

Submission to
**the Review of the *Mental Health Act*
1986**

February 2009

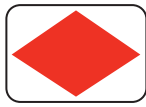
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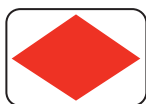
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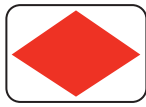
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About the Office of the Public Advocate

The Victorian Public Advocate is appointed by the Governor in Council pursuant to the *Guardianship and Administration Act 1986* (Vic). It is a statutory office, independent of government and government services and can highlight situations in which people with disabilities are exploited, neglected or abused.

The Office of the Public Advocate (OPA) provides advocacy, guardianship and investigation services to people with a cognitive disability. People with a cognitive disability include people with an intellectual disability, a mental illness, an acquired brain injury, dementia and people who are in a coma or otherwise lack the capacity for cognition or communication.

OPA coordinates the Community Guardianship Program and the Private Guardian Support Program, as well as the Community Visitors Program and the Independent Third Person Program. It also has a role in community education, the provision of advice and information and in undertaking research and policy projects.

Introduction

The Public Advocate welcomes the opportunity to respond to the review of the Review of the *Mental Health Act 1986* Consultation Paper. OPA has expressed long standing concerns about the accessibility and responsiveness of the public mental health system in Victoria tabling our Mental Health Community Visitors Report annually in Parliament and making multiple submissions to Victorian and National inquiries and reviews.

The most recent submission was in response to the May 2008 Consultation paper *Because mental health matters: A new focus for mental health and wellbeing in Victoria* (Because mental health matters)¹ which can be found on our website www.publicadvocate.com.au

The short time frames of the review combined with the complexity of the Act mean that this submission is necessarily limited to critical issues. As such, OPA welcomes any further opportunity to have input into the development of the new Act.

Framework for reform

Much critical examination of mental health care system, both nationally and state wide has occurred since Victoria's current *Mental Health Act 1986* was written. The 1993 Burdekin Report found that most state and territory legislation was in breach of the United Nations *Principles for the Protection of Persons with Mental Illness and for the improvement of Mental Health Care* 1991.²



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At the time of the Burdekin Report, the Victorian Act was said to include some of the ‘best provisions in Australia relating to the treatment of mental illness.’³ This is not currently the case, and as outlined in the consultation paper, Victorian legislation lags behind other states in terms of the provisions in place for ensuring the protection of the rights of people with a mental illness.

OPA would like to see Victoria taking the lead again in the treatment and care of mental illness. The principles and directions identified in 2008 review of the mental health service system *Because mental health matters* consultation paper provide a positive new framework for the mental health system in Victoria with a focus on access to health care, early intervention, preventative care, the needs of consumers, carers and families.

In *Because mental health matters*, it was stated that one of the complementary components of the review of the Mental Health Act would be whether the Act provides an ‘effective legislative framework for mental health services in Victoria, and appropriately protects human rights in light of the Victorian *Charter of Human Rights of Responsibilities*’.⁴

This was a broader intention than what has eventuated. The review examines whether the Act provides an ‘effective legislative framework for the treatment and care of people with a serious mental illness in Victoria’⁵ and whether it appropriately protects human rights in light of the Victorian *Charter of Human Rights and Responsibilities* 2007.

It is OPA’s view that while the review consultation paper adequately deals with civil and political rights relating to involuntary treatment and detention, that there is an absence of discussion around the provision of services and support. The focus of the new Act should be on providing a framework for mental health services in addition to what is essentially a framework for involuntary treatment.

Monash University human rights and law commentator, Bernadette McSherry, argues that Australia’s ratification of the International Covenant on Economic and Social Rights which includes the right to ‘enjoyment of the highest attainable standard of physical and mental health’, as outlined in Article 12(2)(d) implies Australia’s willingness to support the provision of mental health services.⁶

The right to health includes the ‘enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health’.⁷

McSherry suggests that recent international human rights developments may lead to a shift to mental health laws that ‘encourage a right to mental health for *all* individuals with mental illness, supported by a right to access appropriate mental health services’.⁸ OPA believes that the review of the Mental Health Act is too narrow and would like to see an Act that provides a framework for access to services for all people with a mental illness not just people who require involuntary treatment.



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Australia's ratification of the United Nations *Convention on the Rights of People with Disabilities* (Disabilities Convention) and the introduction of the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the charter) place an obligation on the Victorian government to ensure that mental health legislation is compliant with human rights. OPA believes the scope of the review is consistent with this and that the principles and objectives of the new Act should be in alignment with these local and international mechanisms for protecting human rights.

OPA notes that in 2007, Professor Bernadette McSherry commenced a five year Australian Research Council Federation Fellowship, the focus of which is rethinking mental health laws. The main aim of this research program is to explore the role the law has and should have in improving access to optimal mental health care and promoting and maintaining good mental health.

The research project is highly relevant to mental health law reform in Victoria. We note that it will not be completed until 2011. OPA submits that the new Act should contain a statutory review provision, similar to s44 of the charter, providing for review of the Act in 3 years, to consider whether the Act is achieving its objectives to protect human rights

¹ Department of Human Services 2008a, *Because Mental Health Matters: A new focus for mental health and well being in Victoria, Consultation paper*, Victorian Government, Melbourne.

² McSherry, B 2008a 'Mental health and human rights: The role of the law in developing a right to enjoy the highest attainable standard of mental health in Australia.'

<http://www.law.monash.edu.au/rmhl/docs/bmcs-08-15-jlm.pdf>

³ Burdekin Report 1993, p73

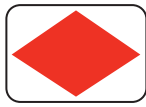
⁴ Department of Human Services 2008a, p7

⁵ Department of Human Services 2008b, *Review of the Mental Health Act 1986: Consultation paper*, Victorian Government, Melbourne, p 1.

⁶ McSherry, B 2008a

⁷ UNCESC general comment No 14, cited by McSherry 2008b, p774

⁸ McSherry 2008a, p776



1. Patient participation in treatment and care

1.1. Rethinking patient participation

Australia's ratification of the Disabilities Convention and the introduction of the charter places an obligation on the Victorian government to ensure that mental health legislation is compliant with human rights. The Victorian government would be advised to incorporate new directions in international mental health law. A key component of this will necessitate rethinking patient participation in treatment and care.

The provisions of the current Act are limited in relation to patient participation in treatment and planning. Whereas the current legislation provides for information to be provided to the patient about their rights, there are inadequate provisions to support patients exercise their rights.

OPA strongly supports the principle of enhanced participation of mental health consumers in decisions regarding their treatment and care. The nomination of a person in addition to the consumer to receive information about treatment and care and the funding of an independent support person to assist the consumer to exercise their rights would enhance this capacity.

The right to funded independent advocacy as seen in Scotland and the mandatory independent second opinion scheme in England and New Zealand provide good examples of the type of support now being provided to mental health consumers in other jurisdictions.

Information needs to be provided at many points through a person's involvement with the mental health system, as well as at the start. Voluntary patients need to be given the same access to information about their rights as involuntary patients.

John Lesser, Chair of the Mental Health Tribunal, has reported that regular shortcomings include incomplete and/or non-compliant treatment plans with issues such as failure to complete review and reporting dates, provide evidence of patient collaboration efforts, specify current medication and to specify any detail of actual treatment proposed.¹

There is a need for training around processes and policy development to ensure that hospitals are equipped with the skills to enable them to undertake treatment planning with consumer and carer involvement.

A stronger mandate is required in relation to processes to ensure consumer and carer participation around treatment planning and a broader range of health professionals explicitly identified as parties to the treatment planning process.



1.2. Exercise of rights in relation to treatment

The Act currently provides that involuntary patients must be given information about their rights in ‘the appropriate prescribed statement’ and that it is the duty of the authorised psychiatrist to ensure that this section is complied with in the approved mental health service.

1.2.1. Mental health consumers – who should receive a statement of rights?

Under the Act, the requirement to provide a statement of rights applies only to ‘patients’ (that is, people on involuntary treatment orders). OPA suggests that a statement of rights should also be provided to persons who voluntarily receive treatment. Firstly, it is not uncommon for a person who initially voluntarily seeks treatment and care to progress to being a patient on an involuntary treatment order.

Secondly, voluntary patients have a right to knowledge about how the Act applies to them, particularly in relation to the issue of consent and the right to involvement in decision-making about treatment.

Recommendation 1.1 Who receives a statement of rights

All patients receiving inpatient treatment should receive a statement of rights (voluntary and involuntary patients).

1.2.2. Who should be responsible for communicating information about rights?

Currently, the responsibility to ensure ‘patients’ are informed of their rights sits with the authorised psychiatrist.

It is noted that, at the time a person seeks mental health treatment or is placed on an involuntary treatment order they are likely to be unclear about their rights. Their mental state may affect their ability to process information. Effective communication may be impeded due to language or cultural differences. It cannot be assumed that a person will understand the information provided to them at the first instance, especially if it is expressed in legal terms. It should be assumed that the information will need to be communicated at various points in time. The requirement needs to be that every endeavour is made to ensure the person is familiar with their rights and encouraged to exercise them, not just that they have been provided with information.

OPA receives calls via our telephone advice service whereby people calling from acute mental health units claim not to have been advised of their rights at the appropriate time of their admission. An Auditor-General of Victoria report in 2002 found that 30 percent of Victorian mental health patients did not know they could appeal their involuntary status, that many found it hard to access such information and that about half didn’t know about legal representation at the hearing.²



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It is possible, of course, that patients were informed but given this information at the acute phase of their mental health admission and have no recollection of being advised. As such, it is important that people are consistently reminded that they have rights and are entitled to exercise those rights. The cultural environment in mental health services needs to be rights focussed.

The responsibility to create a rights-based culture in approved mental health services should sit with the health service provider and the health service provider should be responsible for all people having their rights explained to them. The entire treating team must be committed to ensuring that patients are clearly informed of their rights.

Recommendation 1.2 Understanding rights

Every endeavour needs to be made to ensure the person is familiar with their rights and encouraged to exercise them.

1.2.3. Who should be entitled to receive information about rights?

Information about rights primarily needs to be communicated to the person who is receiving treatment and care. This should be reinforced at the time of admission, and again when the patient is no longer in their acute phase of treatment. Every attempt should be made to advise patients of their rights at the appropriate stage of their treatment.

It may assist with the communication if others are involved. This could include:

- the person nominated by the person receiving treatment and care at the time
- the person nominated by the person receiving treatment and care if there is an advance directives form
- family members
- an independent support person (see below)
- a case manager
- a community visitor
- the Public Advocate

If the person receiving treatment and care does not wish a particular person to be involved, then their choice should be respected. However, it is possible that the person receiving treatment and care may change their mind and so their willingness to have others involved in explaining their rights to them should be revisited as frequently as seems necessary in the particular circumstances.



Recommendation 1.3 Who is entitled to receive information about rights?

Information about rights primarily needs to be communicated to the person who is receiving treatment and care.

A person nominated by the person receiving treatment and care is also able to receive information about rights.

1.2.4. Particular communication issues

- Culturally and Linguistically Diverse
- other impairments (sight impairment, hearing impairment, intellectual disability, acquired brain injury)

The Act currently requires that a ‘patient’ must be given a written statement and an oral explanation of the information in the statement and ‘arrangements must be made to convey the information to the patient in the language, mode of communication or terms which he or she is most likely to understand.’

There are currently 12 languages, in addition to English, in which the patient rights statements are published: Arabic, Cambodian, Chinese, Croatian, Greek, Italian, Macedonian, Serbian, Somali, Spanish, Turkish, Vietnamese.

At least 180 different languages are regularly spoken within Victoria. Approximately 20 percent of the population speak a language other than English at home. Refugees and migrants may be over-represented as consumers of mental health services.

It is important that people for whom English is not their first language or people who are not literate in English (or any language) are not disadvantaged and that every effort is made to convey the statement of a patient’s rights.

It is noted that it can be humiliating and over-exposing for people in smaller ethnic communities to have interpreters present in settings such as a mental health service. Services should be mindful of these sensitivities and a range of options should be available; for instance:

- Accredited interpreters
- If a person requires the information in written format in a language other than the 13 languages currently available then it should be translated into the language they request – (this includes Braille and plain English options)
- Ethnic specific community agencies could have workers professionally trained to fulfil the role of independent support person.

It is possible that for some migrants/refugees their experience of mental health services or detention in their country of origin is significantly different from



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Australia. Some groups of people may be particularly fearful of authority. There needs to be a mindfulness about this and no assumptions made that people may be familiar with their rights or the guarantee that their rights will be protected.

It is noted the transcultural unit which supports area mental health support services in working with culturally and linguistically diverse consumer and carers throughout Victoria can have a significant role in this.

Mental health consumers may have other impairments (sight impairment, hearing impairment, intellectual disability, acquired brain injury, dementia). Expert assistance should be sought to assist with ensuring that communication is effective where it is ascertained that another disability exists.

<p>Recommendation 1.4 Particular communication issues</p> <p>Expert assistance should be sought to ensure that communication is effective for people from CALD backgrounds and for people with particular disabilities.</p>
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1.2.5. Content – what should the information be?

It is not useful to be too prescriptive in the Act as to the contents of a printed patient statement but it should include the following for all voluntary and involuntary patients:

- acknowledgement that people’s rights are enshrined in international conventions;
- reference to the charter;
- explanation about their diagnosis and about their treatment.

and additionally for involuntary patients:

- explanation of all criteria which has resulted in them being placed on an involuntary treatment order;
- encouragement to seek legal advice and legal representation and assurance that assistance will be provided to source this;
- entitlement to a second psychiatric opinion which will inform their assessment and diagnosis and assurance they will be assisted to source this.

<p>Recommendation 1.5 Content of the patient rights document</p> <p>Content of patient rights document should include information about human rights legislation, information about criteria for involuntary orders and diagnosis, the entitlement to legal advice and representation and the right to a second psychiatric opinion.</p>



1.2.6. Role of Independent Support Person

OPA supports the concept of an Independent Support Person (ISP) program. However, it is critical that such program is properly resourced and funded. OPA considers that this program should be independent of the Department of Human Services (DHS) mental health branch and the mental health services.

The Independent Support Person could be involved in:

- assisting with explanation of patient rights;
- assisting with patient input into treatment plan;
- assisting with sourcing legal advice;
- assisting with sourcing consumer advocacy;
- assisting with sourcing a second psychiatric opinion;
- assisting at review and appeal hearings;
- liaising with other key people – treating team and case manager, nominated person, guardian, family;
- assisting with making complaints – both internally to the mental health service as well as to any external complaints bodies.

The ISP would be a paid position and there would need to be at least one such person for each acute setting. Consideration must be given to support of patients who are on community treatment orders who also require assistance with these matters.

OPA considers that the ISP is a role that would properly sit within the Community Visitors Program. This would ensure that the ISP is independent and their work is supported and augmented by the community visitors.

In chapter 4 we also consider the role an ISP may have in monitoring patient well-being in conjunction with the work of community visitors.

Recommendation 1.6 Role of the Independent Support Person

OPA is in support of a funded Independent Support Person (ISP) program that would sit within the Community Visitors Program.



1.3. Patient involvement in treatment planning

The Act was amended in 2004 to require that each patient have a treatment plan. The intention of the treatment plan is ‘to improve communication between treating teams and patients about the treatment patients will receive’.³

Despite the intention, treatment planning has been described as having a number of shortcomings relating to the inadequacy of patient and consumer involvement; poor execution; a lack of specificity about what should be recorded; the lack of a requirement for plans to take into account beneficial alternative treatments or significant risks associated with treatment.⁴

The view expressed by patient advocates that treatment plans ‘rarely contain sufficient detail to adequately inform patients of the plan for their treatment and recovery’ and that the view expressed by a board member that they have been ‘largely viewed as an extra paperwork hurdle’⁵ means that significant work is required for treatment planning to achieve its goal.

1.3.1. Definition of treatment

The definition of treatment in the act as ‘anything done in the course of professional skills to remedy the mental disorder or lessen its ill effects of the pain and suffering which it causes’, lacks specificity. A broadening of the definition of treatment would encourage a more holistic model of treatment planning that incorporates a social model of health perspective.

OPA would like to see a broader conceptualisation of treatment like that seen in the Scottish Mental Health Act which contains a broad definition of medical treatment. It covers treatment for mental disorder and as well as medical treatments like drug treatments and electro-convulsive (ECT). It also covers nursing, care, psychological interventions, habilitation and rehabilitation (*habilitation* and *rehabilitation* includes education and training in work, social and independent living skills).⁶

Recommendation 1.7 Definition of treatment

OPA supports a definition of treatment that incorporates a broader (social model of health) perspective.

1.3.2. Scope/content of treatment plan

The current provisions for treatment planning are inadequate in terms of their scope and the direction they provide to practitioners. A broader definition of treatment is needed as well as additional structure and scope for treatment plans to be based on a broader social model of health perspective.

The way the legislation is currently written ‘the authorised psychiatrist must take into account’ a range of considerations in developing a treatment plan. However, issues



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like ‘beneficial alternative treatments’ and ‘significant risks associated with treatment’ are not required to be incorporated. OPA believes that the incorporation of these areas into the treatment plan is important.

Psychiatrists should be required to consider a range of alternative treatments. For example, greater emphasis should be on the inclusion of allied health staff to ensure that they provide patients with the necessary intervention as part of the ongoing treatment whilst in acute care. e.g. Occupation Therapy for relaxation sessions, psychology and social work (see also Section 1.3.4).

OPA would like to draw the committee’s attention to the Victorian *Disability Act* 2006 where a behavioural support plan and a treatment plan are required for all clients of disability services. Treatment plans for people on Supervised Treatment Orders are structured and detailed.

OPA suggests the following themes be included in a patient treatment plan (similar themes should also apply to treatment plans for people in a CTO).

- assessment summary including current symptoms;
- legal status – and reason for involuntary status;
- nursing/allied health assessments – including psychosocial needs and risk assessment;
- treatment authorised by the authorised psychiatrist;
- significant risks associated with treatment;
- beneficial alternative treatments (this would draw on the experience of allied health professionals who would need to be consulted in the treatment planning phase);
- treatment preferred by patient;
- behaviour support plan, if required – including patient history, triggers and methods for managing triggers;
- discharge plan;
- other parties to the plan (including treating team, independent support person, nominated person, guardian);
- summary of Advance Directive.

Recommendation 1.8 Treatment plans

The Act should contain a clear description of the scope and content of treatment plans.

A comprehensive treatment plan should also apply to patients who are subject to a CTO.



1.3.3. Reporting on the treatment plan

Under the *Disability Act* 2006 there is a requirement for the Authorised Program Officer to provide a report on the implementation of a treatment plan to the Senior Practitioner at the intervals, not exceeding 6 months, specified by the Senior Practitioner.

This reporting requirement and the processes built around it provide additional safeguards for residents of disability services. Similar safeguards could be applied to the new Mental Health Act by specifying how often reviews should take place.

Recommendation 1.9 Review of treatment plans

The authorised psychiatrist, nurse unit manager and allied health staff should be required to review treatment plans, in consultation with the consumer and ‘nominated person’ fortnightly in acute settings and monthly in other settings.

At six monthly intervals, a report on the implementation of a treatment plan should be provided to the Mental Health Office (see chapter 4 Monitoring patient well being).

1.3.4. Parties to treatment planning process

The current Act requires the treatment plan to be prepared, reviewed and revised by the authorised psychiatrist. There is no requirement for the authorised psychiatrist to involve a broader treatment team in treatment planning.

OPA would like to see the treatment plan developed by the authorised psychiatrist in collaboration with the nurse unit manager and allied health staff. Alternative treatments to pharmacological intervention and detention are more likely to emerge through closer involvement of allied health professionals in the treatment planning process. Allied health staff, including a social worker, occupational therapist and case manager should have more prominent opportunities to have input into treatment, care and recovery.

A comprehensive nursing assessment covering physical and psycho social and aspects of care and to be undertaken by the nurse unit manager, in conjunction with allied health staff is seen as a critical part of ensuring that treatment and care is inclusive of the psycho social aspects of care.

Recommendation 1.10 Involvement of a broader treating team in treatment plans

The treatment plan should be developed by the authorised psychiatrist in collaboration with unit nurse manager and allied health staff.



1.3.5. Patient involvement in treatment planning

The current Act states that the authorised psychiatrist must ‘take into account the wishes of the patient, as far as they can be ascertained’. The patient will have the opportunity to involve any guardian, family member or primary carer who is involved in providing treatment planning. This would include their nominated person and/or their Independent Support Person.

OPA believes that in nearly every instance the patient, however unwell, is capable of contributing to the treatment planning process. The wording ‘take into account the wishes of the patient, as far as they can be ascertained’ (in treatment planning) is not strong enough. OPA considers that the patient’s wishes should be given effect to wherever possible (also see the discussion below in relation to advance directives).

The new Act should place the onus on the treating team to ascertain what the patient’s wishes are by:

- communicating with the patient at regular intervals (fortnightly intervals in acute care, monthly in other settings) during the treatment planning process,
- consulting with the ‘patient nominated’ person (carer or family member),
- consulting the patient advance directive, where this is available.

Recommendation 1.11 Patient involvement in treatment planning

Patient wishes must be given effect to in the treatment plan where possible. Patient wishes can be ascertained through regular consultation with the consumer, the patient nominated person and with reference to the patient advance directive, where there is one.

The authorised psychiatrist and unit nurse manager will communicate with the patient, their ‘nominated person’ and/or the Independent Support Person and case manager at regular intervals during the treatment planning process (held at fortnightly intervals in acute care, monthly in other settings).

1.3.6. Carer and family involvement in treatment planning

Community Visitors have reported for a number of years concerns of families and carers who do not feel they are adequately consulted or involved in patient treatment planning. OPA recognises the important perspective that families and carers can bring to treatment planning. We are also aware of the importance of ensuring that the consumer has consented to this involvement. OPA believes that the appointment of a nominated person by the consumer, who would receive information (in conjunction with the consumer) about rights as well as be consulted about treatment and planning, would address this need.



Recommendation 1.12 Carer/family involvement in treatment planning

Carer and/or family members can be made the patient's 'nominated person'.

The consumer could appoint a 'nominated' person at the time of an acute episode or in advance in an advance directive. This could be recorded in the patient's general medical file (located with their GP, where consumer has one) or in their case management file (kept with their case manager where consumer has one).

n/b It is envisaged that the Independent Support Person will play a separate role from the nominated person and act in an independent capacity, play a liaison role between the hospital and carer/family/consumer and have a strong knowledge and understanding of the mental health system.

See also 1.2.3 and 1.2.6

1.3.7. Accessing a second opinion

Processes for reviewing and appealing decisions regarding the way second opinions are managed by the primary treating psychiatrist are needed.

OPA believes that the right to a second opinion is fundamental to patients exercising some decision-making regarding treatment and needs to be incorporated into the new Act (as is the case in New Zealand and England). It is important that this model is adequately funded and resourced to enable consumer access and that the cost is not incurred by the patient..

Recommendation 1.13 Right to a second opinion

Patients wishing to exercise their right to a second opinion about realistic, safe and less restrictive alternative treatments will be assisted by an independent support person to access a second opinion.

Similar to a general medical model, if patients choose a treatment plan based on a second opinion, OPA believes this choice needs to be realised. The ISP and community visitors may support the person to give effect to their choice.

Recommendation 1.14 Value of a second opinion

All efforts will be made to ensure consumers are able to choose their preferred treatment. Where a patient has accessed a second opinion and wishes to make treatment choices based on the second opinion, their treatment plan will be adjusted accordingly.

Where the authorised psychiatrist is at odds with the second opinion, it is suggested that the case goes to the Review Body.



If the Review Body rules against the second opinion being included in the patient treatment plan, it will be incumbent on the Review Body to demonstrate why this is not allowable.

A patient may appeal a Review Body refusal to accept a second opinion.

1.4. Advance directives

An advance directive is a directive made when a person is well that is required to be followed when the person is unwell. The directive is meant to bind both the patient and the treating team. It binds the patient in that the patient, through their directive, has indicated what they consider should happen to them when they are ill in relation to the treatment they may need. It binds the treating team in that they cannot provide treatment outside the terms of the directive.

The NSW Association for Mental Health Inc⁷ submitted to the Australian Human Rights Commission that following areas could be covered in an advance directive:

- symptoms or combinations of symptoms which constituted incapacity for this particular person
- who will take responsibility for recognising these signs/taking the next step
- who should be informed
- whom would you definitely not like to be informed
- what should happen if these signs occur
- previous history, what has helped in the past
- what treatment do you prefer
- what treatment do you refuse to have
- what staff would you prefer to treat you
- what staff would you prefer not to treat you
- which hospital or facility would you prefer to be treated in
- if you were being treated at home, how often would you like to be visited
- if a staff member comes to visit you in your home, how would you wish them to identify themselves to others
- would you like to discuss the implementation of this plan or otherwise) subsequent to an episode of mental illness
- how often this directive should be revised and under what circumstances, e.g. change of staff, closure of hospital, change or relationships.



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Advance directives may cover issues other than medical or psychiatric treatment of the person. Many social directives, such as who should care for the person's children, may be less controversial and can be readily implemented according to the plans in the advance directives document. Directives in relation to who will treat the person will be subject to the availability of the person and therefore may qualify as preferences rather than directives, to be met wherever possible.

Recommendation 1.15 Wishes and advance directives

The advance directives statement may need to distinguish between those directives which must be followed and those that are wishes.

The discussion below will focus on advance directives that relate to psychiatric treatment, the performance of which are mandated by the patient.

1.4.1. An advance directive is made when the person is well

The advance directive is made when the person is well, as this provides credibility to the document as an authentic statement of the person unaffected by their illness. It is difficult to define mental wellness or mental health, we are inclined to do so negatively, such as an absence of mental illness or of the symptoms of mental illness.

It may impugn the value of an advance directive if it could be shown that it was made when the person was unwell. An advance directive should be set up in such a way that there is agreement as to its authenticity. The advance directive should be developed in conjunction with a treating team or specialists in mental health. The document should include a section that attends to this issue. For example, the New Zealand advance directive has a section "confirmation of competence". In the Scottish advance directive a qualified person confirms that:

- he or she saw you sign your advance statement;
- you are well enough to understand and intend the effects of your advance statement.

Recommendation 1.16 Authenticity

An advance directive should be set up in such a way that there is agreement as to its authenticity.

1.4.2. When must an advance directive about treatment be followed?

As an advance directive is made when the person is well, it must be followed unless it is proved that to follow the directive is not in the best interests of the person.

We recommend that, unless there is an emergency (as defined in section 42A of the *Guardianship and Administration Act 1986*), where a health practitioner seeks to go against a person's health directive that they must apply to a review body for approval.



Office of the Public Advocate

The review body may only approve the health practitioner's application where the practitioner demonstrates that it is in the best interests of the patient to provide the proposed treatment contrary to the provisions of the advance directive.

Examples of 'best interests' tests can be found in the *Guardianship and Administration Act 1986* in relation to decisions made by guardians, administrators and persons responsible. Common to all is taking into account, as far as possible, the wishes of the person.

Section 38 sets out the requirements for the person responsible must take into account when consenting to health care in the best interests of the patient –

- (a) the wishes of the patient, so far as they can be ascertained; and
- (b) the wishes of any nearest relative or any other family members of the patient; and
- (c) the consequences to the patient if the treatment is not carried out; and
- (d) any alternative treatment available; and
- (e) the nature and degree of any significant risks associated with the treatment or any alternative treatment; and
- (f) whether the treatment to be carried out is only to promote and maintain the health and well-being of the patient;

All these subsections are relevant, though (b) may not be applicable where the patient has indicated there are certain persons they do not want informed of, or involved in, their treatment and care.

In relation to (a) the New Zealand advance directive document sets out treatments the patient consents to or refuses and the reasons why. The provision of reasons will assist the review body to determine what treatment should be provided. It would also be necessary for the review body to consider the current views and concerns of the patient not just in relation to the proposed treatment but more broadly as to their health and well-being, the person's understanding of their mental health and where they see they are headed if treatment is not provided as requested by the treating physician.

Recommendation 1.17 Following an advance directive

As an advance directive is made when the person is well, it must be followed unless it is proved that to follow the directive is not in the best interests of the person.

Recommendation 1.18 Involvement of review body

A review body may approve treatment contrary to a person's advance directive only where to do so would be in the person's best interests.

**Recommendation 1.19 Determining patient best interests**

In determining what is in a person's best interests, the review body should take into account issues akin to those set out in section 38 of the *Guardianship and Administration Act 1986* and also up-to-date evidence of the person's health as understood by the treating team and the person themselves.

¹ 'Clinical Challenges to Developing, Implementing and Reviewing Treatment Plans for Involuntary Patients' (July 2006) John Lesser President Mental Health Review Board of Victoria. Presentation to DHS forum.

² Auditor-General of Victoria report 2002, cited by Carney T, Beaupert F 2008, 'Mental health tribunals: rights drowning in un-'Chartered' health waters?'

³ Chief Psychiatrist Clinical Practice Guideline: Treatment Plans under the Mental Health Act 1986 – consultation draft 12 October 2004.

⁴ See consumer, carer and practitioner presentations from the Office of the Chief Psychiatrist Forum held in July 2006: <http://www.health.vic.gov.au/chiefpsychiatrist/treatment-plan.htm>.

⁵ Department of Human Services 2008b, p32

⁶ The New Mental Health Act: What's it about? (2005) Scottish Association for Mental Health

⁷ 28 January 1999. http://www.hreoc.gov.au/disability_rights/hr_disab/Wills_subs/nswamh.html



2. Involuntary orders

2.1 Rethinking involuntary orders

The charter and the Disabilities Convention raise important issues for the review of the Act, particularly in relation to the charter right to ‘protection from medical treatment without full, free and informed consent’ and the convention right of ‘respect for physical integrity for people with disabilities, including people with a mental illness on an equal basis with others.’¹

Under the charter, any limitation on human rights by law must take into account the ‘nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relationship between the limitation and its purpose and any restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.’² The introduction of the charter raises questions about whether the criteria for involuntary treatment outlined in the Act provide adequate grounds for the detention and forcible treatment of people with a mental illness.

OPA’s view is that:

- the current grounds allow too much scope for people to be involuntarily detained;
- the lack of specificity regarding the duration of orders allows people to be detained or treated involuntarily for too long without external monitoring or review;
- there is a lack of guidance around how decisions about capacity are made and how to address a person’s refusal to consent;
- there is a lack of clarity about how to apply the concept of risk to self and others;
- the current laws give disproportionate power to the authorised psychiatrist and do not provide enough opportunity for patient input into treatment, care or review or enough opportunity for external scrutiny.

An important feature of the new Act will be how it handles the issue of capacity to refuse medical treatment. While many countries have a definition of capacity in a separate Act dealing with health care and capacity, the Victorian Act has no legal definition of capacity³. OPA would like to see the new Act developed around the principle that substitute decision-making is a last resort as described in Article 12 of the Disabilities Convention and based on the presumption that people with disabilities have an inherent capacity to make their own decisions.

OPA is concerned about the indefinite detention of long stay patients in mental health facilities due to the lack of less restrictive community-based accommodation and support discharge options. OPA believes the government is not meeting its obligations under the charter if the failure to treat someone in a less restrictive setting is due to a service system failure. OPA believes that where the ‘less restrictive’ ground is not applied due to the lack of availability of alternative accommodation and support options, this must be reported to the mental health office.



2.2 Definition of mental illness

The current Act, consistent with other jurisdictions in Australia adopts a definition of mental illness, which includes a list of reasons by which a person should not be considered mentally ill.

OPA favours an expansion of the definition of mental illness and considers the definition adopted by the Northern Territory in the *Mental Health and Related Services Act 1998 (NT)* definition to be more encompassing.

‘mental illness means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised:

(a) by the presence of at least one of the following symptoms:

- (i) delusions;
- (ii) hallucinations;
- (iii) serious disorders of the stream of thought;
- (iv) serious disorders of thought form;
- (v) serious disturbances of mood; or

(b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).’

The Tasmanian *Mental Health Act 1996* includes within the definition of mental illness that it is a condition resulting in ‘involuntary behaviour or serious impairment of the capacity to control behaviour’. OPA recommends that the amended Act incorporate this concept into the definition of mental illness.

OPA considers that the disqualifiers referred to in s.8 (2) of the current Act be retained and consideration be given to adding to this list:

- that the person has an acquired brain damage
- that the person identifies their gender other than by their biological sex.

The definition adopted by the NT Act also requires a determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards and concordant with the current edition of the World Health Organisation, International Classification of Mental and Behavioural Disorders, Clinical Descriptions and Diagnostic Guidelines or the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.



Recommendation 2.1 Definition of mental illness

OPA favours an expansion of the definition of mental illness and considers the definition adopted by the Northern Territory in the *Mental Health and Related Services Act 1998* (NT) definition to be more encompassing.

2.3 Assessment order

The new Act needs to balance the need to provide safeguards when urgent treatment and/or detention is seen to be required with the need to protect the rights of people who are refusing treatment. For this reason, OPA supports the introduction of a staged involuntary treatment process with limitations placed on the length of detention and type of treatment that can be provided at each stage. Involuntary treatment and detention would be provided under the broad category of Involuntary Treatment Order and divided into three orders (see table 1):

1. Assessment Order (AO)
2. Inpatient Treatment Order (ITO)
3. Community Treatment Order (CTO).

The ITO and CTO would both have two stages. This recognises the fact that there is a need for more frequent clinical review and external scrutiny in the first twelve months of involuntary treatment (first stage) to ensure that the grounds for involuntary treatment continue to be met and that the treatment plan is working. In the second stage, review periods are less frequent. In addition, the second stage is tied to a different level of service provision for people on ITOs (see appendix 1 for summary).

Involuntary Treatment Order				
Assessment Order	Inpatient Treatment Order		Community Treatment Order	
	First stage	Second stage	First stage	Second stage

Table 1. Proposed stages for Involuntary Treatment Order

Different grounds would apply for each order. For example, at the assessment stage, one of the grounds for an order to be made would be that the person ‘appears to have a mental illness’. In the second and third stage the person would need to have the ‘symptoms of a mental illness’ (see section 2.5.1).

The model proposed by OPA outlines the duration of each order, the frequency of external review as well as when a nursing assessment and allied health care team assessment should take place and when the various plans should be developed e.g. treatment plan, behaviour support plan, case management plan and discharge plan. Note, chapter 3 External Reviews and Appeals discusses the frequency of external review.



2.3.1 Assessment Order (AO)

An AO would allow for a period of assessment prior to diagnosis as in the model described in the discussion paper. An AO would be sufficient authority for the detention of the person in the approved mental health service until the authorised psychiatrist examines them, as is the case in the request and recommendation process in the current Act.

The authorised psychiatrist, after a clinical assessment, would need to confirm within 24 hours that the person meets the grounds for involuntary detention or discharge them. The AO would last for three days during which time the person could be detained.

Under the AO, there would be limits placed on the type of treatment that could be given – interim treatment to ameliorate symptoms. OPA proposes the development of guidelines by the Mental Health Office (see chapter 4 Monitoring Patient Well-being) to guide types of treatment that can be given. The treatment would not necessarily include medication.

During the assessment stage as in all subsequent stages, the patient's advance directive would be taken into account in determining the most appropriate treatment response. e.g. if the patient advance directive indicated that particular treatment could be provided when the patient's ability to make decisions about the provision of such medical treatment is significantly impaired, then treatment could be given.

OPA proposes that a nursing assessment be required in the assessment stage and where necessary, a behaviour support plan be developed (see chapter 6 Seclusion and Restraint). We believe that this would help to ensure a holistic approach to patient care and management and a more proactive approach to behaviour support⁴.

2.3.2 Inpatient Treatment Order (ITO)

First stage

A first stage ITO would allow for a period of inpatient detention and treatment. While the 'appearance of a mental illness' would be sufficient grounds for detention under an AO, there would need to be more certainty that the person is displaying symptoms of a mental illness for the person to be detained under a first stage order. The grounds would require that a person has the symptoms of a mental illness.

OPA proposes that a patient treatment plan be required within the first week of the first stage ITO.

Second stage

A second stage ITO would place a stronger onus on the mental health facility to provide supports including intensive case management support and specialised discharge planning for people who have been involuntary patients for more than 12 months.



An application for a second stage ITO would require a clinical review which would occur prior to the conclusion of the first stage order. This would be coordinated by the authorised psychiatrist and would involve an internal allied health care team and any relevant external parties (PDRS, MST, case management support) who would develop a case management plan⁵.

2.3.3 Community Treatment Order (CTO)

It is proposed that the CTO, a step-down option in terms of treatment, detention and restrictions, be reconceptualised. The CTO would remain the least restrictive care option but would entitle the patient to case management support, and psychosocial and rehabilitation supports. There would be more limits placed on when an order could be made (see section 2.5.5 and 2.7).

First stage

First stage CTO would outline relevant services, other treatment, care or support services required to support the patient in the community.

Second stage

It is proposed that after the first twelve months of a CTO, orders be made for a longer duration to reduce the number of administrative requirements on the patient (see section 2.4).

Recommendation 2.2 Introduction of staged involuntary treatment process

OPA supports the introduction of a staged involuntary treatment process with limitations placed on the length of detention and type of treatment that can be provided at each stage. Involuntary treatment would be provided under the banner Involuntary Treatment Order and divided into three orders:

1. Assessment Order (AO)
2. Inpatient Treatment Order (ITO)
3. Community Treatment Order (CTO)

2.4 Duration of orders

OPA is concerned that the current Act does not specify the duration of Involuntary Treatment Orders and that orders are infrequently reviewed in Victoria in comparison with other jurisdictions. OPA believes that this is a critical area for reform as it goes to the heart of Article 12 of the Disabilities Convention ‘equal recognition before the law’ which specifies the need for appropriate and effective safeguards to prevent abuse, and restrictions which would apply for the shortest time possible and be subject to regular review by a competent, independent and impartial authority or judicial body.⁶



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OPA would like to see limits placed on the duration of Involuntary Treatment Orders to ensure adequate monitoring of patients and to ensure the grounds for their involuntary detention and treatment continue to be in compliance with the Act and human rights legislation.

Table 2. outlines the duration of each proposed order.

Duration/ review	Involuntary Treatment Order				
	Assessment order	Inpatient Treatment Order (ITO)		Community Treatment Order (CTO)	
		First stage	Second stage	First stage	Second stage
Duration	Up to 3 days	Firstly for 28 days – then for three months for a maximum of four three month orders.	Six months – there is no limit on the number of orders that can be made.	Three months for a maximum of four three month orders.	Six months – there is no limit on the number of orders that can be made

Table 2. Duration of Involuntary Treatment Orders

The ITO, stage one, allows for an initial 28 day order, the duration of which provides for adequate monitoring and review of the patient in the early days of detention and treatment.

It is proposed that the duration of subsequent orders in for first stage ITOs be three months. This recognises the need for continuity as well as relatively frequent review..

It is proposed that the first stage CTO be made for three months for a maximum of four orders. It is proposed that if community treatment is required beyond this period that orders be made for a duration of six months. The purpose of this is to one, ensure adequate review in the first CTO period and two, to reduce the burden on the patient in the second period (once the need for them to be on a CTO has been demonstrated to be more enduring).

Recommendation 2.3 Duration of Involuntary Treatment Orders
 OPA proposes that limits be placed on the duration of Involuntary Treatment Orders to ensure adequate monitoring of patients. OPA proposes that the duration of Involuntary Treatment Orders be specified as outlined in table 2.



2.5 Grounds for involuntary treatment

OPA is concerned that in the current Act, there is no differentiation between the grounds required for a person to be placed on the different types of Involuntary Treatment Orders. For example, the grounds that need to be met for a request and recommendation are the same as those required for a person to be placed on a CTO. The effect of this is that a high level of interpretation is used in determining whether a person meets or continues to meet the grounds for involuntary treatment and/or detention.

There are several areas in relation to the grounds for involuntary treatment and/or detention that OPA believes need clarification or change. There is a lack of guidance around the definition of mental illness, about how decisions about capacity are made, how to address a person’s refusal to consent and how to apply the concept of risk to self and others. The process of reviewing orders and appealing orders would be simplified if more clarity was provided around the grounds.

Table 3 provides a summary of proposed grounds that are discussed in the following section.

Grounds for involuntary treatment and/or detention		Involuntary Treatment Order		
		AO	ITO	CTO
1a	The person appears to be mentally ill;	√	×	×
1b	The person has a mental illness;	×	√	√
2	The person’s illness requires immediate or ongoing treatment that can only be obtained by the person being subject to an involuntary treatment order and that treatment is likely to be of benefit;	√	√	√
3	Involuntary treatment is necessary because of the person’s mental illness as the person poses a specific immediate significant or substantial risk of harm to themselves or others or because discharging the person from the order would result in significant deterioration in the person’s physical or mental condition;	√	√	√
4	The person is unable, by reason of the mental illness, to make reasonable judgements about their psychiatric treatment.	√	√	√
5	That the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or freedom of decision or action;	√	√	√

Table 3. Proposed grounds for involuntary treatment



2.5.1 The person appears to be mentally ill

8(1)(a) the person appears to be mentally ill;

Currently, the appearance of mental illness along with refusal of treatment combined with the authorised psychiatrist's view that the person requires immediate to prevent the deterioration to their mental health is enough for someone to be detained and treated against their will.

The appearance of a mental illness, while adequate in the assessment stage of an involuntary order, is not an adequate ground for ongoing detention and treatment. OPA believes that 'the person has a mental illness' is required for ongoing detention and treatment.

Recommendation 2.4 The person has the symptoms of a mental illness

Maintain ground 8(1)(a) in the assessment order stage (renamed 1a. for the purpose of this document).

Substitute 8(1)(a) in the ITO and cCTO stages for ground 1b. the person has a mental illness.

2.5.2 The person's mental illness requires immediate treatment

8(1)(b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an Involuntary Treatment Order;

2.5.2.1 Efficacy of treatment

The current Act requires that the person's mental illness requires 'immediate' treatment and that treatment can be obtained by the person being subject to an involuntary treatment order.

Some consumers of the mental health system, who oppose involuntary treatment, express the view that the effect of the treatment received (forced detention, forced pharmacological treatment, the experience of seclusion and restraint) do not result in a net benefit for them as consumers of the system⁷. In addition, many aspects of psychiatry do not have a strong evidence base.⁸

To ensure additional safeguards for consumers, OPA believes an important ground for involuntary detention and/or treatment is that there be a reasonable expectation that the treatment obtained on an Involuntary Treatment Order is likely to be of therapeutic benefit. This would require that treatment would only be provided if there was an evidence base to support its efficacy.



2.5.2.2 *The need for treatment*

Where a person is no longer in the acute phase of illness, they may not meet the ground for requiring immediate treatment. For example, someone being discharged on a CTO may not require immediate treatment, but it may be the view of the psychiatrist that they need ongoing treatment to remain mentally well. The application of this ground where ‘immediate’ treatment is not required is problematic.

The ground for ‘immediate treatment’ has most applicability at the assessment stage of treatment and care where the person requires treatment as a matter of urgency. Once a patient is an inpatient, they may not satisfy the ground for ‘immediate treatment’ but ‘ongoing treatment’ may only be possible by them being subject to an involuntary order⁹. Because of the lack of clarity in how to apply this ground, OPA proposes the development of guidelines and training in relation to the application of this ground particularly as it pertains to CTOs.

Recommendation 2.5 The need for treatment

Substitute 8(1)(b) with ground 2. the person’s mental illness requires ongoing or immediate treatment that can only be obtained by the person being subject to an involuntary treatment order and that treatment is likely to be of benefit.

Because of the lack of clarity in how to apply this ground, OPA proposes the development of guidelines and training in relation to the application of this ground particularly as it pertains to CTOs.

2.5.3 Risk to the person or others

8(1) (c) because of the person’s mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person’s physical or mental condition or otherwise) or for the protection of members of the public;

2.5.3.1 *Redefining the seriousness of risk*

Redefining the seriousness of risk is important. If a patient is refusing treatment but does not pose a significant or serious risk to themselves or others, OPA does not believe the involuntary detention and treatment of the person is justified. Involuntary treatment must only be provided for someone’s safety or to prevent immediate or substantiated imminent harm.

2.5.3.2 *Preventing deterioration in the person’s physical or mental condition*

OPA would like to see guidelines developed around the clause (*whether to prevent deterioration in the person’s physical/or mental condition or otherwise*). This qualification currently allows the continued involuntary detention of any patient where the authorised psychiatrist believes that the person’s health is likely to deteriorate without treatment.



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It may be reasonable to apply this ground in the case of a person who has recovered to a large extent and no longer poses an immediate risk to themselves or others but where the history of hospitalisations and relapse have been severe and resulted in significant deterioration in their health and living standards. But it would not be a reasonable to apply this ground in the case of a young person who has experienced their first hospital stay and is being discharged home with family support.

Currently there is no requirement to refer to a patient history of non-compliance with treatment or to specify to what degree any predicted deterioration in health is expected to impact on the consumer or others. As such, any patient can be detained where there was a doubt that they would be able to maintain treatment.

OPA believes that the clause *to prevent deterioration in the person's physical or mental condition* should only be applied where there is a history of recidivism associated with a lack of capacity to maintain a medication regime (where that has been shown to be effective) and where, on discharge, that person has deteriorated to the point where they pose a significant risk to themselves or others.

Recommendation 2.6 Risk to the person or others

Substitute 8(1)(c) with ground 3. Involuntary treatment is necessary because of the person's mental illness, as the person poses a specific immediate significant or substantial risk of harm to themselves or others or because discharging the person from the order would result in significant deterioration in the person's physical or mental condition.

Note. OPA believes that the clause *to prevent deterioration in the person's physical or mental condition* should only be applied where there is a significant history or recidivism associated with a lack of capacity to maintain a medication regime (where that has been shown to be effective) and where on discharge that person has deteriorated to the point where they pose a significant risk to themselves or others.

2.5.4 The person has refused or is unable to consent (also see 2.5)

8(1)(d) the person has refused or is unable to consent to the necessary treatment for the mental illness;

OPA is concerned that the ground 'refusal to consent' in the current Act removes the right competent people with a mental illness have to make autonomous decisions about treatment and care. OPA believes that refusal to consent is not a reasonable criterion for involuntary treatment and should be removed.

The ground 'unable to consent' also needs reconsideration. Because of the difficulty of determining capacity in relation to mental illness and the broad scope for interpreting and applying this ground, OPA proposed the introduction of an alternative ground.

OPA would like to draw attention to the concept of capacity outlined in the Victorian *Guardianship and Administration Act 1986*.¹⁰ Section 22 states that 'is unable by



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reason of the disability to make reasonable judgements...’ then a plenary or limited guardian may be appointed.

OPA notes the ground used in Scotland¹¹, the basis of which is that while a person may have capacity, their ability to make decisions at times may be significantly impaired – ‘because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired’. This also seems a more reasonable than what is in the current Victorian Act.

Recommendation 2.7 The person has refused or is unable to consent

Substitute 8(1)(d) with ground 4. The person is unable, by reason of the mental illness, to make reasonable judgements about their psychiatric treatment.

2.5.5 Cannot receive treatment in a less restrictive manner

8(1)(e) The person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

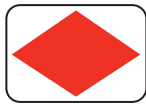
OPA is concerned about the indefinite detention of long-stay patients in mental health facilities due to the lack of less restrictive community-based accommodation and support and discharge options. OPA is also concerned about the large number of people on CTOs in Victoria and the significant limits CTOs place on the person relative to voluntary treatment and care in the community. Some commentators believe that CTOs are being used as an alternative to adequate community-based support and case management (see Section 2.7). Where this is the case, OPA believes this would constitute a breach of the charter.

In light of the charter and the Disabilities Convention, these are areas where much stricter adherence to the grounds needs to be applied. OPA believes that while the ground 8(1)(e) should remain, its application needs to be closely monitored, particularly in relation to long-stay patients and the use of CTOs.

Recommendation 2.8 Cannot receive treatment in a less restrictive manner

This ground should be retained but monitoring of its application in both involuntary treatment orders is needed.

Ground 5. the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom or decision or action.



2.6 Consent to treatment and safeguards

OPA views substitute decision-making as a last resort. This is based on the principle stated in the convention that people with disabilities have an inherent capacity to make their own decisions.

OPA supports the view that people with mental health issues have a right to be involved in decisions regarding the type of treatment they will receive whether or not their ability to consent is significantly impaired by their mental illness. As such, we need to reconsider the framework by which a substitute decision-making role is provided to the authorised psychiatrist.

Assigning this role to one individual does not provide enough safeguards for people subject to involuntary treatment orders. OPA is supportive of the model used in Scotland where a range of checks and consultations are required before treatment is provided when a patient is refusing to consent. OPA believes the clinician must consider the person's reason for not consenting, the views of the involuntary patient and a nominated person together with an advance statement and the efficacy of the treatment before providing treatment.¹²

Safeguards including opportunities for the patient and patient advocate to be involved in decision-making; opportunities for the patient to obtain a second opinion; the requirement for a second opinion in relation to certain treatment; the introduction of staged orders with different grounds; specifying (and shortening) the duration of orders; more frequent external reviews and the introduction of advance directives will help to ensure that Victorian legislation is compliant with human rights.

Recommendation 1.9 Consent

OPA is supportive of the Scottish model where a range of checks and consultations are required before treatment is provided when a patient is refusing to consent.

2.6.1 Second opinion

A second psychiatric opinion scheme is considered necessary, similar to models in New Zealand and England. It could be used in two ways. In the first instance, it could be used by consumers who are unsure about their diagnosis and the course of treatment proposed. It is important that this model is adequately funded and resourced as currently one of the cost of seeking a second opinion is prohibitive. Patients would be assisted in making treatment choices based on the second opinion (see chapter 1).

In the second instance, as in the Scottish model, it would be no longer possible to medicate someone who is no longer significantly impaired for longer than 28 days if they refuse treatment unless an independent psychiatrist provides a second opinion that the person is unable to consent and the treatment is in their best interests (see also section 3.3)

**Recommendation 1.10 Second opinion**

OPA is supportive of a funded independent second psychiatric opinion scheme.

2.6.2 Children

OPA is concerned about the authority the parent has to consent to psychiatric treatment where the child cannot consent due to their level of maturity. The concern is because it results in less scrutiny of the clinical decisions made in treating the child.

Although OPA has yet to substantiate the figures, the recent publicity in the Herald Sun newspaper surrounding the use of ECT in children younger than fourteen raises the issue of whether an independent advocate should be appointed in the case of major psychiatric treatment to represent the best interests of the child. Currently in the case of a request for sterilisation of a child under eighteen and in a request for gender reassignment in a child under eighteen, an independent advocate has to be appointed to represent the best interests of the child.

OPA would like to see children have the benefit of safeguards that apply to involuntary patients such as automatic external review of their orders and a right to appeal. In the case of interventions such as ECT, OPA would like to see an independent advocate appointed to represent the interests of the child.

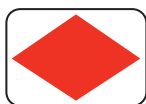
Recommendation 2.11 Children

OPA would like to see children have the benefit of the safeguards that apply to involuntary patients.

An independent advocate should be appointed to represent the interests of the child in relation to special procedures.

2.6.3 Additional safeguards

The new Act should limit the treatment that is able to be provided without patient consent. OPA believes that areas where treatment should be limited include: major pharmacological treatment under an assessment order; in relation to ECT and psychosurgery and in the annual examination of involuntary patients.



Recommendation 2.12 Additional safeguards

Only interim treatment (to ameliorate symptoms) be allowable for people on an assessment order

That ECT only be allowable with the patient’s consent even in an emergency situation. Where the patient cannot consent, the treatment cannot proceed unless the patient has authorised in their advance directive.

That the annual medical examination of involuntary patients only be taken with the patient’s consent. The onus would therefore be on the nursing and medical staff to negotiate a process by which the patient would consent to a medical examination.

Treatment /care	Involuntary Treatment Order		
	AO	ITO	CTO
Detention	√	√	×
Interim (symptom alleviating) treatment	√	√	√
Major pharmacological treatment	×	√ Second opinion needed after 28 days where patient refusing treatment	√
ECT, Psychosurgery	×	Only with patient consent	Only with patient consent
Annual examination	×	Only with patient consent	Only with patient consent

Table 4. Treatment/interventions allowed under Involuntary Treatment Orders

2.7 Community Treatment Orders

OPA is concerned about comparatively high rates of CTOs in Victoria compared to other jurisdictions. This concern is based on whether the benefits outweigh the cost to the individual. CTOs are experienced by many consumers as a highly restrictive intervention.¹³ While there are conflicting reports about the benefits of compulsory treatment in the community, there is enough research to suggest that the benefits to consumers may not justify the nature of the intervention.



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For example a Cochrane Collaboration report reviewing compulsory community and involuntary outpatient treatment for people with severe mental disorders found little evidence to indicate that compulsory treatment was effective in any of the main outcome areas: health service use, social functioning, mental state, quality of life or satisfaction with care. The study concluded that 85 CTOs would be necessary to avoid one hospital admission.¹⁴

In another example, a study of 274 patients on Community Treatment Orders in Western Australia and found that ‘if efficacy is in part defined by reduced hospital admissions and length of stay, our results suggest that this policy is no more effective than not enforcing community treatment.’¹⁵

A number of commentators believe that CTOs are being used as an alternative to adequate community based support and case management¹⁶. There is a question about whether therapeutic gains may be better delivered by enhancing the quality and assertiveness of community treatment for high-risk patients.¹⁷

In Australia there are concerns that CTOs are too widely used. In Scotland, they are applied only to ‘revolving door’ patients and for this reason are possibly seen as fairer and having widespread acceptance¹⁸. Victoria could look at limiting their application to ‘high risk’ patients in this way.

OPA believes there is enough doubt about the effectiveness of compulsory treatment in the community, particularly given their high rate of use in Victoria, to limit their use. More stringent safeguards must be introduced to ensure that they are not simply used as a substitute for properly resourced service systems.

Safeguards could include the development of guidelines around how the grounds for involuntary treatment are applied in CTOs (see recommendations 2.5 and 2.6); the development of a tool for assessing the risk associated with discharge; placing limits on the duration of orders and the inclusion of the right to a range of adequate services and support to people living on CTOs compared to what is the current requirement (see recommendation 1.8).

Recommendations 2.1.3 Community Treatment Orders

CTOs should be limited to people who have a significant history or recidivism or hospitalisation associated with a lack of capacity to maintain a medication regime and where on discharge that person has deteriorated to the point where they pose a significant risk to themselves or others (see recommendation 2.6)

The duration of Community Treatment Orders needs to be limited and the frequency of review increased (see chapter 3 External Reviews and Appeals).

The development of a comprehensive care plan by the authorised psychiatrist for people on CTOs which would specify community care services, relevant services, other treatment, care or services as seen as appropriate (see Section 62 Scottish Act).¹⁹



Office of the Public Advocate

CTOs may include a requirement where the person has to live. This requirement is imposed where the choice of accommodation is relevant to the treatment the person is to receive. Under the current statutory regime OPA considers some applications for guardianship for a person the subject of a CTO to determine their accommodation are unnecessary as the terms of the CTO could resolve this matter. OPA considers the appointment of a guardian in such circumstances an unnecessary restriction of the person's autonomy and interference in the person's life.

Recommendation 2.1.4 Accommodation decisions in CTOs

The new Act or any regulations should provide guidance as to when it may be necessary to seek the appointment of a guardian to make accommodation decisions when a person is also on a CTO.

¹ The charter, s 10 (c); Disabilities Convention, art 17.

² The charter, s 7 (2).

³ McSherry, B 2008b, 'Opening Minds, Not Closing Doors: Rethinking Mental Health Laws', paper presented at Monash University Educate 08 Public Lecture, Melbourne.

⁴ The behaviour support plan would be informed by the patient's advance directive as well as information gained through communication with the consumer and their carer/support person. Also see Chapter 6 Seclusion and Restraint.

⁵ This model is similar to the Intensive Rehabilitation and Recovery Care program for long-stay mental health consumers. Currently it is only able to be accessed by small numbers of people (the first funding round was for 12 people). OPA's view is that long-stay patients should be entitled to a high level of case management support.

⁶ Disabilities Convention, art 12 (4).

⁷ Minkowitz, T 2006, 'No Force Advocacy by Users and Survivors of Psychiatry', Mental Health Commission Wellington, New Zealand.

⁸ See for example "Humanizing Madness. Psychiatry and the cognitive neurosciences" by Niall McLaren, Future Psychiatry Press 2007.

⁹ Where the patient required ongoing treatment but that treatment could be obtained by the patient not being on an involuntary treatment order, the ground would not be met. Related guidelines are needed.

¹⁰ Victorian *Guardianship and Administration Act*, 1986.

¹¹ *Mental Health Act (Care and Treatment) (Scotland) Act 2003 (Scot) s 64 (5)*.

¹² See *Mental Health Act (Care and Treatment) (Scotland) Act 2003 (Scot) s 242, 243* cited by Department of Human Services 2008b, p22.

¹³ See Minkowitz, 2006; See also O'Hagan M, 2003 'Force in Mental Health Services: International user/survivor perspectives', keynote address Australian and New Zealand College of Mental Health Nurses 29th International Conference.

¹⁴ Kisely S, Campbell LA, Preston N (2005) 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders', Cochrane Collaboration Systematic Reviews.

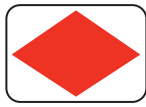
¹⁵ Preston, N, Kisley, S and Xiao, J 2002, 'Assessing the outcome of compulsory psychiatric treatment in the community: epidemiological study in Western Australia', *British Medical Journal*. Vol 324, p4.

¹⁶ See Lawton-Smith, 2005 'A Question of Numbers: The potential impact of community-based treatment orders in England and Wales', Kings Fund, London ; see also Preston et al, 2002; and Minkowitz, 2006.

¹⁷ Preston et al, 2002.

¹⁸ Lawton-Smith, 2006 'Community-based Compulsory Treatment Orders in Scotland: the early evidence', Kings Fund, London.

¹⁹ *Mental Health Act (Care and Treatment) (Scotland) Act 2003 (Scot) s 62*



3. External reviews and appeals

3.1 Rethinking external reviews and appeals

Nowhere is the risk to the individual's liberty more evident than in mental health tribunal review hearings about involuntary detention and treatment.¹ OPA shares the view that there are a number of issues relating to the way the current Mental Health Review Board (MHRB) hearings operate that require legislative change. The review of the Act is an opportunity to consider how to achieve better scrutiny of involuntary treatment orders and better alignment of the processes of the review body with the principles of the charter and the Disabilities Convention.

OPA is concerned about the timing of the external review of involuntary treatment orders. OPA's position is that involuntary treatment orders should apply for the shortest period of time possible and be subject to regular reviews. As identified in the discussion paper, Victoria legislation is out of date in relation to other jurisdictions in regards to review period times. OPA has identified the following issues have been identified as requiring attention:

- the delay between when a patient is made involuntary and when their status is reviewed by the MHRB is too long.
- the time between review periods is also too long resulting in too infrequent external review
- there are often unacceptable delays between when a patient appeals and when a hearing is scheduled.

In addition to the questions raised by the discussion paper, OPA would like to raise several issues relating to the process of MHRB hearings:

- the composition of the Board,
- second opinions,
- hearing times and the
- need for prompt and fair hearings.

Hearing times are of particular significance because Victoria lags well behind other comparative jurisdictions with regard to the time allocated to hearings.² The right to a fair hearing is a human rights principle enshrined in the charter.³

OPA is also concerned about issues in relation to therapeutic jurisprudence. A therapeutic jurisprudence approach recognises the importance of legal processes and the possibility of reforming the *application* of laws rather than just the laws themselves.⁴ OPA believes that issues around process require consideration including patient participation and the participation of others in the external review processes.



3.2 Timing of external review of involuntary orders

Under the current Act, the MHRB must conduct an initial review of the involuntary treatment order within 8 weeks after the order is made. OPA is concerned that this is the longest initial period in Australia and that the delay between involuntarily detention and the external review of a person's circumstances is inconsistent with human rights principles.⁵

Involuntary orders in Victoria are reviewed less frequently than in other states. Under the current Act, reviews are to be held at a periods of not more than 12 months after the order was made. OPA would like to see more frequent reviews introduced in the new Act as a way of ensuring more scrutiny of decisions in relation to involuntary treatment orders occurs.

The current Act specifies that the CTO can be made for a period not exceeding twelve months, that it can be extended for a further twelve months and that there is no limit to the number of times it can be extended. The Act does not specify the frequency at which a person must be clinically reviewed.

As discussed in the previous chapter, OPA supports the separation of Involuntary Treatment Orders into ITO and CTO divisions (see table 1, chapter 2 Involuntary Orders). This would include an initial assessment stage following which a patient would either be discharged, become an inpatient or treated in the community. The proposed timing for external reviews in each stage is outlined in table 4. (See table 2, chapter 2 Involuntary Orders for duration of orders).

<p>Recommendation 3.1 Timing of external review</p> <p>OPA proposes more frequent review of involuntary treatment orders as outlined in appendix 2. of this submission.</p>

3.3 Second opinions

In the current Act, the obligation of the MHRB to consider a second psychiatric opinion obtained by an involuntary patient is unclear. OPA is concerned about this lack of clarity and believes that the Board should have an obligation to consider a second psychiatric opinion obtained by a patient and that patients should be able to utilise a second opinion as a mechanism to make decisions about their own treatment and care.

As outlined in chapter 1, Patient Participation in Treatment and Care, processes for reviewing and appealing decisions regarding the way second opinions are managed by



the primary treating psychiatrist are needed. The right to a second opinion could be incorporated into the new Act, similar to models in New Zealand and England. This is supported by recent research undertaken by the Mental Health Legal Centre. Based on consumer experience at the MHRB, the report recommends that a system to access independent second opinions for use at Board hearings should be developed.⁶

Similar to the second opinion schemes outlined in the consultation paper, OPA supports the use of a second opinion where the patient is refusing to consent. It is proposed that the authorised psychiatrist be required to seek a second opinion after the first 28 day inpatient treatment order where a patient continues to refuse treatment. This evidence would go before the Review Body along with other documents required (including clinical review documents). See also section 2.6.1

Recommendation 3.2 Second opinions

The right to a second opinion and processes for reviewing and appealing decisions the way second opinions are managed need to be developed.

The authorised psychiatrist would be required to seek a second opinion after the first 28 days of an inpatient treatment order where the patient continues to refuse treatment.

3.4 Structure

3.4.1 How the Board is constituted

The purpose of the MHRB is to ensure that the limits placed on individual liberty are scrutinised from a legal point of view with medical and community views providing access to the medical, social and cultural context. As such, OPA believes the current composition of the Board as a three member tribunal with a legal, medical and community representative should be maintained.

OPA supports the perspective that ‘interdisciplinary, multi-member mental health tribunals are vital to the quality of decision-making’.⁷ We believe that three member tribunals should be maintained as the medical, legal and community member are all central to the task of ensuring legal accountability for the deprivation of liberty.

Recommendation 3.3 Constitution of the Board

OPA supports the continuation of a three member Review Body constituting a legal, medical and community member.

3.4.2 Hearing times

The right to a fair hearing is a human rights principle enshrined in the Victorian charter.⁸ Yet, Victoria lags well behind other comparative jurisdictions with regard to the time allocated to review hearings.⁹ A Victorian study undertaken in 2000 found



that MHRB hearings took less than ten minutes on average and nearly two thirds took less than an hour.¹⁰

This is significantly less than the time taken in hearings in other jurisdictions. Lesser (2007) reported that hearings in the UK, Ontario, Canada and Scotland ‘routinely run in excess of two hours’.¹¹ Longer hearing times mean there is more time to review files, treatment plans and goals¹².

Recommendation 3.4 Hearing times
OPA supports the introduction of longer hearing times.

3.5 Process

3.5.1 Therapeutic jurisprudence

OPA is also concerned about issues in relation to therapeutic jurisprudence. A therapeutic jurisprudence approach recognises the importance of legal processes and the possibility of reforming the *application* of laws rather than just the laws themselves.¹³

People are affected by the outcomes of hearings but more strongly by their perceptions about how decisions were made.¹⁴ Mental health consumers have made the point that hearings themselves may seem little more than a formality where the judge rubber stamps the conclusions of the clinical experts- ‘this unfortunate practice undermines the participation or dignitary value of the hearing’.¹⁵

This view is corroborated in a recent study undertaken by the Mental Health Legal Centre where consumer feeling was in general concluded to be one mistrust of the tribunal process.¹⁶ Information received from patient to community visitors also confirm these concerns and further highlight the need for patients to have an appropriate opportunity to be heard at a hearing and supported accordingly.

OPA supports the view that the Review Body’s processes should be improved to engender a culture of participation, dignity and trust. The Review Body’s members should conduct hearings in such a way that fulfils their inquisitorial role and lessens the experience that consumers have of an uneven and adversarial battle and predetermined outcome.¹⁷

OPA believes that two key issues that require consideration in relation to tribunal processes are patient participation and the participation of others.

Recommendation 3.5 Review Body’s processes
Review Body’s processes should be improved to engender a culture of participation, dignity and trust.



3.5.2 Participation by involuntary patients

OPA is concerned that unlike other jurisdictions, there is no requirement for the person to be legally represented or to receive advocacy support for a MHRB hearing. In Victoria, consumer representation at hearings is extremely low. Good representation is essential to the development of effective protection of the rights of consumers.¹⁸

There is a need for consumers to have information available about decisions being made about their care from the commencement of their involuntary treatment. OPA believes this should be provided through a funded Independent Support Person program that would ultimately provide information to consumers about the reason for their ongoing involuntary admission or the continuation of a CTO, undertake advocacy and representation for the consumer throughout the involuntary treatment process (see Chapter 1, Patient participation in treatment and care and Chapter 4, Monitoring patient well-being).

The person would not take the role of a funded legal advocacy program. This role would be undertaken by a trained legal advocate and sit within the Mental Health Legal Centre, Victorian Legal Aid and the Victorian Mental Illness Awareness Council. In addition, consumers should be able to access their files more than 24 hours before a MHRB hearing and consumers should be informed of their right to request a Statement of Reasons at the end of each hearing.

Recommendation 3.6 Participation by involuntary patients

OPA recommends the funding of an Independent Support Person program which would come under the auspice of the Community Visitors Program of the Office of the Public Advocate.

OPA recommends every involuntary patient be provided with access to free legal advocacy.

3.5.3 Participation by others

OPA supports the view that the attendance of or presence of case managers, carers and other people involved in the consumer/patient's care would enable the MHRB undertake a more comprehensive review of a their full circumstances.

The way mental health law operates needs to take account of the interdisciplinary nature of mental health care where social workers, psychologists, case managers, community workers and carers play an important roles alongside the clinical role of psychiatrists.¹⁹

This, and the growing recognition of the importance of consumer voices necessitates revisiting who is involved in the scrutiny of decisions made by psychiatrists regarding involuntary treatment orders. Evidence of people who deal with the patient on a day-



to-day basis - case managers, social workers, registrars and nurses should also be used in addition to evidence of the authorised psychiatrist.

Recommendation 3.7 Participation by others

Greater emphasis should be placed on the evidence of people who deal with the patient on a day-to-day basis i.e. case managers, social workers, registrars and nurses should also provide information in MHRB hearings in addition to evidence of the authorised psychiatrist.

3.6 Psychosurgery review board

OPA proposes that a proper assessment of the functions of the psychosocial review Board be undertaken and an evaluation of the costs and benefits of incorporating its functions under the functions of the Review Body.

Recommendation 3.8 Psychosurgery Review Board

OPA proposes that an evaluation of the costs and benefits of incorporating the functions of the Psychosurgery Review Board be undertaken.

¹ Carney T, Beaupert F, Perry J, Tait D 2008, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?', In *International Trends in Mental Health Laws*, McSherry, B (ed).

² Carney, T and Beaupert, F 2008, 'Mental health tribunals: rights drowning in un-Chartered health waters?', *Australian Journal of Human Rights*, Vol 13(2)

³ The Charter s24(1)

⁴ Beaupert, F 2006, 'Aspects of mental health tribunal processes that may impact on their *therapeutic potential*', paper presented to the Third international conference on Therapeutic Jurisprudence, Perth WA, 7-9 June.

⁵ Carney and Beaupert, 2008

⁶ Topp, V, Thomas, M and Ingvarson, M 2008, 'Lacking Insight: Involuntary patient experience of the Victorian Mental Health review Board', *Mental Health Legal Centre*. Melbourne.

⁷ Carney and Beaupert, 2008, p181.

⁸ The Charter s24(1)

⁹ Carney and Beaupert, 2008

¹⁰ Carney and Beaupert 2008, p 196

¹¹ Lesser 2007, cited by Carney and Beaupert 2008, p 196

¹² Carney and Beaupert, 2008

¹³ Beaupert, 2006

¹⁴ Lind and Tyler 1988, cited by Beaupert, 2006

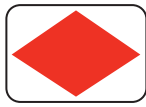
¹⁵ Winik, 2003a, cited by Beaupert, 2006

¹⁶ Topp et al 2008

¹⁷ See Beaupert, 2006, Topp et al 2008

¹⁸ Topp et al 2008, Carney et al 2008

¹⁹ Beaupert, 2006



4. Monitoring patient well-being

4.1 Rethinking patient monitoring

The purpose of the mental health system is to care for the well-being of patients. Illness diminishes our ability to advocate for ourselves. This is more so when the illness is one of the mind. Mechanisms to monitor treatment and care are essential to ensure the well-being and rights of patients are respected and to ensure compliance with legal requirements.

As a community we need ways to proactively monitor how services are providing care that is not be dependent on patients initiating complaints. The existing mechanisms of the Chief Psychiatrist, the Community Visitors Program and the Coroner, as well as the work of the Department of Human Services, could be better integrated and improved by the development of a specialist mental health monitoring body.

4.2 Specialist mental health monitoring body

In Victoria, the Senior Practitioner provides a more extensive monitoring, development, education and training role in relation to the Victorian *Disability Act 2006* than does the Chief Psychiatrist in relation to the Victorian *Mental Health Act 1986*. The Senior Practitioner role was established to ensure that the rights of people subject to restrictive interventions and compulsory treatment are protected. The role includes the development of guidelines in relation to restrictive interventions and compulsory treatment, education, policy making and advice, research and evaluation.

OPA is concerned that currently there is no specialist independent mental health monitoring body in Victoria to safeguard the rights of people with a mental illness, in particular those who are subject to involuntary treatment. OPA believes that this specialist body is needed to monitor the operation of the new Act.

OPA considers that a specialist monitoring body would:

- Report on facilities' compliance with the Act;
- Enforce compliance with the Act through a graduated process emphasizing quality assurance and could culminate in penalties applying to the health service;
- Provide patients with information about their rights
- Develop and review guidelines
- Develop and review best practice standards and propose improvements to government
- Receive and analyse reports on the use of restraint and seclusion
- Monitor treatment plans.



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Those monitoring must have special training in the Mental Health Act and be educated about patient rights as an important part of their role will be providing patients with information about their rights. They need to be able to freely access service information about the treatment of individual patients.

OPA does not envisage the monitoring body being a complaints body, but there needs to be a legislated mechanism that ensures that complaints are made known to the monitoring body. This ensures that complaints can be seen within the broader facility and service system context. From this information it may be possible to determine if there are trends that need to be addressed systemically.

This monitoring body must have a role in reviewing the deaths of people in the state where mental illness is suspected to be relevant to the reason why the person has died.

The monitoring body must have a role in developing new and better standards. The Chief Psychiatrist currently issues clinical guidelines however these are not recognised under the Act. Whilst OPA does not propose a particular model, we do submit that the monitoring body must have the ability to draw upon specialist expertise to drive higher standards in clinical care and respect for the human rights of patients. The codes of practice issued by Parliament in the UK as guidelines for clinicians on how to interpret and apply legislation provide an element of expected compliance that OPA sees as potentially applicable.

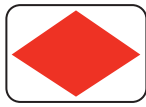
OPA considers that the monitoring body must be independent from the Department of Human Services. In a case before VCAT in 2008 in relation to supervised treatment orders under the *Disability Act 2006*, the Tribunal received submissions from the Senior Practitioner and also State-wide Forensic Services (as it was then known). An application was made by the Department of Human Services, to withdraw the separate (and conflicting) submissions and replace them with one submission from the Department. The Tribunal rejected this application. Both bodies had authentic voices and differing positions that were needed to inform the Tribunal. This case illustrates the importance of independence from the Department and facilities providing care to patients.

For the purposes of this paper we have called the specialist mental health monitoring body the 'mental health office'.

Recommendation 4.1 Mental Health Office

OPA recommends the establishment of an interdisciplinary specialist mental health body to monitor the operation of the *Mental Health Act* with functions as outlined in section 4.2

Monitors with specialist training in the *Mental Health Act* and patient rights may visit premises to monitor that patient care is compliant with the Act and support patients to exercise their rights.



4.3 Community visitors

The Community Visitors Program plays a vital role in inquiring into the standards, legislative compliance, patient assessment and treatment in a least possible restrictive environment, responding to, and reporting on, patient complaints. One cannot underestimate the social capital achieved through the community visitors program. On the one hand the social capital is acquired by the visitors gaining information about the lives of patients, the effect of mental illness, the mental health system and the processes of government to care for this vulnerable group in our community. On the other hand patients seek out the help of visitors (over 250 requests each year made to OPA's advice service).

For patients the visitor is an ordinary member of the community who offers an opportunity for patients to speak in confidence about any matter that is of concern to them. Visitors have the ability to inquire and seek advocacy for the patient should that be needed. Importantly, patients do not see community visitors as part of the bureaucracy. Community visitors endeavour to resolve issues locally through local complaints and reporting mechanisms.

OPA has proposed the introduction of the Independent Support Person (ISP) program, a paid position within the community visitors program. The ISP would have a statutory role to support the patient and to provide advocacy (see 1.2.6 of this submission). We expect that community visitors would have a close relationship with the ISP in relation to particular patients, in assisting patients make complaints, in making reports and also raising issues of a systemic nature that will be reported to the mental health office or taken up directly with the Department of Human Services.

Community visitors cannot be expected to provide an inspectorate for the mental health office, but they are trained to identify issues relating to the care and treatment of patients and to make reports in relation to the standard of the service and documentation. If the community visitors identify issues which could not be resolved locally these could also be referred to the Independent Support Person who would provide further support to the consumer. Issues about compliance with the Act could be reported to the mental health office (n/b issues about 'compliance' are differentiated from 'complaints', which could be referred to the specialist complaints office - see Chapter 5. Complaints).

Currently community visitors only visit facilities that provide 24 hour nursing care. Consequently those mental health services (such as PARC facilities) that do not provide this level of care are not visited. This needs to be changed in the new Act so that all patients in all PARC facilities have access to community visitors.

The Community Visitors Program has achieved significant systemic change since its introduction in 1988. The Community Visitors express frustration at the slow pace of change. The introduction of the mental health office would augment the effectiveness of the Community Visitors Program and the program would be an important source of information for the mental health office in the development of standards and guidelines.



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The new legislation would have to set out the reporting relationship between the Community Visitors and the mental health office. The mental health office would be responsible for the enforcement of the Act. When issues are reported by community visitors to the mental health office it is this office that would ensure compliance by service provider not through Department of Human Services as is the current structure.

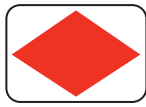
Recommendation 4.2 Community Visitors

Community Visitors should be retained.

The Independent Support Person program should be part of the Community Visitors Program.

The new legislation would set out the reporting relationship between the community visitors and the monitoring body.

Issues arising for community visitors about compliance would be reported to the mental health office to ensure hospital providers comply with the requirement of the legislation rather than the Department of Human Services.



5. Complaints

5.1 Rethinking complaint handling

There are a number of limitations in the current system in relation to the management and response to mental health complaints. Currently there are inconsistent policies and practices for managing complaints at a local level and external complaints handling pathways are unclear. Consumers, families and carers are often uncertain about their options for complaint resolution and it can be extremely difficult to navigate the different pathways. It is critical that consumers, families and carers are clear about complaint resolution options as frequently the poor response to a complaint is more damaging than the concern giving rise to the complaint.

Existing mechanisms lack transparency, independence and accountability. The current system lacks adequate powers and complaints bodies have a limited capacity or role in relation to resolving individual complaints or progressing systemic advocacy matters as a result of complaints.

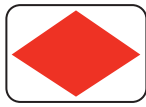
The perception of the lack of independence of current bodies is problematic. Both the Office of the Chief Psychiatrist and the Health Services Commission are funded by the Department of Human Services. The Office of the Chief Psychiatrist is physically located within DHS.

The current system does not encourage complaints and patients report they are fearful of the repercussions of making complaints. The net consequence of this is lack of confidence in services and the loss of opportunity for services to monitor and improve their operation.

The Victorian *Disability Act* 2006 has provisions for a specialist disability complaint handling body to handle complaints relating to disability services. Similarly, complaints about mental health services should also progress to a specialist complaint handling body.

Consumers, families and carers are often unclear about their options for complaint resolution and it can be extremely difficult to navigate the different pathways. It is critical that consumers, families and carers are clear about complaint resolution options as frequently the poor response to a complaint is more damaging than the concern giving rise to the complaint.

Community visitors can assist patients by referring complaints through internal hospital complaint handling procedures. However, community visitors, whilst they have knowledge of the mental health system, are unable to investigate or ensure adequate resolution of the complaint has occurred. This is due to the limitations in the resourcing of the Community Visitors Program and legislative fiat to provide additional advocacy.



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Consumers perceive that internal complaints mechanisms lack independence. Effective complaint resolution procedures are a critical component in service delivery and a key aspect of quality assurance and continuous service improvement. Services must develop and foster a positive culture regarding receiving and managing complaints. This requires adequate resources.

5.2 Key components of a good complaint handling system

A mental health complaint system must be:

- rights-based
- accessible and responsive
- offer genuine encouragement to complain
- provide options for resolution – local and external
- provide for appeals and reviews
- offer assurances that complainants and witnesses will not be discriminated against or victimised
- provide stringent timeframes
- provide clarity about the outcomes the particular pathway offers
- provide skilled and trained personnel with specialist skills in the mental health field.

Information about complaint options should be provided to patients at the commencement of their involvement with a service.

5.3 Local complaints

The *Mental Health Act* 1986 does not currently provide an obligation on mental health services to provide a complaint resolution procedure. By comparison, the *Disability Act* 2006 (s.104) provides that: ‘A disability service provider must institute and operate a system to receive and resolve complaints received by the disability service provider in respect of disability services provided by the disability service provider.’

It is noted that the functions of a community visitor include that they can inquire into any complaint by a person receiving treatment or care for a mental disorder and that a mental health service must ensure a patient can access a community visitor. Whilst community visitors can receive complaints they cannot resolve them.

Therefore it is recommended the amended Act should include a provision similar to s.104 of the Disability Act.

Currently, it appears there is great diversity in the local complaint resolution procedures of hospital systems. Many consumers struggle to navigate systems and seek the assistance of the community visitor program. Some hospitals have a general



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complaint procedure and some have a specific procedure for complaints about mental health services.

We consider that services should develop their own local resolution procedure but that it should be based on best practice. We suggest that the Health Services Commissioner may be well placed to provide some guidance on current thinking about best practice in local complaint resolution procedures.

A complaint procedure needs to specify who can make a complaint. In general, we consider that anyone should be able to make a complaint, however, where the complainant is someone other than the consumer, the wishes of the consumer should be a prime consideration.

A mental health service should be aware there are occasions when they should progress a complaint to appropriate authorities and not rely upon the person who is the object of the complaint to drive a complaint. For instance, OPA is aware of matters where services did not make complaints to the police due to the reluctance of the person, who was the victim of an alleged assault, to make a complaint themselves. There are times a service will have a duty of care to escalate a complaint to the police or other appropriate body

Department of Human Services disability services categorise complaints as Category 1,2,3 thereby requiring certain matters to be escalated to certain personnel to ensure appropriate intervention. A similar system could be developed for mental health services.

Local complaint resolution procedures should be premised on the basis that patients with mental health issues have the same rights as other members of the community to make complaints. Patients report a presumption that that they are regarded as inherently unreliable because they have mental health issues. Local complaint resolution procedures must categorically refute this.

The complaint system must facilitate people with mental health issues raising complaints and being effectively involved in the resolution process.

Recommendation 5.1 Local complaints

It is recommended that all mental health services be required to develop and implement consistent and effective complaint resolution policies and procedures (inclusive of all services under the auspice of Area Mental Health Services).



5.4 Functions and powers of complaints body

Although most complaints should be resolved at a local level there are times, even with an effective procedure, when it is necessary to escalate a complaint to an external body.

An external complaint body could receive complaints and be vested with investigative powers, such as being able to require production of documents and records from the mental health service provider (this should include both public mental health services as well as private mental health providers). This body could then refer legitimate complaints to conciliation if deemed this is likely to lead to resolution. Conciliated outcomes could include whatever the parties negotiate – including apologies, undertakings to change practices and procedures, educating staff about their responsibilities, compensation.

The complaint body would have a responsibility for managing individual complaints but also monitoring such complaints in order to inform systemic change to improve local complaint resolution processes. The body would be able to identify trends, and link in with relevant organisations to publish data and feed into quality systems.

Recommendation 5.2 Functions and powers of complaints body

It is recommended that the function of an external complaints body would include managing individual complaints, referral of complaints for conciliation.

It is recommended that the function of the complaints body also include the identification of trends, publication of data, systemic change.

5.5 Complaints body

The current body responsible for mental health complaints, the Health Services Commission, is not a primary mental health complaints body. Its main area of expertise is general health rather than clinical mental health. OPA agrees that a specialist complaint-handling body with mental health or disability expertise is essential to safeguard the rights of people with a mental illness, and in particular those subject to involuntary treatment under the Act.

A single independent location for making complaints about mental health services is required. The Disability Services Commission, appointed by the Governor in Council, is an independent body that provides specialist complaints conciliation under the Disability Act and has expertise working with people with a cognitive impairment as well as specialist expertise in the area of involuntary treatment and restrictive interventions.

OPA believes there must be an independent, specialist, mental health complaints body that is attached to an existing complaints body, either the Health Services Commissioner or the Disability Services Commissioner.



Recommendation 5.3 Specialist mental health complaints body

OPA recommends that the statutory responsibility for handling mental health complaints is allocated within the Disability Services Commission and that development of this body is undertaken to incorporate the functions and powers outlined in recommendation 5.2.

It is recommended that matters not able to be resolved through conciliation by the Disability Services Commission could be progressed by the complainant to the Victorian Civil and Administrative Tribunal.

It is recommended that complaints about the Disability Services Commission's management of complaints would be made to the Ombudsman.

5.6 Supporting clients

Many patients and carers have little understanding of where to direct complaints. Many have unsatisfactory experiences of going through hospital complaints processes. However, other than the role played by Community Visitors, many patients and carers do not receive support to navigate complaints processes. As indicated, the Community Visitor Program is inadequately resourced to assist patients and carers to the degree necessary.

The Health Services Commissioner has a 'Guide to complaint handling in health services'. There is reference to patients with mental health issues and patients with cognitive impairment issues but the fact they are included as 'special interest' groups reflects that the document is premised on the notion of a competent person. A significant cultural shift needs to be made so that a complaint resolution system in the mental health system assist patients to access complaints regardless of the patient mental health status.

Independent specialist mental health advocacy services already play a key role in protecting the rights of mental health consumers. OPA would like to see further funding of these services to undertake a specialist complaints advocacy function. In addition, the Independent Support Person or the nominated family member (see Chapter 1 Patient participation in treatment and care) could play an important role in supporting consumers to access complaints systems.

Recommendation 5.4 Supporting clients

It is recommended that the Independent Support Person (see Chapter 1 and Chapter 4) play a role in providing specialist advocacy and support in relation to complaints.

It is recommended that the resources of specialist mental health advocates such as Victorian Legal Aid, Mental Health Legal Centre and the Victorian Mental Illness Awareness Council be enhanced so that they can play a more effective role in representing complainants.



5.7 Integrating complaints for service improvement

Mental Health Service improvement mechanisms need to be integrated at all points throughout the mental health system through the coordinated monitoring and reporting of complaints.

Systems need to be put in place to ensure that complaints made at a local level are fed up to the specialist mental health complaints body. To ensure public accountability and transparency, these complaints as well as those made directly to the specialist body should be regularly reported back to services and made publicly available.

Complaints need to be analysed to enable targeted service improvement. Service specific annual reports would be one useful way of providing feedback to mental health services on key issues that have been raised and outstanding issues that need to be addressed.

Systems need to be put in place to ensure that complaints received by the specialist complaints body are reported to the Mental Health Office (See Chapter 4). This will ensure that complaints are contextualised within the broader facility and service system. It will enable the Mental Health Office to determine if there are trends that need to be addressed systemically through the development of guidelines, policy development, standards etc.

Recommendation	Service improvement
OPA recommends a transparent and accountable system of local and public reporting in relation to mental health service complaints	
OPA recommends the development of systems to ensure that complaints are reported to the Mental Health Office (Chapter 4) to determine if there are trends that need to be addressed systemically through the development of guidelines, policy development, standards etc.	



Case example: Relationship between individual complaint handling and systems monitoring

Individual complaint

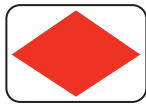
It is reported to the Community Visitor Program by a patient that on a given day she was denied lunch as a form of punishment. The Community Visitor program (the individual support worker) could raise the matter at a local level to see if it could be resolved informally. If not, the individual (again with support) might make a formal complaint under the local complaint resolution procedure. If the individual was not satisfied with the process or outcome of the local resolution procedure then she might escalate her complaint to the specialist mental health complaint handling body.

Systems monitoring

It is reported to the Community Visitor Program that a program manager at a mental health service issued a direction to staff that no patient was to be provided with lunch on a given day. In such circumstances, the issue (if true) raises concerns at a systemic level regarding that service and the conduct of the program manager, we would expect the Community Visitor program (the Individual Support Person) to try to raise and resolve this matter at a local level and, if considered necessary, progress concerns to the Mental Health Office.

Loop back from individual complaints to systems monitoring

If, over time, the Community Visitor Program became aware of a trend of similar complaints across different mental health services they might treat it as a systems issue and progress their concerns to the Mental Health Office.



6. Seclusion and restraint

6.1 Rethinking seclusion and restraint

OPA is concerned about current seclusion and restraint practices in Victorian mental health inpatient settings and emergency departments. Participants of the international study tour undertaken as part of the National Seclusion and Restraint Project reported that there is a high incidence in the use of these techniques for confining or immobilising people in Victoria relative to practice in the US and elsewhere¹.

These practices can be extremely traumatic for patients and may contribute to post traumatic stress disorder and as mentioned in the discussion paper, have been associated with patient deaths. High rates of seclusion and restraint in hospital settings may contribute to high assault rates, aggressive behaviour in future admissions, patient and staff injury and a culture of custodial care.²

The reduction and potential elimination of seclusion and restraint was identified as one of four national mental health safety priorities in 2008. The National Seclusion and Restraint Project was established to explore and address this issue. Preliminary findings from the Beacon demonstration sites provide evidence that changes in culture and practice in mental health settings in Victoria are successful in reducing the use of these practices³.

Compliance with human rights is a significant driver for change in this area. The Disabilities Convention states in Article 17 (Protecting the integrity of the person) that ‘every person with disabilities has the right to respect for his or her physical and mental integrity on an equal basis with others,’ and in Article 15 (Freedom from torture or cruel, inhuman or degrading treatment) that ‘no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment.’

Experts in human rights and law expect that Article 17 will severely limit the use of seclusion and restraint practice.⁴ The Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment is also expected to act as a driver for more restrictions on the way these practices are used around the world.

In this section we draw on the principles and procedures developed as part of the National Seclusion and Restraint project. OPA encourages the adoption of these definitions, principles, procedures and encourages their inclusion in the new Act. Although there is no statutory requirement for states to adopt the work of the National project, we believe that the culmination of twelve months of collaboration by experts and consumers in this area, represents contemporary good practice approach to seclusion and restraint and that legislation should be amended accordingly.



6.2 Physical restraint

Physical restraint, is defined as the ‘skilled hands-on immobilisation or the physical restriction of a consumer to prevent the consumer from harming themselves or endangering others or to ensure the provision of essential medical treatment.’⁵

OPA supports the intention of regulating this practice to ensure better training, guidance and monitoring and review. The grounds for physical restraint should be broadly consistent with the scheme for mechanical restraint.

Regulating the practice would ensure that staff are training in safe practices and that these have been endorsed by the appropriate clinical governing body.

Recommendation 6.1 Physical restraint

OPA recommends the regulation of physical restraint in a way that is broadly consistent with the regulation of mechanical restraint.

6.3 Grounds for mechanical restraint and seclusion

OPA would like to see the grounds for mechanical restraint and seclusion limited to situations where there is an immediate or imminent serious risk to health or safety. The decision to apply restraint should only be used when all other less restrictive options have been tried, considered or excluded.

The following principles should guide the development of new grounds for seclusion and restraint⁶:

- A sensitive assessment of the needs and risks for the consumer is undertaken at the time of admission identifying proactive de-escalating strategies that ensure restraint and seclusion are only used where absolutely necessary and as a last resort;
- Wherever possible, consumers and their carers should be involved in collaborative decision-making about the options for the management of disturbed/violent behaviour;
- Restraint is intended to prevent harm to the consumer, staff or others;
- The clinical decision to apply restraint or to seclude should only be taken when all other less restrictive options have been tried, considered or excluded;
- Restraint/seclusion should not be used as a punishment or a threat, as part of a treatment program or because of staff shortages
- Restraint should be used for the shortest possible time and must adhere to the principle of care in the least restrictive manner.



Recommendation 6.2 Grounds for mechanical restraint and seclusion

OPA recommends the grounds for mechanical restraint and seclusion limited to situations where there is an immediate or imminent serious risk to health or safety and that it is only used when less restrictive options have been tried.

6.4 Monitoring seclusion and restraint

The seriousness of the practice of seclusion and its impact on the individual cannot be underestimated. OPA supports the more frequent and thorough review and monitoring of a secluded person. Visual observations of a secluded person should be continuous to ensure the safety of the consumer⁷.

Staff involved in the episode of restraint should ensure that the consumer's breathing is unobstructed, their position is posturally appropriate to ensure their safety and their level of consciousness and distress is closely monitored.⁸

The need for continuing an episode of restraint or seclusion should be assessed frequently as long as the consumer remains secluded and restrained. This assessment should be undertaken by two staff, one of whom was not involved in the initial decision and the reasoning for continued seclusion/restraint should be documented at least every 15 minutes.⁹

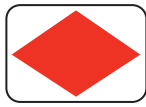
Examination by the authorised psychiatrist should be as soon as practicable after commencement or seclusion and restraint, at more frequent intervals (for episodes of restraint, this is recommended to be at intervals of not more than one hour)¹⁰ and on cessation of the intervention.

Recommendation 6.3 Principles

OPA recommends more frequent and purposeful monitoring of people undergoing seclusion as well as more immediate and more frequent clinical examination of patients subject to seclusion and restraint (for episodes of mechanical restraint, at intervals of not more than one hour) .

6.5 Ending an episode of seclusion and restraint

The draft procedures for ending an episode of restraint developed by the National Seclusion and Restraint Project cover reviewing, recording, reporting, documentation and clinical and operational overview. OPA is broadly supportive of the intention and detail around these procedures.



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The following principles should guide the cessation of an episode of seclusion and restraint¹¹:

- Restraint must be ceased when the consumer is no longer an acute risk to themselves or others.
- Following all episodes of seclusion and restraint, the consumer must be examined by a medical practitioner and any adverse outcome, such as physical injury or emotional trauma sustained, properly treated, recorded and reported.
- On ceasing restraint or seclusion, the senior registered nurse on duty must ensure that the risk assessment is completed and the individual management plan reviewed.
- A debriefing with the consumer should be facilitated as soon as appropriate. This will inform any necessary amendments to the consumer's individual management plan.

Recommendation 6.4 Ending an episode of seclusion or restraint

It is recommended that restraint or seclusion be ceased when the consumer is no longer an acute risk to themselves or others.

OPA recommends that the review panel consider the draft procedures of the National Seclusion and Restraint Project in relation to ending an episode of seclusion and restraint.

6.6 Regulation of physical restraint

Regulation of physical restraint should be undertaken by people with appropriate qualifications, experience and training. Consumers should be cared for by staff who have undertaken appropriate training and who have a sound knowledge of relevant legislation and preventative consumer care interventions including de-escalation and/or conflict resolution.

Recommendation 6.5 Regulation of physical restraint

It is recommended that physical restraint only be undertaken by people with appropriate qualifications, experience and training who are authorised to undertake this task.



6.7 Additional safeguards

OPA believes the external monitoring of episodes of seclusion and restraint by an appropriate body is an important aspect of accountability.

OPA strongly believes that the consumer and carer should be involved in collaborative decision-making about the options for managing disturbed behavior. As discussed in this submission, Chapter 1, OPA supports the use of the patient advance directive as an important piece of evidence to determine the appropriate management of a patient's behaviour. As outlined in Chapter 2, OPA believes that a formal nursing assessment at the commencement of inpatient care (during the assessment order stage) is an essential aspect of patient assessment.

Together, the advance directive and nursing assessment in consultation with the patient and carer, should identify a individual management plan that includes proactive de-escalation strategies to ensure that restraint and seclusion are used only as last resorts. OPA believes that this approach should be supported/required by legislation.

The model provided by the Victorian *Disability Act 2006* is worth considering, where disability service providers are required to submit the patient behavioral management plans to the Senior Practitioner. This provides another level of accountability. It also necessitates that providers develop proactive rather than reactive strategies for managing behaviour. The issue of reporting and accountability has been explored in detail by the National Seclusion and Restraint Project. OPA supports the levels of reporting and accountability outlined in that work and encourages consideration of them in the current review.

OPA believes that reporting the incidents of seclusion and restraint to an external body is required and believes that this would sit well with the Mental Health Office (see Chapter 4) because of its functions in relation to the development of guidelines, good practice, standards and reporting. The body could also oversee behavior support plans, similar to the role played by the Senior Practitioner in relation to the *Disability Act 2006*.

Recommendation 5.7 Additional safeguards

OPA recommends the use of the patient advance directive and the nursing assessment as the foundation of the patient behavior support plan.

OPA recommends a higher level of accountability in relation to seclusion and restraint which would necessitate reporting to the Mental Health Office (see Chapter 4).



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¹ National Seclusion and Restraint Project – see website

<http://www.nmhsrp.gov.au/c/mh?a=da&did=1003613> – accessed February 09

² From a presentation given to the National Forum on Seclusion and Restraint, by Peninsula Health, November 2008.

³ Eleven demonstration sites were established to trial good practice in relation to seclusion and restraint, including one at Forensicare and one at the Peninsula Health Service

⁴ McSherry, 2008b.

⁵ National Seclusion and Restraint Project, draft guidelines August 2008 (definitions)

⁶ National Seclusion and Restraint Project, draft guidelines August 2008 (draft principles)

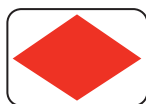
⁷ National Seclusion and Restraint Project, draft guidelines August 2008 (draft procedures)

⁸ National Seclusion and Restraint Project, draft guidelines August 2008 (draft procedures)

⁹ National Seclusion and Restraint Project, draft guidelines August 2008 (draft procedures)

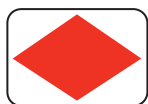
¹⁰ National Seclusion and Restraint Project, draft guidelines August 2008 (draft procedures)

¹¹ National Seclusion and Restraint Project, draft guidelines August 2008 (draft procedures)



Appendix 1 Proposed stages of involuntary treatment and descriptions

Type of order	Description of order	Authorised by	Treatment possible	Other support mechanisms
Assessment order	Sufficient authority for the detention of the person in the approved mental health service until examined by the authorised psychiatrist Allows for a period of assessment prior to diagnosis.	Authorised medical practitioner Authorised psychiatrist	Short term detention order to determine what treatment is required. Treatment to ameliorate symptoms only Helped by advance directive	Nursing assessment Behavioural support plan
Inpatient Treatment Order <i>First stage</i>	Allows for a period of detention and compulsory treatment.	Authorised psychiatrist Externally reviewed within 7 days of the making of an order. Authorised psychiatrist be required to seek a second opinion after the first 28 day inpatient treatment order where a patient continues to refuse treatment.	Psychiatric treatment Helped by advance directive and other mechanisms to support consumer involvement in decision-making outlined in Section 2.6 – Consent to treatment and safeguards	Treatment plan developed within the first week
Inpatient Treatment Order <i>Second stage</i>	Inpatient order – for patients who require longer term rehabilitation and care.	Authorised psychiatrist Externally reviewed within 14 days of the making of an order. Confirmation by external body within two weeks	As above	Comprehensive case management plan undertaken with allied health care team and any relevant external parties (PDRS, MST, case management support). Discharge plan
Community Treatment Order <i>First stage & Second stage</i>	Allows for a period of compulsory treatment and support in the community.	Authorised psychiatrist Externally reviewed within 7 days of the making of an order.	As above	Comprehensive treatment and care plan which would specify community care services, relevant services, other treatment/care/services required for recovery/support



Appendix 2 Timing of external reviews

Timing of reviews	Involuntary Treatment Order				
	Assessment order	Inpatient Treatment Order		Community Treatment Order	
		First stage	Second stage	First stage	Second stage
Duration of order	Up to 3 days	Firstly for 28 days – then for three months for a maximum of four three month orders.	Six months – there is no limit on the number of times it can be made can be made.	Three months for a maximum of four three month orders.	Six months – there is no limit on the number of times it can be made can be made.
External Review	Confirmed within 24 hours by AP	Automatically within 7 days of the making of an order.	Automatically within 14 days of the making of an order.	Automatically within 7 days of the making of an order.	Automatically within 14 days of the making of an order.
Clinical review	Within 24 hours	Before the 28 day period concludes and prior to the conclusion of any subsequent order.	Before the six month order concludes.	Before the three month order concludes.	Before the six month order concludes.