klimidis et al., 1999; Stolk, Minas & Klimidis, 2008 - see references at the end of this document). For example, in 2004/05, Victorian mental health data show that 54.5% of Australian-born patients were admitted involuntarily, compared with 65.1% of CALD patients, a statistically significant difference (Stolk et al, 2008, p. 24). One possible explanation for this finding is that clinicians have difficulty assessing clients who speak English with low proficiency, do not book interpreters, and rely on involuntary admission to conduct a more comprehensive assessment. This was an acknowledged strategy used by clinicians in Crisis Assessment and Treatment Teams (CATTs) in a study conducted by Stolk (2005). Anecdotal evidence suggests that underutilisation of interpreters is an ongoing issue, but the extent of this problem is unknown.

Failure to book an interpreter when required would seem to contravene the right, under the International Convention on the Rights of Person with Disabilities to "liberty and security of person on an equal basis with others and freedom from unlawful or arbitrary deprivation of liberty: (Article 14; Department of Human Services, 2008, p. 12).

If a person is from a culturally and linguistically diverse (CALD) background and speaks English with low proficiency, he/she may not understand:

- a) that they may have a mental illness, as conceptions of mental illness vary across cultures (Andary, Stolk & Klimidis, 2003; Salize & Dressing, 2005);
 - b) that they are in need of treatment;
 - c) that the state has the legal right to detain them for that treatment;
 - d) any of the procedures involved in involuntary detention and treatment;
- and
- e) that involuntary treatment is likely to be time-limited, and she/he and family can be involved in treatment decision-making.

- CALD patients may associate involuntary processes with oppressive government activities experienced or observed their country of origin, and may expect to be detained coercively and indefinitely if they have a mental illness, as people with a mental illness may have been in their home country (Alem, 2000; Minas, .2008).
- Patients who have undergone traumatic experiences as refugees, or in their home country, may be re-traumatised by involuntary processes.

For such a client to have the capacity to consent it should be mandated that a CALD patient's proficiency in English is assessed, that an appropriately qualified interpreter is booked if required, and that the clinician takes sufficient time to attempt to ensure that the patient is sufficiently informed of all aspects of their diagnosis, admission and treatment for consent to be able to be given. The need for involuntary processes may be avoided if the CALD client and mental health clinician are able to communicate effectively. "In the mental health setting communicative demand are complex" and in the presence of mental illness "capacity to communicate in a second language is further impaired" (Miletic et al, 2006, p. 2).

"A well-trained and well-briefed skilful interpreter can provide a bridge across the communicative chasm between mental health workers and clients when do not share a common language" (Miletic et al, 2006, p. 2). When available, a NAATI (National Accreditation Authority for Translators and Interpreters) Level 3 (or Professional) Interpreter should be booked for mental health interpreting purposes (Miletic et al, 2006, p. 3).

A simple instrument for assessing English proficiency, shown below, may be found in the Victorian Transcultural Psychiatry Unit's Guidelines for working effectively with interpreters in mental health settings (Miletic et al., 2006, p. 14, www.vtputi.org.au).

English proficiency scale

1. Unable to have an everyday conversation (e.g., understands simple greetings)
2. Able to have an everyday conversation but not proficient enough to discuss clinical information
3. Able to communicate well, can readily discuss clinical information

Is an interpreter required? 1 to 2 Yes; 3 No. Please note that a client may move from category 3 to category 2 or 1 during phases of acute illness.

These Guidelines provide further useful information on communicating effectively with the aid of an interpreter.

Training in culturally sensitive practice should also be a requirement for mental health staff to enhance understanding of cultural and linguistic factors that may be relevant to CALD patients' presentation and behaviour.

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

See response to Q. 6.

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

See response to Q. 6

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?

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?

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

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

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

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

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

To ensure that CALD patients with low English proficiency understand the reasons for and nature of treatment proposed, his/her English proficiency should be assessed (see recommendations in Q 6) and an interpreter booked if necessary.

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

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

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?

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

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

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?

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

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

Chapter 4 questions: Patient participation in treatment and care

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?

The English proficiency of CALD carers should be assessed (as recommended in Q. 6) to enable them to understand and co-operate with mental health service provision when CALD patients are required to undergo involuntary processes, including involuntary admission, restraint, or seclusion, as well as when treatment is initiated. As for CALD patients, the CALD carer may not understand:

a) that the patient may have a mental illness, as conceptions of mental illness vary across cultures (Andary, Stolk & Klimidis, 2003; Salize & Dressing, 2005);

b) that they are in need of treatment;

c) that the state has the legal right to detain them for that treatment;

d) any of the procedures involved in involuntary detention and treatment;
and

e) that involuntary treatment is likely to be time-limited, and she/he and family can be involved in treatment decision-making.

- CALD carers may associate involuntary processes with oppressive government activities experienced or observed their country of origin, and may expect to be detained coercively and indefinitely if they have a mental illness, as people with a mental illness may have been in their home country (Alem, 2000; Minas, .2008).
- Carers and patients who have undergone traumatic experiences as refugees, or in their home country, may be re-traumatised by involuntary processes.

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

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

See response to Q. 6. CALD patients should be assisted in understanding and exercising their rights by having them fully explained with the aid of a suitably qualified interpreter. The presence of a CALD patient advocate may be advisable.

Translated information

At present brochures translated into 12 languages relating to patients' rights are available in printed form and on Victoria's Mental Health Services' website at <http://www.health.vic.gov.au/mentalhealth/patientrights/downloads.htm#1>. Whether these languages meet the needs of the current refugee and migrant populations, needs to be reviewed. If major changes are made to the Mental Health Act then new translated brochures will need to be written incorporating these changes. It is not known to what extent mental health staff use these brochures when working with CALD patients, and whether they accompany these brochures with verbal explanations (as required), with the aid of an interpreter when necessary.

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

See response to Q. 6

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

See response to Q. 15.

(b) The content of treatment plans?

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

Q30. 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?

Chapter 5 questions: Electroconvulsive therapy

Q31. How should the new Act regulate and monitor:

(a) Premises on which ECT is provided?

(b) Persons who administer ECT?

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

Employment of qualified interpreters for CALD patients with low English proficiency (and their carers), should be mandated when ECT is planned, following the guidelines described in Q. 6.

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

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

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

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

Chapter 6 questions: Restraint and seclusion

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

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

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

Employment of qualified interpreters for CALD patients with low English proficiency (and their carers), should be mandated when restraint is used, following the guidelines in response to Q. 6.

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

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

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 so authorised?

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?

See response to Q. 6

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

Chapter 7 questions: review and appeals

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?

Q46. 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 an involuntary order?

(b) Subsequent external reviews of involuntary orders?

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

At present the Act appropriately states that "The Board may appoint..., an interpreter approved by the Secretary," (p. 68). It is recommended, however, that appropriate qualifications for mental health interpreting (see response to Q.6) be specified. Furthermore prior to Board reviews, it should be required of

mental health staff that CALD patients with low English proficiency be fully informed (with the aid of an interpreter) of the procedures they are about to undergo and the reasons for them. Anecdotal evidence suggests that this does not always occur.

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

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

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?

Chapter 8 questions: Monitoring patient wellbeing

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?

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 patient wellbeing and achieve service improvement?

Q53. (a) What death review functions and powers should the new Act contain?

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

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

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

Chapter 9 questions: Complaints

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

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?

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

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

Chapter 10 questions: Confidentiality and information sharing

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

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

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

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

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?

Please attach any further comments.

The review of the Mental Health Act 1986 provides an important opportunity to ensure equitable treatment of patients from culturally and linguistically diverse (CALD) backgrounds. While the 1986 Act endeavours to address the special cultural and linguistic needs of CALD patients, there are areas of mental health practice where

legislation may improve equity in treatment and outcome. Some of these areas are addressed in this response.

References

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