

Submission in response to the Mental Health Bill Exposure Draft 2010

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1. Introduction

- 1.1 The Office of the Public Advocate (OPA) has considered the Department of Health's *Exposure Draft Mental Health Bill 2010* and welcomes the opportunity to respond. OPA's experience with the *Mental Health Act 1986* (the Act) is as the guardian for people with a mental illness who have an associated cognitive impairment, the holder of investigative powers under the guardianship legislation, and as part of its function to manage the Community Visitors Program.
- 1.2 OPA would like to congratulate the Department of Health on its efforts to introduce a stronger human rights focus to the Act in line with local and international developments in human rights law. In particular, the introduction of a staged involuntary treatment process, the introduction of a higher threshold for involuntary treatment, more regular external reviews, and the proposed time limits placed on Inpatient Treatment Orders and Community Treatment Orders, provide stronger safeguards for patients.
- 1.3 New mechanisms such as the nominated person, second opinion scheme, Mental Health Commission and the Review Officers have potential in the area of monitoring and promotion of patient care, wellbeing and rights. However, OPA has concerns about the scope of the roles given to the nominated person, the Review Officers and the Mental Health Commission. The potential for independence in the current formulation of the second opinion psychiatrists scheme and the Mental Health Commission are also an issue.
- 1.4 The Exposure Draft could be improved in several areas. The recognition of advance statements is a positive development, particularly the reference to them in treatment planning and the need for them to be taken into account by the Mental Health Tribunal. However the absence of a stronger legal status for advance statements means that they can be easily overridden. OPA believes that for advance statements to be a meaningful part of patient treatment planning, a more thorough process needs to be activated when an Authorised Psychiatrist wants to provide treatment counter to a patient's expressed wishes.
- 1.5 While the new criteria for an Inpatient Treatment Order are more progressive than the 1986 Act, inconsistencies between the various sections of the Exposure Draft (s3(2), s64(d), s70(c), s125(1)(a)) are of concern. The grounds for involuntary treatment are a contested site in involuntary treatment legislation and the inclusion of section 125(1)(a) (that a person 'has the capacity to consent to the administration of treatment for mental illness and does not give consent') is perplexing. It

runs counter to what is intended by the presumption of capacity principle (s7(2)) and the new grounds for involuntary treatment (s70).

- 1.6 OPA's position is that where a person has the capacity to consent but is refusing to consent, that they should not be subjected to treatment. In Victoria, people are protected from unwanted medical treatment by the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter) right relating to the 'protection from torture and cruel, inhuman or degrading treatment' which states that a person must not be 'subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.' (section 10(c))
- 1.7 Another area in which improvement could be made is in the area of seclusion and restraint. The Department's acknowledgement in the *Review of the Mental Health Act Consultation Paper 2008* (the Consultation Paper), that restrictive interventions have been associated with deaths and the recognition of relationship between these practices and Charter rights suggested that there would be significant changes in this area. However, the Exposure Draft does not go far enough. OPA would like to see more limits placed on the use of seclusion and restraint, consistent with human rights principles, with the aim being to reduce and where possible, eliminate their use.
- 1.8 It is disappointing that many of the progressive rights protection mechanisms proposed in the Consultation Paper have been adopted without the advocacy or systemic change functions associated with the original models. The mental health commission models described in the Consultation Paper had a rights-monitoring function that would sit alongside a research, analysis and systemic change function. Similarly, the Review Officer role had the potential to be associated with a broader rights protection and advocacy function like the New Zealand District Inspector role. However, the exclusive focus of the proposed Victorian Mental Health Commission on complaints and the narrow focus of the Review Officers on 'errors' and 'remediation' in relation to Involuntary Treatment Orders are too limited. Proposals relating to the proposed Mental Health Tribunal don't address the critical issue of therapeutic jurisprudence in mental health tribunals, an issue around which there has been significant research in Australia in recent years.
- 1.9 Finally, OPA would like to reiterate the point made in our earlier submission about the absence of reference to a right to mental health services and support in mental health legislation in Victoria. The proposed new Act fails, as did the previous Act, to provide a framework of rights for the provision of mental health services, in addition to regulating involuntary treatment and detention. As a signatory to the *International Covenant on Economic, Social and Cultural Rights* (ICECSR), Australia

has a responsibility to ensure the ‘enjoyment of the highest attainable standard of physical and mental health’ article 12). An exclusive focus on involuntary detention and treatment will not enable us to achieve this aim. What is needed in Victoria is a stronger articulation of the responsibility of government to provide accessible services for people when needed. Preventative services, inpatient services and community-based support services are all required. Involuntary treatment and detention are one aspect of a much larger problem.

2. Nominated Person

2.1 OPA supports the concept of a nominated person but believes the role as it is defined in sections 157(2)(a) and 157(2)(b) - ‘receiving information under this Act’ and ‘being consulted about decisions relating to treatment’ – is not significant enough.

2.2 Further details of the role are interspersed throughout the Act. OPA proposes that these be brought into section 157(2) to enable greater transparency. As such, the potential scope of the role defined in section 157(2) would include:

- (a) receiving information under the Act;
- (b) being consulted about decisions relating to treatment;
- (c) notification that the person has been detained;
- (d) notification prior to discharge or transfer;
- (e) notification that a compulsory order has been made, varied or revoked;
- (f) notification where restraint or seclusion are used;
- (g) notification of Mental Health Review Tribunal hearings including any application for ECT or psychosurgery;
- (h) receiving a copy of statement of rights;
- (i) receiving a copy of the treatment plan.

2.3 Consumers may not wish their nominated person to receive all such information. It is suggested that a consumer form or schedule would include tick boxes by which the consumer would indicate which information they wished the nominated person to be given.

2.4 Many consumers will not have completed the processes enabling them to appoint a nominated person. As such, the Act needs to specify that the provision of information to a nominated person does not exclude significant others/carers from being provided with information the consumer has consented to sharing with them.

2.5 OPA supports a greater onus on the treating team to undertake meaningful consultation with carers/significant others and the nominated person, where the consumer has consented to this.

3. Advance Directives

3.1 OPA believes that advance directives (re-named advance statements) have not been given a high enough legal status and authority in the new Act. A stronger authority for advance statements would be more consistent with the *International Convention on the Rights of Persons with Disabilities* (the Disabilities Convention) and the Charter and was expected, given the prominence of these instruments in the Consultation Paper.

3.2 Article 17 of the Disabilities Convention - the 'right to respect for his or her physical and mental integrity on an equal basis with others' - is particularly pertinent to decisions regarding treatment, as is section 10 of the Charter - 'Protection from torture and cruel, inhuman or degrading treatment' - the latter stating that a person must not be 'subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent' (s10(c)).

3.3 In the Exposure Draft, any individual or body required to make a decision in relation to the treatment of a patient must only 'have regard to an advance statement' (s154(1)). OPA maintains the position that an advance statement should be followed, unless it is proven that to follow the statement is not in the best interests of the person.

3.4 In section 154(4), where a body or individual wishes to make a decision which is inconsistent with the wishes and preferences of the patient expressed in their advance statement, the mental health service provider must only 'record the circumstances and the reasons for doing so' (s154(4)(a)). OPA believes that for the advance statement to be a meaningful part of patient treatment planning, a more thorough process needs to be activated when an Authorised Psychiatrist wants to provide treatment counter to a patient's expressed wishes.

3.5 OPA maintains its position that unless there is an emergency, where a mental health service seeks to go against a person's advance statement, they must apply to the review body for approval to follow a different course of action, particularly where it is in relation to a refusal of a specific treatment or medication. Then, only the review body would be able to approve treatment contrary to a person's advance statement and only on the grounds that to do so would be in the person's best interests.

- 3.6 It is suggested that a ‘statement of reasons’, included as part of the advance statement, would assist the review body to determine what treatment would be provided in the case where there was conflict between the treating doctor’s view and the patient’s expressed wishes.
- 3.7 OPA proposes an alignment between the witnessing requirements for advance statements and the Victorian Parliamentary Law Reform Committee’s witnessing requirements for proposed Enduring Powers of Attorney. This is outlined in recommendation 15: ‘the Powers of Attorney Act require all power of attorney documents to be witnessed by two witnesses, one of whom is authorised to witness affidavits or is a medical practitioner.’

4. Capacity

- 4.1 There are inconsistencies between definitions of capacity in sections 3(2), 64(d), 70(c) and 125(1)(a).
- 4.2 The capacity test outlined in section 3(2) has three aspects. A person has capacity for the purposes of the Act ‘if the person is capable of –
- a) understanding the nature and effect of the decision; and
 - b) making the decision freely and voluntarily; and
 - c) communicating the decision in a manner such that another person can understand what the decision is.’ (s3(2))
- 4.3 The criteria for an assessment order outlined in section 64(d) describes four aspects of decision-making: ‘because of the person’s apparent mental illness the ability of the person to make decisions about the provision of treatment is significantly impaired as the person is unable to –
- (i) understand the information relevant to the decision; or
 - (ii) retain that information; or
 - (iii) use, weigh or appreciate that information as part of the process of making the decision; or
 - (iv) communicate the decision in a manner such that another person can understand what the decision is.’(s64(d)).
- 4.4 The criteria in section 70(c) is consistent with section 64(d). The criterion is drawn from the Scottish Mental Health Act and replaces section 8(d) in the *Mental Health Act 1986* (that ‘the person has refused or is unable to consent to the necessary treatment for the mental illness’). The new grounds reflect a welcome higher threshold for involuntary treatment than seen in the 1986 Act. OPA argued in our original submission to the Act, as

did others, that ‘refusal to consent’ is not a reasonable criterion for involuntary treatment and should be removed.

- 4.5 OPA also argued that the ground ‘unable to consent’ needed further extrapolation as the term lacks clarity. We proposed a similar definition to the Scottish Mental Health Act (s64(5)(d)) where ‘because of the mental disorder, the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired’(see Consultation Paper).
- 4.6 Section 125(1)(a) reintroduces the idea of ‘refusal to consent’ and in doing so, highlights a serious inconsistency between this and sections 64(d) and 70(c). This is of concern not only because of the lack of coherence but because it runs counter to the general principle on the presumption of capacity outlined in section 7(2) which states that ‘a person with a mental illness is presumed to have the capacity to make decisions about matters relating to their mental illness if the person appears capable of doing the things specified in section 3(2).’
- 4.7 Victorian Charter rights cannot be said to have been respected in legislation that allows treatment to be given to a patient who ‘has the capacity to consent to the administration of treatment for mental illness and does not give consent’ (s125(1)(a)). The pertinent Charter rights are ‘recognition and equality before the law’ (section 8) and ‘protection from torture and cruel, inhuman or degrading treatment’ (section 10). Section 10(c) states that: ‘person must not be subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.’ OPA’s view is that where a person has the capacity to consent to treatment that these protections should remain in place.

5. Second Opinion Psychiatrists

- 5.1 OPA supports the inclusion of a second opinion scheme in the new Act but some amendments are required for the scheme to be more independent. OPA is particularly concerned about the three month delay required before a second opinion scheme comes into play and the lack of opportunity for consumers to instigate the second opinion process and be provided with advocacy to support this.
- 5.2 OPA proposes that the scheme should apply where the patient refuses to consent *and* does not have the capacity to consent, not where the patient to consent *or* does not have the capacity to give consent’ as proposed in the Exposure Draft (s126((1)(b)). Patients who have the capacity to consent and do not consent should not be receiving treatment (see section 4 of this submission).

- 5.3 From a human rights perspective, the timing of the second opinion is problematic. The Charter clearly states that ‘A person must not be subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.’ (section 10(c)). A patient who is refusing treatment should not be treated without recourse to a second opinion in a timely manner.
- 5.4 OPA believes that a patient who is refusing treatment should be entitled to a second opinion within the first 28 days of an Inpatient Treatment Order not after treatment has been administered for a ‘continuous period of 3 months’ as the Exposure Draft suggests (see section 126(1)). The delay is also problematic from a pragmatic perspective. Given that the average length of stay for adult inpatient units across the state is from 8-22 days (see Boston Consulting Group 2006), most patients will be discharged before they receive this entitlement.
- 5.5 It is also of concern that the second opinion process is initiated by the mental health service and that the second opinion psychiatrist is appointed by the mental health service provider. This doesn’t provide either independence of opinion or agency for the consumer. OPA believes that the patient or a patient advocate (e.g. nominated person, family member, carer or guardian) should be able to instigate a second opinion process and appoint an independent psychiatrist, and that this should be provided within 28 days of treatment.
- 5.6 It is proposed that second opinion outcomes become part of the Chief Psychiatrist’s annual report.

6 Review Officers

- 6.1 The Review Officers and the Mental Health Commission are two of the new mechanisms for monitoring patient rights and wellbeing. While these are welcome additions to the mental health landscape, as they are currently defined and structured, they lack breadth and independence.
- 6.2 OPA has concerns about the qualifications, functions, appointment, location and independence of the Review Officer role as it is currently defined. In our original submission, we sought an independent support role that would advise a person of their rights, support them in exercising those rights and play an advocacy role. There is evidence that personal advocacy can assist individual recovery and individuals will often need this to negotiate treatment options and to ensure their wishes are included in treatment planning.

6.3 The current Review Officer role focus on managing errors and remediation in relation to the involuntary order is too narrow. Other aspects of treatment, care and patient rights also require monitoring and review (for example, seclusion and restraint, ECT, privacy, second opinion and advance statements). OPA suggests that the following functions be included under the Review Officer role:

- (a) Support patient in exercising rights under the Act (e.g. patient input into treatment planning and sourcing a second opinion);
- (b) Liaison with treating team, case manager, nominated person, guardian and significant others;
- (c) Provision of independent advocacy in relation to treatment and rights;
- (d) Assistance in sourcing legal advice and external advocacy;
- (e) Assistance in making complaints;
- (f) Assistance at review and appeal hearings.

6.4 OPA understands that the Review Officers are likely to be based at the Mental Health Tribunal. We believe this is likely to entail a conflict of interest given the instrumental role of the Tribunal in processes relating to involuntary orders. Review Officers must be independent from the Tribunal, the mental health services and the Department of Health in order to ensure independence from the bodies where mistakes or omissions may be made.

6.5 One option to overcome the problem of independence is for the Review Officers to sit within the Community Visitors Program. Being within the Department of Justice would ensure they are able to scrutinise and monitor processes in relation to involuntary treatment more effectively as they would be independent of the body that funds mental health services. The advocacy function of the Office of the Public Advocate would sit well with the broader advocacy function for the Review Officers that is proposed above.

7 Mental Health Commission

7.1 Victoria has an opportunity to play a lead role in mental health law in Australia through the introduction of an independent Mental Health Commission that would safeguard the rights of people with a mental illness.

7.2 The Mental Health Commission, as it is described in the Exposure Draft, is a positive development in that it will perform a much needed specialist mental health complaints function but it is a poor cousin of the models illustrated in the Consultation Paper as its focus appears to be almost

solely on complaints. OPA would like to see the establishment of an independent Mental Health Commission to perform a rights-monitoring function that would sit alongside research, analysis and systemic change functions.

7.3 In relation to its complaints function, the powers described in the Exposure Draft are adequate. The Commission has the power to investigate, conciliate and issue compliance notices. However, there is a conflict of interest inherent in the Commission sitting within the department that directly funds mental health services. It will only be able to exercise this power in a meaningful way if it is independent from the Department of Health.

8 Seclusion and Restraint Principles

8.1 The Consultation Paper acknowledged the association between the practices of seclusion and restraint and deaths and trauma. The need to consider Charter rights such as ‘freedom of movement’ (s12), the right to ‘humane treatment when deprived of liberty’ (s22) and ‘protection from torture and cruel, inhuman or degrading treatment’ (s10) in developing a new act was also clearly acknowledged. The Exposure Draft does not realise these in any meaningful way. OPA would like to see more limits on the use of seclusion and restraint, consistent with the Charter and the National Mental Health Safety Priority of ‘reducing use of, and where possible eliminating, restraint and seclusion’.

8.2 If the intention of the new Act is to limit the use of restraint and seclusion and to drive changes in clinical practice, then a stronger emphasis on planning alternative interventions needs to be articulated. This could include teaching staff de-escalation techniques, developing patient behaviour management plans, the provision of comfort rooms and the provision of post-seclusion incident reporting. The requirement for mental health facilities to demonstrate what alternative less restrictive strategies have been sought and to explain why they are not appropriate is an important way of monitoring, evaluating and improving practices.

8.3 The following principles are more in line with the reform agenda suggested by the Charter and the National Seclusion and Restraint project and are proposed for inclusion in section 136:

- (a) The purpose of this part is to protect the rights of persons with a mental illness who are subject to restrictive interventions by ensuring that facilities have alternative strategies in place and that restrictive interventions are only used if the requirements of this part are met.

- (b) Mental Health facilities must have alternative strategies and facilities in place for managing safety issues (harm to self and harm to others).
- (c) An assessment of needs and risks for the consumer is undertaken as early as possible in admission which identifies proactive de-escalating strategies to ensure seclusion and restraint are only used as a last resort.
- (d) Each patient on an Inpatient Treatment Order must have a behaviour management plan associated with their treatment plan developed in consultation with the patient, carer and nominated person. The plan will outline proactive strategies for managing safety issues.
- (e) The behaviour management plan must be approved by the Authorised Psychiatrist and registered with the Chief Psychiatrist. If seclusion and restraint are identified as strategies, the practices can only be used as prescribed in the behaviour management plan and for the period of time covered by the plan. The Chief Psychiatrist will regularly report on behaviour management strategies being used.
- (f) Seclusion in the case of a person who is self-harming or suicidal may present a heightened risk of harm to the consumer and should not be undertaken without a risk assessment.
- (g) Restraint and seclusion can only be used if they are included in, and are in accordance with the person's behaviour management plan. Where a behaviour management plan is yet to be developed (for patients on an Assessment Order for example), restrictive interventions may be used only if necessary as a matter of urgency:
 - (i) to save the person's life; or
 - (ii) to prevent suffering or relieve pain or distress.

8.4 In recognition that the use of seclusion and restraint can be traumatic for consumers and that the consumer may need support at this time, it is recommended that the nominated person/family member/carer/guardian be contacted (with the prior consent of the consumer) as soon as practicable to the time of the commencement of a restrictive intervention (see section 138).

9 Bodily Restraint

9.1 OPA would like to see section 139(1)(a) expressed as a prohibition rather than a necessity. Instead of saying that 'restraint is necessary because ...', it would read, 'the use of bodily restraint is prohibited except where...'

- 9.2 OPA would like to see reference to less restrictive options (section 139(1)(b) expanded to include a description of less restrictive options. For example, ‘bodily restraint may only be applied for the purposes of preventing a consumer from causing injury to themselves or others, after proper consideration of other less restrictive means which achieve the same aim, such as use of break-out, relaxing or self-soothing rooms.’
- 9.3 OPA would like to propose an addition to section 139(1): That ‘bodily or chemical restraint should not be used as a behaviour management technique but only where there is a serious risk of harm to self or others.’
- 9.4 While OPA acknowledges that in some instances bodily restraint may be necessary for the administration of medical treatment (section 139(1)(a)(i)), we would like to express serious concerns about this practice. We would like a statement included that this can only occur when it is the least restrictive course of action.
- 9.5 The omission of any reference to mechanical restraint involving the use of furniture (including beds with cot sides, chairs with tables fitted on their arms) (*Mental Health Act 1986*, s81(1A)) is a concern. Does this mean that this practice is not regulated and hence permissible in mental health settings? It is a particular concern in psycho-geriatric settings where these practices have been reported.
- 9.6 It is unclear why the application of bodily restraint is not time bound. Given the evidence cited in the Consultation Paper that 91.5% of episodes of mechanical restraint in 2007/08 were for less than four hours (and given the relatively aged population who experience restraint - more than two thirds were on patients over 65 years of age), it is suggested that a reasonable maximum period for mechanical restraint might be four hours (refer to the National Mental Health Seclusion Project Guidelines).
- 9.7 Appropriate clinical review should be undertaken by two staff – one of whom was not involved in the initial decision to apply restraint (see section 139(4)(b)).
- 9.8 Consistent with a four hour maximum period for mechanical restraint, OPA would like to see the interval between which the Authorised Psychiatrist (or delegate) must examine the patient under restraint raised to hourly examinations (see section 139(4)(c)).
- 9.9 OPA would like to see no exceptions to the interval between which the Authorised Psychiatrist must examine the patient under restraint (see section 139(5)).

9.10 OPA would like minimum qualifications and training for people administering bodily restraint. It is not appropriate for hospital security staff without medical training to perform this task as this may be experienced as a loss of dignity for patients. As such, the Chief Psychiatrist may make guidelines specifying the qualifications *and* training required by a person authorised to apply bodily restraint (see section 140).

10 Seclusion

10.1 OPA would like to see section 141(1)(a)(1) expressed as a prohibition rather than a necessity: Instead of ‘seclusion is necessary because...’, it would read ‘the use of seclusion is prohibited except where...’.

10.2 OPA would like to see the reference to less restrictive options (section 141(1)(b) expanded. For example, ‘seclusion may only be applied for the purposes of preventing a consumer from causing injury to themselves or others, after proper consideration of other less restrictive means which achieve the same aim, such as use of break-out, relaxing or self-soothing rooms.’

10.3 OPA would like to propose a further qualification to the use of seclusion outlined in section 141(1): That ‘seclusion should never be used as a behaviour management technique but only where there is a serious risk of harm to self or others.’

10.4 It is a concern that seclusion is not time bound. It is suggested that a reasonable maximum period of seclusion might be four hours (refer to the National Mental Health Seclusion Project Guidelines).

10.5 Appropriate clinical review should be undertaken by two staff – one of whom was not involved in the initial decision to place the patient in seclusion (see section 141(4)(c)).

10.6 Consistent with a maximum period for seclusion, OPA would like to see the interval between which the Authorised Psychiatrist (or delegate) examines the patient in seclusion raised to hourly examinations (see section 141(4)(d)).

10.7 OPA would like to see no exceptions to the interval between which the Authorised Psychiatrist must examine the patient in seclusion (see section s141(5)).

11 Involuntary Treatment Orders

General

11.1 OPA is in general agreement with the processes around the Assessment Order, Inpatient Treatment Order (ITO) and Community Treatment Order (CTO). The introduction of a higher threshold for involuntary treatment, a staged involuntary treatment process, more regular external reviews and the proposed time limits placed on ITOs and CTOs provide stronger safeguards for patients. We have some suggestions regarding inconsistencies and would like to propose some additions.

Criteria for Involuntary Treatment

11.2 The Department needs to ensure that the criteria for an Involuntary Treatment Order (section 70) and a CTO (section 71) are consistent with the Act as a whole – which is currently not the case (see section 4 of this submission).

Regard to certain matters

11.3 Section 72 is a welcome and important supplement to the criteria for involuntary treatment and may be an area around which training guidelines could be developed.

11.4 Adding a reference to the presumption of capacity principle outlined in section 7(2) would also be helpful in section 72. Add: ‘A person with a mental illness is presumed to have capacity to make decisions about their mental illness if the person appears capable of doing the things specified in sections 70(c) and 71(c).’

Preparation of a treatment plan

11.5 Section 132(1)(a) refers to the mental health service provider’s responsibility to prepare a treatment plan ‘before an Extended Community Treatment Order is made in respect of the person.’ This should read ‘before an Extended Treatment Order is made in respect of the person.’

11.6 Section 132(1)(b) refers to the mental health service provider’s responsibility to prepare a treatment plan ‘before the person is discharged into the community’. It is unclear why the treatment plan would be prepared on discharge rather than on admission.

11.7 There is an inconsistency between section 132(1)(b) where it states that a treatment plan must be prepared ‘before the person is discharged into the community’ and section 132(4) where it states that ‘the preparation of a treatment plan is not a precondition to the person being discharged into the community.’ Section 132(1)(b) should stand.

Making an Inpatient Treatment Order

11.8 OPA believes the 28 day period before an external review of an Inpatient Treatment Order occurs (see section 73(5)) is too long and would like to see an automatic review within 7 days as proposed in our original submission.

Criteria for a Community Treatment Order

11.9 As part of the criteria for a CTO, OPA would like to see a more descriptive reference to services that would advise clinical services to liaise with PDRS, Mobile Support Teams, allied health and other community-based services. Section 71(e) would then become ‘services for the provision of the appropriate clinical and/or alternative treatment and support exist in the community and are available to the person and will be provided to the person.’ OPA believes that connecting the consumer with a broader range of services reduces the likelihood of re-admission.

11.10 Where decisions regarding accommodation are part of a treatment plan and a requirement about where the person is to live is specified in a CTO, a guardian should not be involved in accommodation decisions. This could be added to section 72 – ‘regard may be had to certain matters’.

12 Mental Health Tribunal

12.1 While it is positive that issues like more frequent reviews of involuntary treatment orders are required under the new Act and that a range of views must be taken into account in considering the extension of involuntary treatment orders, OPA is concerned that cultural matters relating to therapeutic jurisprudence have not been addressed. The issue of time needed to conduct hearings and issues relating to a culture of participation, dignity and trust could be included in a set of guiding principles for the Tribunal.

12.2 Principles guiding hearings could include reference to review members being required to 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’ (from Beaupert, 2006, cited in OPA submission 2008).

12.3 Section 90, ‘Matters to which Tribunal must have regard’ and section 91, ‘Review of treatment plan’ provide clarity for the consumer and the mental health provider about rights and responsibilities relating to treatment planning. However, they are difficult to find in the document and would be more accessible under Division 4, ‘The Mental Health Tribunal’.

12.4 OPA is concerned that the Tribunal is likely to sit within the Department of Health and that this would compromise its independence. We suggest that, in order to enhance its independence, the Tribunal should be funded by and report to the Department of Justice. OPA agrees with the suggestion put to us that the Mental Health Tribunal could form one of the services of a protective tribunal, separate from the Victorian Civil and Administrative Tribunal, which would also take the responsibility for guardianship matters.

12.5 Having access to documents (see schedule 2, c17) prior to a hearing is important for consumers and their advocates. However, consumers are often only able to access these documents on the day of the hearing and do not have time to read and digest material before their hearing. This section should include reference to the need for consumers to have access to documents in a timely manner and prior to the hearing.

12.6 It is also noted that while consumers are entitled to have representation before the Tribunal (schedule 2, c8), that there is no associated requirement for this to be funded and made available. OPA believes that all consumers going before the Tribunal should have a right to funded representation and/or advocacy.

13 ECT

13.1 The increased rigor and accountability seen in the processes pertaining to ECT are positive (see section 142). The additional oversight of the Mental Health Tribunal and two registered medical personnel being required where a person does not provide consent are also positive and necessary developments.

13.2 OPA's position is that where a person has the capacity to consent and does not consent to ECT, it should not be administered.

13.3 ECT should only be able to be given without consent (in the case where the ability of the person to make decisions about treatment is significantly impaired) where a second opinion (independent of the mental health service) is given and where it does not conflict with the patient's advance statement and where it is necessary to save the person's life. Consideration must also be given to the person's 'best interests'.

14 Community Visitors Program

- 14.1 OPA supports the retention of the important monitoring role of community visitors as outlined in the Exposure Draft.
- 14.2 Proposed change to section 51(1): The Governor in Council may on the recommendation of the *Public Advocate* appoint community visitors within the meaning of the *Health Services Act* 1988. This change would provide consistency between the Mental Health Act and the *Disability Act* 2006 (n/b the older *Health Services Act* 1988 has community visitors appointed by Governor in Council and nominated by the Minister).
- 14.3 Proposed change to section 52(2): The Governor in Council may on the recommendation of the *Public Advocate* remove a community visitor from office. This change would provide consistency as described in 14.2.
- 14.4 OPA notes the exclusion of schedule 5 from the 1986 Mental Health Act in the Exposure Draft and wishes to draw this to the Department's attention. The following provisions with regard to community visitors have not been included: clause 1(2)(c), clause 1(4), clause 1(5) and clause 2(5)(f).
- 14.5 Proposed change to section 53: The functions of a community visitor are to (a) visit a designated mental health service (delete *in the region for which the community visitor is appointed*).
- 14.6 Proposed change to section 56(1): The Community Visitors Mental Health Board will receive *quarterly reports* from the community visitor for each region on visits made since the last report.
- 14.7 Proposed change to section 56(2): The Public Advocate may at any time access the reports on the performance by community visitors of their functions in the manner directed by the Public Advocate.
- 14.8 OPA advocates that patients receiving care and treatment at PARC facilities should have access to community visitors. OPA acknowledges that PARC facilities do not provide 24 hour nursing care, however the provision of care for many facilities operates with 24 hour staffing. PARC facilities are considered as extensions of mental health treatment and care to support patients experiencing an acute episode working towards recovery. To continue to ensure persons with a mental illness are treated with dignity and respect, OPA advocates that the Community Visitors Program should extend to patients who receive short-term and intensive treatment and care in PARC facilities.

- 14.9 The introduction of Review Officers has the potential to monitor and better improve the rights for persons receiving mental health treatment and care. OPA is concerned that the reporting relationship between the Community Visitors Program and the Review Officers lacks clarity in the Exposure Draft, particularly the manner in which matters may be referred between the two statutory roles.
- 14.10 It is unclear why sections 174 to 176 are separated from Division 7 when they deal with issues regarding visits, powers of inspection and requests to see community visitors. It would simplify things if they were all included under Division 7.

15 Voluntary Patients

- 15.1 The inclusion of Part 4 ‘Voluntary Patients’ (sections 59-62) addresses some but not all of the issues that came about as a result of voluntary patient status being removed from the 1986 Act.
- 15.2 The backdrop to the need for change is a lack of articulated rights for voluntary patients. OPA has been concerned for some time about reports of voluntary patients being threatened with being made involuntary if they do not comply with treatment. This is one example of why an articulated rights framework for voluntary patients is critical.
- 15.3 Section 61(2) describes the features of a statement of rights for voluntary patients. In addition to subsections (a) to (i), which are important, OPA suggests the provision of ‘informed consent for all aspects of treatment and care’, the right to a ‘behaviour management plan’ and the right to a ‘treatment plan’ should be included.
- 15.4 The right of voluntary patients to access treatment and care is another issue that is not addressed. OPA would like to see a greater emphasis on the right of voluntary patients to proactively access urgent clinical care prior to requiring involuntary admission. Early intervention, where possible, would help to reduce involuntary admissions and preserve consumer autonomy and decision-making about their own treatment and care.

16 Non-Psychiatric Treatment

- 16.1 There is currently a lack of consistency around substitute decision-making in relation to non-psychiatric treatment between the *Guardianship and Administration Act* 1986 and mental health legislation.

16.2 The *Guardianship and Administration Act 1986* (sections 36-42) address issues of medical consent in detail. OPA proposes that if a person receiving treatment under the Mental Health Act requires and is unable to consent to non-psychiatric treatment that the provisions of the *Guardianship and Administration Act* should apply.

17 Security Patients

17.1 OPA acknowledges the reform objectives to the existing provisions relating to security and forensic patients in the Exposure Draft. In practice prisoners are routinely transferred to Thomas Embling Hospital, which enables prisoners to access safeguards that apply to voluntary and involuntary patients.

17.2 There are an increasing number of prisoners experiencing mental health issues in a system with reduced bed capacity for prisoners. OPA would like to see consideration of similar rights and protections for prisoners undergoing mental health treatment in the prison environment as there are for people being treated in mental health units as voluntary and involuntary patients.