

Review of the *Mental Health Act 1986*

Consultation paper – December 2008





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Cover artwork

Graeme Doyle, *The Horse - "A Poor Man's Guernica" or Landscape on Another Planet (detail)*, 1971-2000.

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Ministerial foreword

In May 2008 I announced a review of the *Mental Health Act 1986* (the Act) to examine whether it provides an effective and contemporary legislative framework for the treatment and care of Victorians with a serious mental illness. The Act imposes obligations on government, enshrines protections for people subject to it and regulates the provision of involuntary treatment and other practices.

When passed in 1986, the Act led Australian reform of mental health legislation. Since then, unprecedented changes have occurred in the way that services are delivered. This period has also seen significant developments in international and local human rights law especially the Victorian *Charter of Human Rights and Responsibilities* and the United Nations' *Convention on the Rights of Persons with Disabilities*.

While the Act has been amended frequently over the past two decades, a comprehensive review is required to ensure the Act effectively protects the rights articulated in these documents. It is also necessary to ensure the legislative framework of the Act reflects the current context within which mental health care occurs and underpins the Victorian Government's aspirations for mental health services into the future.

The Victorian Government is currently developing a statewide reform vision for mental health services. Responses to the consultation paper *Because mental health matters: A new focus for mental health and wellbeing in Victoria*, received earlier this year, will help shape Victoria's new mental health strategy and our future service system. The vision emphasises the fundamental importance of flexible, consumer-oriented services with an increased focus on recovery. Legislation plays a key part in reflecting and facilitating these objectives.

In June 2008 Mr Ben Bodna AM, Ms Dominique Saunders and Mr Wayne Schwass were appointed to an independent panel to lead public consultations on this review. This panel, the Community Consultation Panel, is supported by the legislation review team within the Mental Health and Drugs Division of the Department of Human Services.

Sadly Ben Bodna, the inaugural chair of the panel, passed away suddenly in October. I was shocked and greatly saddened by his death. Ben made important contributions to this review that were marked by a passion for human rights and a keen interest in understanding consumer issues and experiences. I am sure that Ben's belief in the value of talking directly to consumers, their families and carers will be continued throughout this review process.

Mr Julian Gardner has since been appointed to chair the panel. Mr Gardner is also chair of the independent Expert Advisory Group (EAG) consisting of stakeholders and key experts, which was appointed to provide specialist knowledge and advice on the complex issues contained in this paper. I thank all members of the EAG for their input, invaluable advice and commitment to this review.

We aim to introduce new mental health legislation into the Victorian Parliament in 2010. It is my hope that this consultation paper will promote high levels of input and I encourage all interested members of the Victorian community to make their views on the future shape of the Act known to the panel. These submissions will help ensure our aspirations for the future of Victoria's mental health law become a reality.

A handwritten signature in black ink, appearing to read 'Lisa Neville'. The signature is fluid and cursive, written in a professional style.

The Hon Lisa Neville MP
Minister for Mental Health



Abbreviations used in this paper

<i>Because mental health matters</i>	<i>Because mental health matters: A new focus for mental health and wellbeing in Victoria</i>
CAT service	crisis assessment and treatment service
CSC	Child Safety Commissioner
Disabilities Convention	<i>International Convention on the Rights of Persons with Disabilities</i>
ECT	electroconvulsive therapy
HSC	Health Services Commissioner
HPP	Health Privacy Principles in the <i>Health Records Act 2001</i> (Vic)
MWC	Mental Welfare Commission for Scotland
MHAC	Mental Health Act Commission (England and Wales)
PDRS services	psychiatric disability rehabilitation and support services
the Act	<i>Mental Health Act 1986</i> (Vic)
the board	Mental Health Review Board
the charter	<i>Victorian Charter of Human Rights and Responsibilities</i>
the department	Department of Human Services
the panel	Community Consultation Panel
QAC	quality assurance committee
VCAT	Victorian Civil and Administrative Tribunal
VQC	Victorian Quality Council

Terminology used in this paper

There is continuing debate about the most desirable or acceptable terminology to describe people who have a mental illness and receive involuntary treatment and care. Diverse and profoundly conflicting views on terminology are acknowledged. However, for the purpose of this paper, it has been necessary to settle on descriptors that are clear and easily understood by the reader.

In this paper, ‘patient’ is used when describing laws applicable to both voluntary and involuntary patients. ‘Involuntary patient’ means a person subject to an involuntary treatment order or community treatment order, unless otherwise stated. ‘Voluntary patient’ refers to a person who is receiving treatment and care for a mental illness, but not under an involuntary treatment order or community treatment order.

In this paper, ‘carer’ is used to describe a person involved in the ongoing care or support of a person with mental illness.



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1. Scope of the review and consultation process

1.1 Introduction

This review provides an opportunity for widespread comment, debate and input from patients, carers, mental health practitioners, other stakeholder groups and the broader community about the *Mental Health Act 1986* (the Act) and how it might be improved.

This consultation paper is designed to stimulate discussion and invite submissions. Its purpose is to raise key issues, not to fully explore technical legal matters. Comment is welcome on any matter related to the Act.

1.2 Review terms of reference

This review will examine whether the Act provides an effective legislative framework for the treatment and care of people with serious mental illness in Victoria. This review will aim to ensure that the new Act appropriately protects human rights in light of the Victorian *Charter of Human Rights and Responsibilities* (the charter).

Any proposals for reform will take into consideration:

- Victorian Government priorities, including the principles and reform goals identified in the statewide reform vision for mental health services, *Because mental health matters: A new focus for mental health and wellbeing in Victoria*, due for release by the end of 2008.
- the evidentiary bases for reform
- the Victorian legal framework
- the rights and responsibilities articulated in the charter and international human rights documents
- Australian and international models for mental health legislation
- regulatory principles, including those in the *Victorian guide to regulation*
- the impacts of proposed reforms and associated implementation issues.

This review will not examine the pathways by which security and forensic patients enter the mental health service system or the mental health-related dispositions contained in the *Sentencing Act 1991* (Vic) and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic), nor will this review consider in detail the operation of cross-border provisions in the Act.

1.3 Consultation paper

This paper will examine possible ways to strengthen or improve:

- the Act's role in promoting recovery
- patient participation in treatment and care decisions, including placing patients at the heart of the Act
- the existing rights-based approach to involuntary treatment and care
- the effectiveness and accessibility of mechanisms to oversee treatment and care
- the Act's responsiveness to the needs of families and carers.

Each chapter is divided into several sections: an introduction, brief description of the current operation of the Act and service framework, followed by some key issues and questions to inform ideas for the future.

Chapter 2 provides a brief overview of the Act and the major policy and service changes that have occurred in Victoria since the Act was passed in 1986. Recent developments in Victorian policy and in human rights law are also explored. The chapter concludes with a discussion of the proposed framework for reform.

Chapter 3 outlines the grounds on which a person can be placed on an involuntary order under the Act and processes for obtaining consent to psychiatric and non-psychiatric treatment under the Act. It also outlines some of the safeguards that accompany treatment, as well as how they could be strengthened. It examines assessment orders in other jurisdictions and raises key issues relating to the grounds for involuntary orders.

Chapter 4 describes the requirements in the Act designed to ensure that involuntary and voluntary patients are informed of, and involved in, their treatment and care. It considers strategies that may enhance the ability of patients to participate in decisions that affect them. These include ways to improve patients' understanding of their rights and involvement in treatment planning both before and during episodes of involuntary treatment.

Chapter 5 discusses a number of issues currently associated with electroconvulsive therapy (ECT) use in Victoria, particularly as they relate to patients who are unable to consent to ECT. It also examines whether licensing of ECT services is an effective and efficient way to regulate the safe performance of ECT.

Chapter 6 examines the use of restraint and seclusion in Victoria and explores whether further or different regulation is required.

Chapter 7 outlines the current arrangements in the Act for external reviews and appeals of involuntary orders. Consideration is given to how to achieve greater oversight of involuntary orders including more frequent reviews by a body external to mental health services.

Chapter 8 discusses the monitoring functions performed under the Act by the Chief Psychiatrist and community visitors, and considers the monitoring mechanisms in use in some other jurisdictions. It also examines clinical leadership roles, as well as the potential need to recognise codes of practice and clinical guidelines in the Act.

Chapter 9 examines the adequacy of the current Victorian complaint handling system for patients of mental health services, their families and carers. It explores ways in which the current system could be improved, as well as some of the features that are essential to an effective and efficient complaints system.

Chapter 10 outlines the circumstances in which identified information about patients of mental health services can be lawfully disclosed without their consent. Consideration is given to how the Act could improve information sharing, including with guardians, family members and carers, or to a person nominated by the patient.

1.3.1 Issues not addressed in this paper

Some of the issues raised in this paper may have resource and related workforce implications that are not discussed in detail in this paper. Potential resource implications associated with particular reform options will be discussed in the final report.

1.3.2 Review limitations

The principal focus of the Act is on people whose mental illness is severe and may necessitate involuntary treatment and care. While the Act regulates some structural and service delivery issues affecting broader mental health service provision for all patients, there are limitations on the kinds of systemic challenges that can be addressed through legislation. In many circumstances, these problems are more effectively dealt with through the kinds of policy reforms proposed in the whole-of-government mental health strategy, *Because mental health matters*, or in a combined policy and legislative response.

1.4 Community Consultation Panel

The Community Consultation Panel (the panel) is conducting the consultation phase of this review, including leading the public consultations and providing the Minister for Mental Health (the Minister) with advice on proposals for reform. The panel is supported by the legislation review team in the Mental Health and Drugs Division of the Department of Human Services (the department). The panel comprises the following people.



Mr Julian Gardner, Chair

Legal consultant specialising in human rights and social justice. Mr Gardner recently led a review of the *Victorian Equal Opportunity Act 1995*. He was Victoria's Public Advocate from 2000 to 2007 and prior to that he was president of the Mental Health Review Board. Mr Gardner has a strong background in community law.



Ms Dominique Saunders

Corporate Counsel at Western Health, sessional lawyer member of the Mental Health Review Board and a council member of the Law Institute of Victoria. Ms Saunders has previously worked as an advocate for mental health consumers and has a strong background in human rights law.



Mr Wayne Schwass

Mr Schwass' own personal experience with depression was the driving force behind him establishing The Sunrise Foundation of which he is the CEO. Mr Schwass played 282 VFL/AFL games for North Melbourne and the Sydney Swans between 1988 and 2002. He was a member of North Melbourne's 1995 pre-season premiership team and the 1996 AFL Centenary Premiership team.

Mr Ben Bodna AM was appointed in June 2008 as the inaugural chair of the panel. The panel, the Expert Advisory Group and the departmental staff involved in this review were all very saddened by Ben's sudden passing on 20 October 2008.

Ben was Victoria's first Public Advocate between 1986 and 1993. He was a former president of UNICEF Australia, a former president of Philanthropy Australia and was Director General of then Victorian Department of Community Welfare Services.

Ben's contributions to this review were marked by a strong sense of humanity towards people affected by mental illness. Ben showed an untiring enthusiasm to take on the intellectual challenge involved. This review will benefit from the legacy of goodwill that Ben has left behind.

1.5 Expert Advisory Group

The Expert Advisory Group consists of a range of stakeholders and key experts to inform this review, as listed below.

Mr Julian Gardner, Chair	Legal consultant specialising in human rights and social justice (also chair of the panel)
Ms Lisa Brophy	Chief Social Worker, North West Area Mental Health Service
Dr Thomas Callaly	Executive Director and Clinical Director, Mental Health, Drugs and Alcohol, Barwon Health
Ms Isabell Collins	Director, Victorian Mental Illness Awareness Council
Dr Ian Freckelton SC	Barrister
Hon Jim Kennan SC	Barrister
Hon Rob Knowles	Chair, Food Standards Australia New Zealand and Commissioner National Health and Hospital Reform Commission
Hon John McGrath AM	Chair, Mental Health Ministerial Advisory Committee
Ms Vivienne Topp	Lawyer, Mental Health Legal Centre Inc

1.6 Review timetable

The proposed timetable for the remainder of this review is:

- public consultation including meetings with key stakeholders in December 2008 to February 2009 and public forums in February 2009
- final report published in 2009
- public consultation on final report including meetings with key stakeholders in 2009
- Mental Health Bill to Parliament in 2010.

1.7 Relevant documents

If you intend to make a submission, you may wish to obtain copies of the Act and the *Mental Health Regulations 2008* (Vic). The legislation can be downloaded via the Victorian Legislative and Parliamentary Documents website at <www.legislation.vic.gov.au>.

Hard copies of the legislation are also available from:

Information Victoria
505 Little Collins Street
Melbourne VIC 3000
Tel: 1300 366 356
Website: www.bookshop.vic.gov.au

1.8 Further information and copies of this consultation paper

Further information on this review and copies of this consultation paper can be found at the department's website at <www.health.vic.gov.au/mentalhealth/mhactreview>. Hard copies can be obtained by contacting the review enquiry line on 1300 656 692. There is also a key questions paper for those who prefer to make a less detailed submission.

1.9 How to make a submission

Submissions must be in writing. To make a submission, please email <mhactreview@dhs.vic.gov.au> or send your written submission to:

The Community Consultation Panel
Mental Health Act Review
Mental Health and Drugs Division
Department of Human Services
GPO Box 4057
Melbourne VIC 3001

There is an optional template available on the website. If you require assistance in making a submission, please call the enquiry line on 1300 656 692.

Closing date for submissions is 5:00pm on Friday 27 February 2009.

Submissions will be treated as public documents and placed on the department's website at <www.health.vic.gov.au/mentalhealth/mhactreview>. If you do not want your submission to appear on the website, please mark it as confidential.

Please note: Notwithstanding any such marking, correspondence and submissions to the department may be the subject of a request for access under the *Freedom of Information Act 1982* (Vic). The department will notify you in circumstances where a request is made and where the department may be required to disclose your submission.

1.10 Questions

Each chapter of this consultation paper poses a series of questions on key issues. A list of the questions posed in this consultation paper is contained in appendix 1. These are not intended to be exhaustive and comments need not be limited to these questions.



2. Background and framework for reform

2.1 Introduction

The reform of the Act will be informed by responses to this paper and by a number of policy, system and legal developments. In particular, the new Act should be compatible with the charter and consistent with Australia's international human rights obligations. This is a new and complex area of law and policy. A key element of this review consultation process will be to gain input from the community on the best way to implement human rights obligations.

This chapter provides a brief overview of the Act and the major policy and service changes that have occurred in Victoria since the Act was passed in 1986. Recent developments in Victorian policy, as well as local and international human rights law, are also explored. The chapter concludes with a discussion of the proposed framework for reform, and seeks community input on these issues.

2.2 Background

2.2.1 1980s

The Act came into operation in 1987 after a five-year period of policy development and consultation. At the time, the Act sought to better define and protect the rights of people with serious mental illness consistent with international trends. It also reflected a desire for stronger clinician and service accountability and increased transparency in the regulation of involuntary treatment and care.

The objects of the Act introduced in 1987 provide for the treatment, care and protection of people with a mental illness as well as the protection of members of the public. They also provide for restrictions on individual liberty and interference with rights, dignity and self-respect to be kept to a minimum. The Act was the first in Australia to introduce involuntary treatment in the community.

The Act established grounds for involuntary treatment orders. It also established the Mental Health Review Board (the board) to enable external review of the authorised psychiatrist's decision to treat a person involuntarily, and to hear appeals. The Act incorporated oversight of certain interventions and treatments including ECT. In addition, the position of the Chief Psychiatrist was established to oversee the medical care and welfare of patients.

2.2.2 1990s

By the early 1990s, deficiencies in the quality of mental health care and policy across Australia led to the establishment of a national approach to mental health and the reorientation of institutionally based mental health services to those based in the community.¹ The 1991 *National mental health statement of rights and responsibilities* marked the commencement of this reform commitment between the Commonwealth, states and territories.² It was followed in 1992 by the *National mental health policy and National mental health plan*.³ Two subsequent plans have been endorsed nationally.

1 Australian states and territories are principally responsible for funding, delivery and management of both community and hospital-based mental health services. See also: Meadows G and Singh B (eds) 2001, *Mental health in Australia: Collaborative community practice*, Oxford University Press, Melbourne; Human Rights and Equal Opportunity Commission 1993, *Report of the National Inquiry into the Human Rights of People with Mental Illness*, Australian Government Publishing Service, Canberra.

2 Australian Health Ministers' Conference 1991, *Mental health statement of rights and responsibilities*, Australian Government Publishing Service, Canberra.

3 Australian Health Ministers' Conference 1992, *National mental health policy*, Australian Government Publishing Service, Canberra.

Consequently, the 1990s saw prolific policy and service redevelopment in Victoria.⁴ All Victorian stand-alone mental health services and their clinical workforces were integrated into the general hospital system. Direct management of services also passed from the department to general hospitals. Twenty-one area-based mental health services were created to deliver public specialist mental health services across Victoria, and to respond to the different needs of individuals over time.

Structural reforms resulted in the highest and most restrictive level of care being provided in acute and secure extended care inpatient beds. The community-based services that were created include psychiatric crisis intervention, continuing care, assertive outreach, community residential support and community bed-based alternatives to acute admission.⁵ As part of these reforms, Victoria's non-clinical psychiatric disability rehabilitation and support (PDRS) service system also expanded significantly.

A review of the Act commenced in 1994 to reflect these structural reforms. As part of the review, the Act was reconfigured to reflect the integration of public mental health services with general health services. The review also took account of the 1991 United Nations' *Principles for the protection of persons with mental illness and for the improvement of mental health care* and the *National mental health statement of rights and responsibilities*.⁶ National model mental health legislation was developed in 1994 and also influenced the review.⁷ Clear principles of treatment and care were incorporated into the Act and its overarching objects were amended to increase consistency with these documents.⁸

4 Department of Health and Community Services 1994, *Victoria's mental health service: the framework for service delivery*, Victorian Government, Melbourne; Department of Health and Community Services 1994, *Victoria's mental health service: improving access through co-ordinated client care*, Victorian Government, Melbourne; Department of Health and Community Services 1996, *Better outcomes through area mental health services*, Victorian Government, Melbourne.

5 Area mental health services also have access to statewide or regional specialist services. These include: forensic mental health services, secure extended care services, personality disorder services, mother and baby services, transcultural services, Aboriginal services, and services for persons with eating disorders, dual diagnosis, dual disability or brain disorders.

6 United Nations 1991, *Principles for the protection of persons with mental illness and for the improvement of mental health care* (the UN Principles), GA Res 46/119, UN DOC A/Res/46/119.

7 The University of Newcastle Centre for Health Law, Ethics and Policy 1994, *Report to the Australian Health Ministers' Advisory Council National Working Group on model mental health legislation*, vol. 1, Department of Human Services and Health, Newcastle.

8 An overview of key provisions of the current Act, including the objects and principles, is contained in appendix 2.

2.2.3 Other key amendments to the Act

Recent amendments have ensured the Act's effective continued operation, particularly in light of the community-based model of care. These include:

- strengthening the Chief Psychiatrist's powers to visit mental health services and enabling senior clinicians from the sector to assist the Chief Psychiatrist in conducting investigations and monitoring functions
- introducing stand-alone forensic mental health services governed by a council established by the Act
- further refining of the objects, definitions and grounds for involuntary treatment in the Act
- refining the community treatment order provisions
- introducing mandatory treatment plans for involuntary patients, together with a requirement for review of these plans by the board
- establishing cross-border provisions to facilitate the interstate transfer of patients.

For a summary of the current operation of the service system, see appendix 3.

2.3 Current application of the Act

The specialist public mental health services described above have continued to develop since the reforms of the mid 1990s. A person may now access the specialist system in a number of ways, including referral via a general practitioner or private psychiatrist, or through family or friends.⁹ A person may also seek assistance through a hospital emergency department, the police or other emergency or crisis services.

There are approximately 60,000 Victorians currently registered as patients of specialist public mental health services. Of these, the Act applies predominantly to people whose mental illness is severe and who are found to require treatment involuntarily.¹⁰ In these circumstances, the person must have refused or be unable to consent to the necessary treatment and care and require immediate treatment for their health or safety or the protection of the public. There also must be no less restrictive manner in which treatment can be provided. Approximately 9,000 registered patients, most commonly adults, were involuntary for some period during 2007–08.¹¹ The Act is used far less frequently for children and adolescents.¹²

9 Primary mental health care services, especially general practitioners, are increasingly the first contact point for people with a mental health issue and play a vital role in early identification and referral of people with serious mental health issues.

10 The most common diagnoses of people receiving public mental health services are schizophrenia and major affective disorder: Department of Human Services 2008a, Operational Data Store, Unpublished data.

11 In 2007–08, 15.5 per cent of patients registered on the shared electronic records system within public sector mental health services in the 18–24 age group were involuntary for some period in the year, compared with 19.9 per cent of adults in the 25–65 age group. Approximately 11 per cent of registered patients in the aged care sector were involuntary at some period during 2007–08: Department of Human Services, 2008a.

12 In 2007–08 approximately 3 per cent of registered patients under 18 years of age were treated involuntarily for some period in the year: Department of Human Services, 2008a.

Involuntary treatment can only be provided through an approved mental health service. Each approved mental health service must appoint an authorised psychiatrist whose statutory responsibilities and powers include the power to consent to treatment on behalf of an involuntary patient. The Act also sets out the responsibilities of medical practitioners and nurses. In addition, it regulates the functions of psychologists, social workers and occupational therapists who may be involved in a patient's treatment and care.

2.4 The need for a new vision

Recent policy and human rights developments have created the impetus for this review of the Act. These include the current development of a new statewide strategy for Victorian mental health services, the introduction of the charter and the ratification of the *International Convention on the Rights of Persons with Disabilities* (Disabilities Convention).¹³ The impact of each of these developments is explored below.

2.4.1 *Because mental health matters*

In late 2006 work commenced on a new Victorian whole-of-government mental health strategy. In May 2008, following targeted consultations with stakeholders, the Minister released the *Because mental health matters* consultation paper.¹⁴ While acknowledging Victoria's strong record in mental health service reform over many years, the paper recognises that there are existing and emerging gaps in the current system.

The *Because mental health matters* consultation paper argues that a more balanced system of clinical, psychosocial, primary and acute care is required with greater engagement of general health and social services.¹⁵ It articulates a reform vision underpinned by prevention and recovery imperatives. The vision includes all Victorians having the opportunities they need to achieve optimal mental health and wellbeing, with those experiencing mental health problems receiving timely, quality treatment and support to enable full community participation.

A large number of submissions have been received in response to the *Because mental health matters* consultation paper, which will contribute to the development of a new mental health strategy by the end of 2008. This review of the Act will be informed by the strategy vision for Victoria's future mental health service system.

2.4.2 *Charter of Human Rights and Responsibilities*

The charter commenced full operation in 2008 and enshrines a number of rights derived from the *International Convention on Civil and Political Rights*.¹⁶ The charter provides a legislative framework that protects and promotes human rights in Victoria. The new Act should be compatible with the rights protected in the charter.

13 *Convention on the Rights of Persons with Disabilities* (Disabilities Convention), Opened for signature 13 December 2007, GA Res 61/106, UN Doc A/Res/61/106, (entered into force 3 May 2008).

14 Department of Human Services 2008b, *Because mental health matters: A new focus for mental health and wellbeing in Victoria, Consultation paper*, Victorian Government, Melbourne.

15 Department of Human Services, 2008b.

16 *International Convention on Civil and Political Rights*, Opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

Currently, the Act is likely to engage a number of charter rights. These include rights to:

- recognition and equality before the law (section 8)
- life (section 9)
- protection from torture and cruel, inhuman and degrading treatment (sections 10(a)–(b))
- be free from medical or scientific experimentation or treatment without full, free and informed consent (section 10(c))
- freedom of movement (section 12)
- privacy and reputation of person (section 13)
- protection of children in their best interests (section 17)
- enjoy one’s own culture (section 19)
- liberty and security of person (section 21)
- humane treatment when deprived of liberty (section 22)
- a fair hearing (section 24).

The charter recognises that human rights are not absolute but may be limited in certain circumstances, taking into account certain factors. Section 7 of the charter provides that a human right may be subject only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom and taking into account all relevant factors including:

- 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
- any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

2.4.3 International Convention on the Rights of Persons with Disabilities

The Disabilities Convention commenced operation on 3 May 2008.¹⁷ It was ratified by the Australian Government on 17 July 2008. The purpose of the Disabilities Convention is to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities (including mental illness), and to promote respect for their inherent dignity’.¹⁸ A number of its provisions are relevant to this review of the Act, including rights to:

- equality and non-discrimination (Article 5)
- consider the best interests of the child as primary in all actions concerning children (Article 7)
- equal recognition as persons before the law (Article 12)¹⁹
- safeguards relating to the exercise of legal capacity to prevent abuse including measures that respect a person’s rights, will and preferences (Article 12(4))

¹⁷ For further discussion of the Disabilities Convention, see Lawson L 2007 ‘The United Nations Convention on the Rights of Persons with Disabilities: New era or false dawn?’, *Syracuse Journal of International Law and Commerce*, vol.34, no.2.

¹⁸ Disabilities Convention, art 1.

¹⁹ Article 12 of the Disabilities Convention also requires that countries recognise that people with disabilities enjoy legal capacity on an equal basis with others in all aspects of life and shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

- effective access to justice on an equal basis with others (Article 13)
- liberty and security of person on an equal basis with others and freedom from unlawful or arbitrary deprivation of liberty (Article 14)
- freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15)
- respect for physical and mental integrity on an equal basis with others (Article 17)
- live independently in the community (Article 19)
- respect for privacy (Article 22)
- equal access to health services including on the basis of free and informed consent (Article 25).

Countries that have ratified the Disabilities Convention are required to adopt strategies to pursue the general obligations and ensure the full realisation of all human rights for all people with disabilities.²⁰ Commentators have argued that the Disabilities Convention has ushered in a ‘new era’ in human rights and that its detailed provisions require ‘reshaping of societies in a way required by no other human rights treaty’.²¹

The Disabilities Convention therefore raises a range of issues for this review of the Act. For example, some commentators have argued that Article 17 will severely limit treatments such as ECT.²² It has also been argued that the Disabilities Convention contains a presumption that people with disabilities are capable of making their own decisions and any other form of decision making must be seen as a measure of last resort.²³ Some commentators have argued the Disabilities Convention may therefore shift the focus from substituted decision making (as currently provided for in the Act) to supported decision making.²⁴ This review seeks input on these issues.

2.5 The framework for reform

In light of the developments in human rights law and changes in mental health policy, the Act requires reconsideration for a new era. The service system and domestic and international policy context are now vastly different to those that confronted government in the early 1980s. While the Act has been amended frequently since 1986 to keep pace with policy and service reforms, frequent amendment over time has arguably made the legislative scheme more complex to interpret and less internally consistent. As in 1986, the new Act must look to the future.

A fundamental threshold issue is whether an involuntary treatment scheme should be maintained and, if so, whether it should be stand-alone legislation or form part of generic capacity legislation. This reflects complex debates about how best to balance respect for personal autonomy and intervention when a person poses a risk to themselves or others. Despite these debates, most international and local jurisdictions have maintained involuntary treatment schemes in separate mental health legislation.

20 Disabilities Convention, art 4(1).

21 Lawson, 2007 p.618.

22 McSherry, B 2008a, ‘Opening minds not locking doors’, paper presented at Monash University Educate 08 50th Anniversary Public Lecture, October, Melbourne, p.14.

23 McSherry, 2008a p.12, citing Kayess R and Fogarty B 2007, ‘The Rights and Dignity of Persons with Disabilities: A United Nations Convention’, *Alternative Law Journal*, vol.32, no.1, pp.22–23.

24 McSherry, 2008a, citing Lawson, 2007 p.597; Weller P ‘Supported decision-making and the achievement of non-discrimination: The promise and paradox of the Disabilities Convention’ in McSherry B (ed) 2008b, *Law in context: International trends in mental health laws*, The Federation Press, Annandale, pp.85–110.

Consistent with these approaches, it is intended that Victoria will maintain a scheme for involuntary treatment under separate mental health legislation and this consultation paper reflects this position. Stand-alone mental health legislation currently provides the best means to articulate and protect patients' rights and maximise individual autonomy in Victoria. In an increasingly complex mental health service system, stand-alone legislation will enable statutory safeguards that respond specifically to the identified needs of people with serious mental illness and those who support them.

As indicated in chapter 1, this paper will examine possible ways to strengthen or improve:

- the Act's role in promoting recovery
- patient participation in treatment and care decisions, including placing patients at the heart of the Act
- the existing rights-based approach to involuntary treatment and care
- the effectiveness and accessibility of mechanisms to oversee treatment and care
- the Act's responsiveness to the needs of families and carers.

These themes reflect the government's priorities for the new Act. The following provides an overview of how they are dealt with in this consultation paper, and how the Act's objects, principles and departmental objectives might be reframed to support these priorities. Input is then sought on these issues.

2.5.1 The Act's role in promoting recovery

The *Because mental health matters* consultation paper describes a recovery orientation that promotes access to responsive, patient-centred, effective and coordinated support and treatment.²⁵ This review will explore how a recovery orientation can be better reflected in the Act. A primary consideration in this review involves exploring the ways in which diverse needs of individuals could be better recognised and respected in the Act.²⁶

2.5.2 Patient participation in decisions about treatment and care

Supporting patients to participate in decision making is a key contributor to the effective protection of human rights.²⁷ The way patients are currently informed of their rights and the provisions relating to treatment plans are considered in this context. The creation of an advance statement scheme is also explored. A number of the chapters discuss the best way to support patient participation in decisions about treatment and care. As a result, improved safeguards and increased access to support and advocacy are also explored.

2.5.3 A stronger human rights focus

This review will aim to ensure that the new Act appropriately protects human rights in light of the charter and Australia's international human rights obligations. Recent human rights developments raise major implications for the Act and this is a new and complex area of law and policy. An important aspect of this review consultation process is to gain input from the community on the best way to implement human rights obligations.

²⁵ Department of Human Services, 2008b.

²⁶ Sections 5(a)(ii) and 6A(g) of the Act require that the needs of people be taken into account by the department and service providers when treatment and care decisions are being made.

²⁷ A number of relevant instruments recognise the principle that patients should be actively involved in treatment decisions. See: World Health Organization 1996, *Mental health care law: Ten basic principles*, WHO, Geneva, Principle 5; Disabilities Convention, Preamble para (n).

2.5.4 Effective and accessible mechanisms to oversee treatment and care

Effective and accessible mechanisms to monitor treatment and care and deal with complaints underpin the framework for reform. This paper examines how patient wellbeing could be monitored and the optimal structures to achieve this. Current mechanisms for complaint handling are also discussed including how these processes could be strengthened.

2.5.5 Responsiveness to the needs of families and carers

Consistent with the *Because mental health matters* consultation paper, this paper explores how the Act could better respond to the needs of families and carers. In particular, it considers the issues surrounding information sharing with families and carers, and other ways in which the roles of families and carers might be formally recognised in the Act.

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

2.6 The objects and principles in the Act

In order to implement these priorities, it is anticipated that the existing principles, departmental objectives and functions in the Act will require amendment.²⁸ Some of the ways in which this might occur include:

- an explicit recognition in the principles that treatment should be voluntary wherever possible and that any decision about a patient must take into account the patient's views, wishes, beliefs and values to the greatest extent practicable
- a principle that mental health services protect rights, minimise interferences with them and promote rehabilitation and recovery
- a function to support development of mental health services to assist carers and facilitate the provision of information, education and support to carers.

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

28 These are contained in sections 4 and 6A of the Act, and are summarised in appendix 2.

3. Involuntary orders

3.1 Introduction

Outside the mental health context, the law generally recognises the right to consent to, or refuse, medical treatment. In the mental health context, laws can operate to limit this right. Contemporary mental health legislation limits the circumstances in which involuntary treatment can be given by defining what constitutes mental illness and by containing grounds that must be met before a person can be treated involuntarily.¹

The provision of involuntary treatment raises many of the rights contained in the charter and Disabilities Convention.² Importantly, the charter contains the right to protection from medical treatment without ‘full, free and informed consent’ and the Disabilities Convention contains a right to respect for physical and mental integrity for people with disabilities, including people with a mental illness, on an equal basis with others.³

It has been argued that the Disabilities Convention contains a presumption that people with disabilities, including people with a mental illness, are inherently capable of making their own decisions and any other form of decision making must be seen as a measure of last resort.⁴ It is therefore necessary to reconsider the framework of the Act that enables substitute consent to most treatments by the authorised psychiatrist.

This chapter outlines the grounds on which a person can be placed on an involuntary order under the Act and processes for obtaining consent to psychiatric and non-psychiatric treatment under the Act. It also outlines some of the safeguards that accompany treatment, as well as how they could be strengthened. It examines assessment orders in other jurisdictions and raises key issues relating to the grounds for involuntary orders.

3.2 Victorian legislative framework

3.2.1 Grounds for involuntary orders

The primary objective of the Act is to provide for the care, treatment and protection of mentally ill people who do not or cannot consent to that care, treatment or protection.⁵ The Act limits who can be treated involuntarily. It defines ‘mental illness’ and contains five grounds that must all be met before a person can be placed on an involuntary order. The grounds are as follows.⁶

- **Appears to be mentally ill:** The person must appear to be mentally ill. Mental illness is defined in the Act as ‘a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory’.⁷ A person cannot be considered to be mentally ill solely because of certain beliefs or views.⁸

1 The term ‘grounds’ is used in this consultation paper to describe the legal ‘criteria’ for placing a person on an involuntary order.

2 See chapter 2 for an overview of the rights engaged by the Act.

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

4 McSherry B 2008, ‘Opening minds not locking doors’, paper presented at Monash University Educate 08 50th Anniversary Public Lecture, October, Melbourne p.7, citing Kayess R and Fogarty B 2007, ‘The rights and dignity of persons with disabilities: A United Nations Convention’, *Alternative Law Journal*, vol.32, no.1, pp.22–23.

5 The Act, s 4(1)(a).

6 The Act, s 8(1).

7 The Act, s 8(1A). The definition covers psychotic disorders such as schizophrenia and non-psychotic disorders such as disorders of mood, severe obsessive compulsive disorder, anorexia nervosa and dementia.

8 The Act, s 8(2).

- **Requires immediate treatment:** The person's mental illness must require immediate treatment obtainable on an involuntary order.
- **Necessary for health or safety or public protection:** Because of the person's mental illness, involuntary treatment must be necessary for the person's health or safety (whether to prevent a deterioration in physical or mental condition or otherwise) or for the protection of members of the public.
- **Refusal or inability to consent:** The person must have refused or be unable to consent to necessary treatment for the mental illness. There is no definition in the Act of what constitutes capacity to consent to treatment.⁹
- **No adequate less restrictive treatment available:** The person must not be able to receive adequate treatment for the mental illness in a manner that is less restrictive of the person's freedom of decision and action.

3.2.2 Making involuntary orders

The Act sets out the process for making involuntary orders, including the powers that can be used to apprehend and transport a person to a mental health service to enable this to occur. This process is summarised in appendix 4. It consists of a 'request' and 'recommendation' that a person be placed on an involuntary order.¹⁰ If an involuntary order is made by a medical practitioner or mental health practitioner, the authorised psychiatrist must examine the person within 24 hours to confirm whether or not the person meets the grounds for an involuntary order.¹¹

Interim psychiatric treatment can be provided after an involuntary order is made but before the authorised psychiatrist has confirmed the order. A medical practitioner can consent to interim psychiatric treatment if the person requires immediate treatment, is unable to consent and the treatment is in the person's best interests.¹² If the person has the capacity to consent but refuses to consent, interim psychiatric treatment cannot be provided.

Within 24 hours, the authorised psychiatrist must confirm whether or not the person meets the grounds for an involuntary order. The authorised psychiatrist must discharge the person if the person is found not to meet all five grounds; otherwise, the authorised psychiatrist must confirm the involuntary order.¹³ The Act requires that, wherever possible, people should be treated in the community.¹⁴ This means that when confirming an involuntary order the authorised psychiatrist must, wherever possible, order that the person receive the involuntary treatment in the community

9 Clinicians rely on the common law test to determine whether a person has capacity. In summary the test is whether or not the person understands the nature of the illness and the proposed treatment, any alternatives and the option of no treatment. For examples of a capacity test in Victorian legislation see section 36(2) of the *Guardianship and Administration Act 1986* (Vic), and section 85(3) of the *Health Records Act 2001* (Vic).

10 The Act, s 9.

11 The Act, s 12AC.

12 The Act, s 12AB.

13 The Act, ss 12AC(2)(a)–(b), 37. However, under sections 12A–D of the Act the authorised psychiatrist can apply in writing to the Chief Psychiatrist to continue the involuntary detention and treatment of a person for a period of three months where, though not satisfying the grounds for an involuntary order, the person meets other strict criteria as confirmed by a committee of three psychiatrists including the Chief Psychiatrist. These provisions have never been exercised.

14 The Act, ss 4(2)(a)–(b), 6A(b).

on a community treatment order rather than as an inpatient on an involuntary treatment order.¹⁵ If the authorised psychiatrist does not make a community treatment order the person will receive involuntary treatment as an inpatient.

The Act does not specify the duration of an involuntary treatment order or the frequency at which a person must be clinically reviewed. A person on a community treatment order must be clinically reviewed at 'regular intervals' to ensure they continue to meet the grounds for involuntary treatment.¹⁶ A community treatment order can be made for up to 12 months and can be extended for further periods not exceeding 12 months.¹⁷ The authorised psychiatrist must examine the person before extending the order. There is no limit to the number of times a community treatment order can be extended.

3.2.3 Psychiatric treatment

The Act requires that involuntary patients must be given treatment for their mental illness and must have a treatment plan.¹⁸ Treatment is defined in the Act as using professional skills to 'remedy' the mental illness or 'lessen its ill effects or the pain and suffering which it causes'.¹⁹ After the authorised psychiatrist has confirmed an involuntary treatment order, it is generally the authorised psychiatrist who consents to and determines psychiatric treatment if the person has refused or is unable to consent.²⁰ The Act excludes legally appointed guardians and agents from being able to consent to psychiatric treatment for involuntary patients who are unable to consent.²¹

However, under the Act, psychosurgery and ECT have different requirements in relation to consent. Psychosurgery can only be performed on a person who has provided informed consent to the procedure and where the Psychosurgery Review Board has also provided consent.²² ECT can be performed on a person who has provided informed consent;²³ however, where a person is unable to give informed consent to ECT, consent may be provided by the authorised psychiatrist.²⁴

3.2.4 Non-psychiatric treatment

Non-psychiatric treatment can be provided to a person who has given informed consent; however, in an emergency urgent non-psychiatric treatment can be provided without consent.²⁵ The requirements for informed consent to non-psychiatric treatment are different depending on whether the treatment is major non-psychiatric treatment (such as chemotherapy) or other

15 The Act, ss 12AC(5), 14. Detailed information about the operation of community treatment orders can be found in the Department of Human Services 2005, *Chief Psychiatrist's guideline: Community treatment orders*, Victorian Government, Melbourne, available at <www.health.vic.gov.au/mentalhealth/cpg/cto.htm>.

16 The Act, s 14A.

17 The Act, ss 14(3)(a), 14B.

18 The Act, ss 12AD(1), 19A. Treatment plans are considered in chapter 4.

19 The Act, s 3.

20 The Act, s 12AD(2).

21 The Act, s 3A(b)-(c).

22 Psychosurgery is defined in section 54(1) of the Act as surgery on the brain with the purpose of altering a person's thoughts, emotions or behaviour. Part 5, Division 1 of the Act governs the use of psychosurgery in Victoria.

23 See section 53B of the Act for requirements relating to informed consent to psychosurgery, ECT and major non-psychiatric treatment. Under section 84 of the Act a failure to comply with these requirements is an offence.

24 Consent arrangements for ECT are discussed in chapter 5.

25 The Act, s 84(3).

non-psychiatric treatment.²⁶ The requirements for informed consent to major non-psychiatric treatment are the same as for psychosurgery and ECT. These requirements reflect the seriousness of major non-psychiatric treatment and the practice in general health where people are not required to give written consent to minor medical procedures.

The Act does not allow the authorised psychiatrist to provide substitute consent for any person who has the capacity to consent to non-psychiatric treatment. Rather, there is a requirement that the person give informed consent as referred to above. Where an adult involuntary patient is unable to give informed consent to any non-psychiatric treatment, consent may be given by the person's legal guardian or agent.²⁷ In the case of a child or young person, consent to non-psychiatric treatment may be given by a parent or guardian.²⁸ The authorised psychiatrist can provide consent for an adult, child or young person who is unable to give informed consent if there is no guardian or agent available, willing or able to make the decision.²⁹

The Act also requires that every involuntary patient must be examined at least once a year to assess their mental and general health.³⁰ The Act is unclear in relation to whether the annual examination of an involuntary patient can take place if the person does not consent. The authorised psychiatrist is required to send a report of the examination to the Chief Psychiatrist.³¹

3.3 Rethinking involuntary orders

3.3.1 Definition of mental illness

One of the ways in which the Act limits who can be treated involuntarily is by defining what constitutes mental illness. The definition of 'mental illness' in some other jurisdictions means a medical condition that, in addition to being characterised by a significant disturbance of thought, mood, perception or memory as is the case in Victoria, may also be characterised by an impairment of 'volition' and 'orientation'.³² These definitions also include a list of symptoms that must be present and require that, in determining whether a person has a mental illness, internationally accepted medical standards must be followed.

The Act specifies exclusions on which basis alone a person may not be considered to be mentally ill.³³ For example, a person cannot be considered to be mentally ill due only to an antisocial personality. However, a person with an antisocial personality can be placed on an involuntary order if they also 'appear to be mentally ill' and meet the other grounds for an involuntary order.

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

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

26 The Act, ss 53B, 83(2). Pursuant to section 84(1) of the Act the Chief Psychiatrist decides which procedures are classified as major non-psychiatric treatment. For further information on the procedures, see: Department of Human Services 2008, *Chief Psychiatrist's guideline: General medical health needs, annual examination, non-psychiatric treatment, special procedures and medical research procedures*, Victorian Government, Melbourne, p.6.

27 The Act, s 85(1)(a)(i)-(v).

28 The Act, s 85(1)(b)(i)-(iii).

29 The Act, ss 85(1)(a)(v), 85(1)(b)(iv).

30 The Act, s 87(1).

31 The Act, s 87(2).

32 See, for example: section 6 of the *Mental Health and Related Services Act 1998* (NT).

33 The Act, s 8(2).

3.3.2 Assessment order

One of the grounds in the Act is that *the person appears to be mentally ill*. This means there need only be an appearance of a mental illness for a person to be made an involuntary patient rather than an actual diagnosis of mental illness. Unlike Victoria where there is a single set of grounds for involuntary orders, some jurisdictions separate the involuntary treatment process into stages with different grounds. Typically these include an assessment order, a second stage order and a third stage order. The first stage is an assessment order that allows for a period of assessment prior to a diagnosis of mental illness. Second and third stage orders allow involuntary treatment following a diagnosis of mental illness as an inpatient or in the community.

An assessment order typically lasts around one to five days during which an assessment is conducted (usually by a medical practitioner) to decide whether a person meets the grounds for involuntary treatment.³⁴ An advantage of an assessment order is that the grounds for making second and third stage orders can be stricter than the grounds for making an assessment order.³⁵ This approach provides greater clarity about when a person can be involuntarily assessed to determine whether or not they meet the grounds for involuntary treatment.

In Queensland the assessment stage requires that a person ‘appear to have a mental illness’.³⁶ A second stage order can then be made only if the person meets the stricter grounds for involuntary treatment that require that the person ‘has a mental illness’.³⁷ Involuntary treatment cannot be given during the assessment stage in Queensland. However, some jurisdictions allow involuntary treatment to be given during the assessment stage.³⁸

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

3.3.3 Grounds for involuntary orders

As described above, the Act contains five grounds that must all be met before a person can be placed on an involuntary order. In other jurisdictions there are a range of approaches to the grounds for an involuntary order. These approaches raise key issues for consideration including how to address a person’s refusal or inability to consent to treatment and the level of risk to the person or others required for the making of an involuntary order. These key issues are discussed in the following paragraphs.

34 For example, in Queensland a person can be detained for assessment for an initial period of 24 hours, which can be extended and further extended for a maximum duration totalling 72 hours, whereas in New Zealand the first assessment period is five days and can be extended for two further periods of 14 days each.

35 Short-term and longer term orders are considered in chapter 7.

36 *Mental Health Act 2000* (Qld), s 13(1)(a).

37 *Mental Health Act 2000* (Qld), s 14(1)(a).

38 *Mental Health Act 2000* (Qld), s 44. For example, New Zealand allows involuntary treatment during an assessment stage.

3.3.3.1 Refusal or inability to consent

In Victoria, one of the five grounds that must be met before a person can be placed on an involuntary order is that the person *has refused or is unable to consent to necessary treatment for the mental illness*.³⁹ In the Northern Territory and Queensland, a person with capacity can be placed on an involuntary order if they have ‘unreasonably refused’ proposed treatment.⁴⁰ Some commentators question whether it is ever appropriate to involuntarily treat a person who has capacity to consent and has refused treatment. Deciding whether a person has capacity to consent can also be difficult due to the lack of guidance for clinicians as to the basis on which this decision may be made.⁴¹ There are no requirements in the Act for clinicians to follow when making this decision.

In Scotland, the grounds include that a person’s ability to make decisions about treatment is ‘significantly impaired’ by their mental illness.⁴² The underlying basis for this ground is that a person with a mental illness may have capacity, yet their ability to make decisions may, at times, be significantly impaired. The other grounds in Scotland are: that the person has a mental disorder; treatment is available and will benefit the person; if treatment is not provided there will be a significant risk to the person or others; and the order is necessary.⁴³ Deciding whether a person’s ability to make decisions about treatment is significantly impaired may be a clearer test to apply than deciding whether a person has capacity because it is less legalistic. It may also be similar to a ‘lack of insight’ test. There is much debate about what it means to lack insight. As a result, most international and local jurisdictions do not have an insight test in their grounds for making involuntary orders.

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

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

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

Q9. In what circumstances, if any, should the new Act permit a person to be placed on an involuntary order where the person has capacity to consent and is refusing treatment?

3.3.3.2 Risk to the person or others

In Victoria, another of the grounds that must be met is that *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*. To meet this ground, treatment must be necessary for only one of these purposes. For example, it is sufficient if treatment is necessary for the person’s health or safety to prevent deterioration in the person’s mental condition.

³⁹ The Act, s 8(1)(d).

⁴⁰ *Mental Health and Related Services Act 1998* (NT), s 14(b)(iii); *Mental Health Act 2000* (Qld), s 14(1)(f).

⁴¹ Clinicians rely on the common law test to determine whether a person has capacity.

⁴² *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 64(5)(d).

⁴³ *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 64(5).

Some commentators argue that involuntary treatment should only be permitted to protect the person or others from serious harm or death.⁴⁴ The argument is that involuntary treatment to protect the person's health or safety or to protect others (where no level of seriousness is specified) is unlikely to be sufficient for involuntary treatment. It has also been argued that raising the level of seriousness required may prevent timely intervention before a crisis is reached.⁴⁵

In other jurisdictions there are a range of approaches to the seriousness and immediacy of risk required. Some jurisdictions have a similar ground to Victoria.⁴⁶ Other jurisdictions require a likelihood of *serious* or *imminent* or *significant* risk to the person or others. For example, in the Australian Capital Territory there must be a likelihood of 'serious harm' to self or others or 'serious' mental or physical deterioration.⁴⁷ In the Northern Territory there must be a likelihood of 'imminent harm' to the person or others, or 'serious mental or physical deterioration'.⁴⁸ In Scotland the grounds include that there must be a 'significant risk' to the person's health, safety or welfare *or* to the safety of any other person.⁴⁹ There is also a separate ground that requires that treatment is 'available' for the person '*which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms, or effects, of the disorder*'.⁵⁰ In Victoria, the Act does not require that the treatment be likely to be effective. Such a requirement may assist in clarifying what is regarded as 'necessary' treatment.

Q10. How should the new Act address the issue of the seriousness and immediacy of risk in the grounds for an involuntary order as they apply to: (a) The person? (b) Others?

3.3.3.3 Other grounds

The range of approaches to the grounds required for an involuntary order raise many other issues for consideration. For example, in many other jurisdictions the ground 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* is not included. Where a person is no longer in the acute phase of an illness, deciding whether or not a person requires immediate treatment can be difficult, both for the authorised psychiatrist and for the board when conducting reviews and appeals. The board has stated that deciding whether a person requires immediate treatment involves an evaluation of the likelihood of imminent relapse, the possible severity of relapse and the degree of disruption a relapse would be likely to cause should the person immediately cease medication.⁵¹

44 See, for example: Richardson G 2005, 'The European Convention and mental health law in England and Wales: Moving beyond process?' in *International Journal of Law and Psychiatry*, vol.28, no.2, p.134.

45 See: Diesfeld K and Freckelton I 2006, 'Mental health law and therapeutic jurisprudence' in Freckelton I and Petersen K 2006, *Disputes and Dilemmas in Health Law*, The Federation Press, Annandale, p.99.

46 For example, in Western Australia and South Australia.

47 *Mental Health (Treatment and Care) Act 1994* (ACT), s 28(b).

48 *Mental Health and Related Services Act 1998* (NT), s 14(b)(ii).

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

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

51 *RD* (1997) VMHRBD 10 (30 April 1997) 425.

The remaining ground that must be met is that *the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of action or decision*. There are a range of views about what constitutes the least restrictive manner of providing treatment to a person. In considering this ground the board has regard to: the state of the person's health; their capacity to consent to treatment required for their illness; the availability of adequate and appropriate services; and the patient's social circumstances.⁵²

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

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

3.3.4 Consent to treatment and safeguards

Actively involving patients in decisions about their treatment and care recognises the importance of autonomy and independence including the freedom to make their own choices.⁵³ The Act currently recognises the ability of involuntary patients to consent to a limited range of treatments, such as ECT, psychosurgery and non-psychiatric treatment, by providing for informed consent to these treatments. Some jurisdictions recognise the ability of involuntary patients to provide informed consent to a wider range of treatments.

For example, in Scotland, where there is an 'significant impairment' ground, unless treatment is urgently required an involuntary patient is given an opportunity to consent to a wide range of treatments while remaining on an involuntary order.⁵⁴ If a clinician considers an involuntary patient is unable or refusing to consent, before providing treatment the clinician must consider: the person's reason for not consenting; the views of the involuntary patient and a nominated person together with any advance statement;⁵⁵ and the efficacy of the treatment. Further, treatment can only be provided if it is in the person's best interests and the clinician must record the reasons in writing.⁵⁶

In Scotland there are additional safeguards if treatment is to continue beyond two months. An involuntary patient who is unable or refusing to consent can only receive medication after two months if an independent psychiatrist provides a second opinion that the person is unable to consent, or is refusing consent, and the proposed treatment is in the person's best interests.⁵⁷ The reason for refusal must also be taken into account. Second psychiatric opinion schemes also exist in New Zealand, England and Wales.⁵⁸ The scheme in England and Wales involves a panel of psychiatrists engaged by the Mental Health Act Commission (MHAC), an independent multidisciplinary commission.

52 The Act, s 8(1)(e).

53 Disabilities Convention, Preamble (n)-(o).

54 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), ss 242(3), 243.

55 Advanced statements are discussed in chapter 4.

56 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 242(5).

57 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 240(4).

58 *Mental Health Act 1983* (England and Wales), s 58; *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), s 59(2)(b).

The Act does not make any special provision for issues relating to the capacity of children and young people. In practice, the parent or guardian of a child is permitted to consent to psychiatric treatment where the child cannot consent due to their level of maturity, rather than due to their mental illness. The advantage of this approach is that children and young people are generally treated as voluntary patients. The disadvantage is that children and young people do not have the benefit of the safeguards that apply to involuntary patients, such as automatic external review of their orders by the board nor the right to appeal to the board.

- Q13. What requirements, if any, should the new Act contain to enable involuntary patients to provide informed consent to a wider range of psychiatric treatment?**
- Q14. If a second psychiatric opinion scheme is considered necessary, in what circumstances should the new Act require a second opinion?**
- Q15. What additional safeguards, if any, in relation to treatment decisions made by the authorised psychiatrist should the new Act include?**
- Q16. Should the new Act include a best interests requirement in relation to treatment decisions made by the authorised psychiatrist?**
- Q17. How should the new Act address the issue of children and young people who do not have capacity to consent to treatment due to their mental illness?**

3.3.5 Frequency of clinical review and annual review

Regular clinical reviews are necessary to monitor whether involuntary patients continue to meet the grounds for involuntary treatment. They are also a means to ensure that involuntary patients are being provided with appropriate treatment and are being treated in the least restrictive environment and in the least intrusive manner possible. As noted above, the Act does not specify the frequency of clinical reviews for involuntary inpatients. However, the role of the treating team includes monitoring the ongoing need for involuntary treatment.

Mental health laws in some jurisdictions specify the frequency of clinical reviews. For example, in New South Wales clinical reviews must be carried out at intervals of not more than three months.⁵⁹ In addition, external reviews by a tribunal must occur at the end of an initial stage, at least once every three months in the first year of an order and at least six monthly thereafter.⁶⁰

⁵⁹ *Mental Health Act 2007 (NSW)*, s 39.

⁶⁰ *Mental Health Act 2007 (NSW)*, s 37(1).

The Act requires the authorised psychiatrist to conduct an annual examination of the mental and general health of every involuntary patient, yet is unclear about whether this can occur if a person refuses to give consent.⁶¹ The annual examination requirement is critical for a number of reasons. It provides an opportunity to identify any medical conditions that require treatment and ensures any side effects of psychiatric treatment can be identified and appropriately managed.

This is particularly important in relation to involuntary patients who are treated as an inpatient for long periods of time. Currently the Act requires that the results of annual examinations be reported to the Chief Psychiatrist. It may be more appropriate for the examination to be reported at a local level.

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

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

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

3.3.6 Community treatment orders

The use and efficacy of community treatment orders in mental health has been the subject of significant research and debate over the past decade.⁶² As part of this research, Victoria's well-established community treatment order scheme has been examined over recent years both in terms of the extent of its use and potential outcomes. It has been argued that the Victorian scheme, when compared with others in Australia and internationally, appears effective in producing positive health outcomes.⁶³ However, research has identified the comparatively higher use of community treatment orders in Victoria.⁶⁴ Commentators have noted that concerns about community treatment orders in Victoria include the possibility that they are used too readily and for lengthy periods, and with some people for whom there is no evidence of their effectiveness.⁶⁵ It may also be argued that despite significantly increased demand and increased acuity, the change in use is not significant and remains broadly targeted on a small core population of seriously ill people.

61 The Act, s 87. Further, the Chief Psychiatrist's guideline advises that a patient on a community treatment order who refuses to cooperate should not be forcibly physically examined: Department of Human Services, 2008 p.5.

62 See, for example: Dawson J et al 2003, 'Ambivalence about community treatment orders', *International Journal of Law and Psychiatry*, vol.26, no.3, pp.243–255; Segal S and Burgess P 2006, 'The utility of extended outpatient civil commitment', *International Journal of Law and Psychiatry*, vol.29, no.6, pp.525–534.

63 Dawson, 2005 p.29.

64 Dawson, 2005 p.43.

65 Dawson, 2005 p.61.

Like Victoria, some jurisdictions use the same grounds for deciding whether a person receives involuntary treatment as an inpatient or in the community.⁶⁶ Other jurisdictions have separate grounds tailored to each situation.⁶⁷ Changing the grounds may result in community treatment orders that are more effectively targeted and may increase or decrease the number of people on community treatment orders. Similarly, increasing the frequency of clinical reviews and limiting the duration of orders may also have an impact on the number of people on community treatment orders.⁶⁸

- Q21. If separate grounds for a community treatment order are considered necessary, how should they differ from the grounds for making an involuntary treatment order?**
- Q22. What should be the duration of a community treatment order in the new Act?**
- Q23. Should there be any restrictions on the type of treatment that can be given under a community treatment order in the new Act?**

⁶⁶ Such as in Queensland.

⁶⁷ Including in New South Wales and the Northern Territory.

⁶⁸ This is discussed in chapter 7.



4. Patient participation in treatment and care

4.1 Introduction

In order to actively participate in their treatment and care, patients require information about their rights and proposed treatments, and assistance to exercise their rights. There are clear benefits to strengthening patient participation. Research suggests that patients who are involved in their treatment and care have a better experience of involuntary treatment and better outcomes including a lower rate of involuntary readmission.¹

As outlined in the previous chapter, the Disabilities Convention states that people with disabilities, including people with a mental illness, should be actively involved in decisions affecting them.² It contains a right for people with disabilities, including people with a mental illness, to respect for physical and mental integrity on an equal basis with others.³ This chapter describes the requirements in the Act designed to ensure that patients are informed of, and involved in, their treatment and care. It considers strategies that may enhance the ability of patients to participate in decisions that affect them. These include ways to improve patients' understanding of their rights, and involvement in treatment planning before and during episodes of involuntary treatment.

4.2 The Victorian context

4.2.1 Rights to information

The Act recognises the fundamental importance of providing information to patients. This is reflected in the objects and principles of the Act.⁴ These include that all patients be informed of, and make use of, the provisions of the Act. Further, that they are provided with appropriate and comprehensive information about their illness, proposed and alternative treatments (including medication) and services available to meet their needs. In addition, every person who is made an involuntary patient must be advised of their rights and be provided with other information in specified circumstances as described below.

4.2.2 Statement and explanation of rights

The Act imposes a duty on the authorised psychiatrist to provide each person placed on an involuntary order with a statement and explanation of rights and entitlements.⁵ A treatment-specific statement and explanation must also be provided to patients prior to certain treatments, such as psychosurgery and ECT.⁶ If the person does not appear to understand the explanation, the authorised psychiatrist has a further duty to make arrangements to convey the information in a language or manner that the person can understand.⁷ In practice the treating team often performs these obligations.

Statements of rights are not intended to be exhaustive. Rather they are designed to ensure that patients are informed of the rights that are most relevant to them at certain times during their treatment.

1 Rosenman S 2000, 'Efficacy of continuing advocacy in involuntary treatment', *Psychiatric Services*, vol.51, no.8, pp.1030–1033.

2 Disabilities Convention, Preamble (n)–(o).

3 Disabilities Convention, art 17.

4 The Act, ss 4(1)(e), 6A(e).

5 The Act, s 18(4).

6 The Act, ss 53B(2)–(4).

7 The Act, ss 18(3), 53B(3).

Statements of rights are printed as booklets and have been translated into 12 languages.⁸ The information to be contained in the booklets is prescribed in the Victorian *Mental Health Regulations 2008*.

There are a number of services that can also assist patients to understand their rights. Patients can seek legal advice from the Mental Health Legal Centre, Victoria Legal Aid or other legal advisers. Community visitors and the Public Advocate can also have a role in explaining rights. In addition, mental health services employ consumer consultants to promote the rights of patients, including developing patient-friendly strategies to engage patients in their treatment and care.⁹

4.2.3 Other information

There are a number of other circumstances where the Act requires information to be provided to involuntary patients. For example, an involuntary patient must be:

- provided with a copy of their treatment plan¹⁰
- informed of and provided with a copy of a community treatment order when it is made, extended or varied¹¹
- informed when a community treatment order is revoked by the authorised psychiatrist, or revoked or varied by the board¹²
- given notice of an appeal or a review of their involuntary treatment order by the board¹³
- given access to their file and other documents to be given to the board¹⁴
- provided with a statement of reasons for the board's determination within 14 days of a request¹⁵
- given information in order to provide informed consent to specific procedures including psychosurgery, ECT and major non-psychiatric treatment.¹⁶

In addition, the Act requires that all involuntary patients, including persons on a community treatment order, must have access to a number of documents.¹⁷ These include the Act, contact details for the board, the Public Advocate, the Chief Psychiatrist, community visitors, Victoria Legal Aid, the Ombudsman and the Health Services Commissioner (HSC).

8 See: Department of Human Services 2008, *About your rights*, Victorian Government, Melbourne, viewed 5 October 2008, <www.health.vic.gov.au/mentalhealth/patientrights/index.htm>

9 Department of Human Services 2003, *Program management circular: Guidelines for Consumer Consultant Program*, Victorian Government, Melbourne, p.1.

10 The Act, s 19A(6)(a).

11 The Act, ss 14(4)(a)(b), 14B(5)(a)(b), 14C(2)(a)(b).

12 The Act, ss 14D(3)(a), 36C(5)(a), 36C(6)(a)–(b).

13 The Act, s 32(1).

14 The Act, s 26(7).

15 The Act, s 27(1).

16 The Act, ss 53B(2)–(4)

17 The Act, s 19.

4.2.4 Right to be involved in the development of a treatment plan

When a person receives involuntary treatment, the Act imposes a direct duty on the authorised psychiatrist to prepare a treatment plan that takes the person's wishes into account as far as they are ascertainable.¹⁸ A treatment plan must contain an outline of the treatment the person is to receive.¹⁹ In addition, the Act requires that a treatment plan for a person on a community treatment order patient contain the names of treating team members and details of where and when treatment is to be provided.²⁰ The Act does not contain any other requirements for what must be recorded on the treatment plan, such as a person's wishes.

The authorised psychiatrist must ensure that the treatment plan is discussed with, and a copy provided to, the involuntary patient.²¹ When preparing, reviewing and revising a treatment plan, in addition to taking the person's wishes into account, the authorised psychiatrist is also under a duty to take into account:

- the wishes of any guardian, family member or carer, unless the patient objects
- beneficial alternative treatments
- the nature and risks of the proposed treatment and any alternative treatments.²²

Each time an involuntary patient appears before the board, the Act requires the board to review their treatment plan.²³ The board reviews involuntary orders within eight weeks of the making of the order and at least every 12 months thereafter.²⁴ Further, an involuntary patient may appeal at any time.²⁵ When reviewing the treatment plan, the board must determine whether the authorised psychiatrist has complied with the Act when making, reviewing and revising the plan, and that the plan is capable of being implemented.²⁶ If the board determines otherwise, it may order that the authorised psychiatrist revise the treatment plan.²⁷ The board does not consider it has the power to direct the authorised psychiatrist to change the type of treatment an involuntary patient is to receive, such as particular medications.²⁸

4.2.5 Challenging treatment decisions

Involuntary patients have the right to a second psychiatric opinion.²⁹ An involuntary patient's case manager or authorised psychiatrist can assist a patient to obtain a second psychiatric opinion. Other ways to challenge treatment are to appeal to the board, which has the power to discharge a person from an involuntary order, or to make a complaint to the Chief Psychiatrist who has powers, following an investigation, to direct changes to treatment or discharge.³⁰

18 The Act, s 19A(2).

19 The Act, s 19A(3).

20 The Act, s 19A(4).

21 The Act, s 19A(6). There is no requirement that any guardian, family member or carer be given a copy of the treatment plan. Issues associated with providing information to families and carers are considered further in chapter 10.

22 The Act, s 19A(2).

23 The Act, s 35A(1).

24 The Act, ss 30(1), (3). See chapter 7.

25 The Act, s 29(1).

26 The Act, s 35A(1).

27 The Act, s 35A(2)(a).

28 See, for example: 06-049 [2005] VMHRB 11 (27 September 2005).

29 The Act, s 18(1)(a).

30 The Chief Psychiatrist's powers are contained in sections 106 and 106AB of the Act.

4.2.6 Participation at board hearings

Involuntary patients have the right to appear at board hearings.³¹ The Act provides a right for involuntary patients to authorise any person, including a lawyer or a support person, to be their representative before the board.³²

4.3 Rethinking patient participation

4.3.1 Assisting patients to understand and exercise their rights

As discussed above and elsewhere in this paper, the Act sets out the rights of involuntary patients, including to be involved in a treatment plan, appeal their involuntary order, obtain a second psychiatric opinion, appear at board hearings, and to send and receive correspondence. Despite the requirement in the Act that every person placed on an involuntary order is to be provided with a written statement and explanation of their rights, patient advocates argue that many involuntary patients are not aware of their rights.³³ Other jurisdictions offer a range of legislative strategies to assist involuntary patients to understand and exercise their rights as discussed below.

4.3.1.1 Nominated person

Many jurisdictions require a statement of rights to be provided to a member of the patient's family or carer at certain times. The information in the statement assists them to understand the law relating to involuntary treatment, the consequences of being an involuntary patient and the rights of involuntary patients.³⁴ Some jurisdictions enable patients to nominate a person to receive information such as a statement of rights. Currently there is no provision in the Act for a patient to nominate a person to receive information about their treatment and care.

In New South Wales a patient may decide who receives information except in specifically defined circumstances.³⁵ A nomination by a patient must be respected unless there is a reasonable belief that this may put the person or others at risk of harm, or that the person was incapable of making the nomination.³⁶ A nominated person could assist an involuntary person to exercise his or her rights to appeal their involuntary order and appear at external review hearings.

4.3.1.2 Independent support person

Some jurisdictions facilitate rights advice through an independent support person in recognition that the treating team may not be best placed to explain information about rights to patients.³⁷ Commentators argue that the treating team has a perceived conflict of interest when undertaking

31 The Act, s 26(1). However, pursuant to section 26(6) of the Act, the board may prevent an involuntary patient from attending where it is satisfied that this would be detrimental to the involuntary patient's health.

32 The Act, s 26(3). See chapter 7 for a further discussion.

33 Mental Health Legal Centre Inc. 1996, *Mental Health Legal Centre annual report 1995/1996*, MHLCC, Melbourne, p.10.

34 See, for example: *Mental Health and Related Services Act 1998* (NT), s 87; *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 260(2)(a).

35 There is a prescribed list of persons that must be given the information: *Mental Health Act 2007* (NSW), s 71(1).

36 *Mental Health Act 2007* (NSW), s 72.

37 See, for example: *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s 12(8).

the statutory function of informing patients of their rights.³⁸ This is because the treating team's primary role is to provide treatment and care, not advocate on behalf of patients. Time and resource constraints in mental health services may also compound these challenges for the treating team. An independent support person could assist an involuntary patient to exercise his or her rights to be involved in treatment planning, appeal their involuntary order and appear at external review hearings.

An example of an independent support person occurs in New Zealand where district inspectors, who are qualified lawyers appointed by New Zealand's Minister of Health, have specific statutory functions to advise involuntary patients of their rights, support them in exercising their rights, and receive and investigate complaints of breaches of their rights.³⁹ In England and Wales, MHAC performs the function of providing rights advice. Its primary purpose is to visit involuntary patients to ensure they are aware of their rights and receive assistance in exercising them.⁴⁰

An independent support person may also perform a personal advocacy role. In Scotland every patient has a right of access to funded independent advocacy.⁴¹ Research suggests that personal advocacy can assist patient recovery. A study conducted in the Australian Capital Territory found that a support person, independent from the mental health service, was beneficial in presenting the patient's voice throughout the involuntary treatment process including negotiating treatment in the patient's best interests.⁴² The study demonstrated that this type of advocacy significantly improved the experience for both involuntary patients and staff. The support person was involved in negotiating treatment options, thereby ensuring the respectful inclusion of the wishes of involuntary patients. This also ensured their needs were recognised in circumstances where the treating team were not alert to these needs. Maintaining advocacy throughout their involuntary admission also led to a significant reduction in involuntary readmissions.⁴³

Q24. What obligations, if any, should the new Act impose in relation to informing a patient's family, carer or nominated person of a patient's rights?

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

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

38 Lesser J 2007, *Review and decision making for persons with a serious mental illness: achieving best practice, A cross-jurisdictional evaluation of involuntary mental health review and decision-making systems*, Report prepared for The Winston Churchill Memorial Trust of Australia, p.66.

39 See: *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s 94; New Zealand Ministry of Health 2003, *Guidelines for the role and function of district inspectors*, New Zealand Ministry of Health, Wellington, p.vii.

40 See: Atkinson J 2007, *Advance directives in mental health theory, Practice and ethics*, Jessica Kingsley Publishers, London and Philadelphia, p.36.

41 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 259(1).

42 Rosenman S, Korten A and Newman L 2000, 'Efficacy of continuing advocacy in involuntary treatment', *Psychiatric Services*, vol.51, no.8, p.1030.

43 Rosenman et al, 2000 p.1029.

4.3.2 Informing voluntary patients of their rights

Currently the Act does not require that a statement of rights be given to voluntary patients. Certain jurisdictions require this. Such a requirement could inform voluntary patients of their rights under the Act, which currently include:

- the applicable principles of the Act, including that, wherever possible, treatment and care is to be provided in the community and that patients should be involved in planning their treatment and care⁴⁴
- the safeguards that apply to ECT and psychosurgery
- the applicable confidentiality and information-sharing provisions in the Act that enable information to be provided to a patient's family or carers⁴⁵
- an explanation of the circumstances in which they may meet the grounds for involuntary treatment.

These rights are unique to patients receiving treatment and care for a mental illness. They do not apply to other general health patients. Providing voluntary patients with a statement of their rights could improve their awareness and understanding of their unique rights, and improve their treatment and care experience.

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

4.3.3 Patient involvement in treatment planning

Patient advocates argue that treatment plans have been ineffective in facilitating patient involvement in treatment and care and that they rarely contain sufficient detail to adequately inform patients of the plan for their treatment and recovery. Patient advocates also argue that the current powers of the board mean it is ineffective as a mechanism to review treatment plans because it cannot direct the type of treatment an involuntary patient is to receive. Decisions of the board also suggest that, in practice, treatment plans are poorly executed and do not always reflect the person's preferences or family and carer involvement.⁴⁶ According to one board member, they 'have been largely viewed as an extra paperwork hurdle and it is uncommon to see the signature of the person concerned on them'.⁴⁷ Patient advocates argue that an independent support person, as described above, is often necessary to facilitate meaningful patient involvement in the development of a treatment plan.

The Act requires that a treatment plan be prepared and provided to every person who is an involuntary patient, but it does not specify what must be recorded on the treatment plan. The most comprehensive treatment plans incorporate individual service plans and address relapse prevention, resulting in a more holistic approach aimed at assisting the patient's recovery.⁴⁸ Currently the Act does not require that the individual service plan be incorporated. Further, although the Act requires the authorised psychiatrist to take into account any beneficial alternative treatments available and significant risks associated with treatments, these matters do not need to be recorded on the treatment plan.

44 The Act, s 6A.

45 The Act, s 120A.

46 See, for example: 07-116 [2007] VMHRB 4 (21 February 2007).

47 McSherry, B 2008, 'Opening minds not locking doors', paper presented at Monash University Educate 08 50th Anniversary Public Lecture, October, Melbourne, p.13.

48 See appendix 5 for a definition of an individual service plan.

Some of these difficulties could be overcome by prescribing the format or incorporating requirements in the Act for what must be recorded on the treatment plan, however, it may be difficult to achieve a consistent approach among different services.

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

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

4.3.4 Accessing a second psychiatric opinion

A major concern of some involuntary patients and their representatives is how to challenge treatment decisions made by the authorised psychiatrist. Board decisions suggest that this depends upon the person's ability to access an independent second psychiatric opinion about realistic, safe and less restrictive treatment alternatives.⁴⁹ Although there is a right in the Act to a second psychiatric opinion, involuntary patients are often unable to exercise this right because an independent psychiatrist is costly and difficult to access.⁵⁰ Further, if a second psychiatric opinion is obtained, the obligation of the authorised psychiatrist to review treatment based on the opinion is unclear.

As discussed in the previous chapter, in Scotland, an involuntary patient who is unable or refuses to consent can only receive medication after two months where an independent second opinion certifies that the person is unable to consent or is refusing and the proposed treatment is in the person's best interests.⁵¹ Similarly, in England and New Zealand, an independent second psychiatric opinion scheme is mandatory. Introducing this type of scheme in Victoria could remove the difficulties involuntary patients currently experience in accessing a second psychiatric opinion. This issue is discussed further in chapter 3.

4.3.5 Advance statements

An advance statement is a written statement setting out a person's wishes and preferences for future treatment and care in the event that the person becomes unable to make such decisions.⁵² It may also contain lifestyle preferences or emergency arrangements to ensure that practical measures are addressed while the person receives involuntary treatment.⁵³

49 See, for example: 06-124 [2006] VMHRB 1 (2 May 2006).

50 Delaney S 2003, 'An optimally rights recognising mental health tribunal - What can be learned from Australian jurisdictions', *Psychiatry, Psychology and Law*, vol.10, no.1, 2003, p.72.

51 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), ss 240(4), 241(1).

52 The term 'advance statements' has been chosen to reflect the Scottish model of advance statements and to distinguish from other types of advance statements known as 'advance directives', 'living wills', 'advance care plans', 'Ulysses agreements' and so on, that reflect their different content and status in law. The Scottish model is a written statement, drawn up, signed and witnessed when the person is well, which sets out how he or she would prefer to be treated (or not treated) in the event of future illness. Clinicians and the Scottish tribunal must take notice of an advance statement but are not bound by it. If the wishes in the advance statement have not been followed, a written record of reasons must be sent to the patient, the patient's nominated representative and the Mental Welfare Commission for Scotland: Scottish Executive 2005, *The new Mental Health Act: A guide to consent and treatment, information for service users and their carers*, Scottish Executive, Edinburgh.

53 See: Topp V and Thomas M 2008, 'Advance directives for mental health, *New paradigm: social inclusion*, *The Australian Journal on Psychosocial Rehabilitation*, p.51.

Currently the Act does not make any reference to advance statements.⁵⁴ Including advance statements in the Act could be a means to strengthen patient participation in decision making. The *Because mental health matters* consultation paper identifies advance statements as a mechanism by which this could be achieved.⁵⁵

The Mental Health Legal Centre argues that advance statements are of great interest to patients as they afford a real opportunity for meaningful collaboration.⁵⁶ It has recommended that advance statements be recognised in legislation and is currently undertaking a research project to explore their use. The inclusion of advance statements in the Act could also facilitate involvement of families and carers by allowing patients to specify in what circumstances they should be contacted.

For advance statements to be effective, the authorised psychiatrist would need to be required by the Act to take them into account in making treatment decisions. Other jurisdictions in Australia, including the Australian Capital Territory, South Australia and Tasmania, have recently noted clear and broad public support for advance statements to be incorporated in legislation.⁵⁷ Many international jurisdictions with human rights charters already provide for statutory advance statements in mental health, including Scotland and the United States.

Introducing advance statements into the Act would raise a range of issues such as: the types of wishes and preferences that can be included; whether an advance statement can nominate an agent to make decisions; the support required to assist persons to make advance statements; whether advance statements should be made in consultation with clinicians; the capacity of the person when making an advance statement; who should be involved in witnessing an advance statement; the circumstances in which an advance statement must be taken into account; in what circumstances they can be overridden; and the consequences if an advance statement is not followed.⁵⁸

Q30. If an advance statement scheme is considered necessary: (a) What requirements should the new Act contain to ensure their effectiveness? (b) In what circumstances, if any, should the new Act allow an advance statement to be overridden?

54 The status of advance statements at common law in Victoria is unclear: See: Rees N 2007, 'Learning from the past, looking to the future: Is Victorian mental health law ripe for reform?', *Proceedings of the Mental Health Review Board of Victoria 20th Anniversary Conference*, Mental Health Review Board, Melbourne, p.8.

55 Department of Human Services 2008, *Because mental health matters: A new focus for mental health and wellbeing in Victoria, Consultation paper*, Victorian Government, Melbourne, p.85.

56 The Mental Health Legal Centre prefers the term 'advance directives'. Mental Health Legal Centre Inc, 1999 p.23.

57 See, for example: Department of Health and Human Services 2007, *Review of the Mental Health Act 1996 Discussion paper*, Tasmanian Government, p.64.

58 See: Rees, 2007; Weller P 2008, 'Advance directives and the translation of human rights principles in mental health law – towards a contextual analysis', *Proceedings of the Quarterly Mental Health Consumer, Carer and Community Forum*, Mental Health Community Coalition, Canberra.

5. Electroconvulsive therapy

5.1 Introduction

ECT is a therapeutic intervention in which modified seizures are induced by the selective passage of an electrical current through the brain. ECT is performed under general anaesthetic and is most commonly prescribed for treatment of severe depression.¹ Use of ECT in Victoria is regulated under the Act as is the case in most contemporary mental health legislation.

ECT is an effective treatment for severe depression and some other mental illnesses,² however, negative perceptions and concerns about its use are prevalent in the community.³ ECT can result in side effects for patients, including memory loss, and there is continuing clinical discussion and debate about ECT dosage techniques.⁴

Providing ECT to patients who do not have the capacity to consent raises a number of issues regarding the human rights articulated in the charter and Disabilities Convention.⁵ Importantly, the Disabilities Convention contains a right to respect for physical and mental integrity on an equal basis with others, which commentators have argued will severely limit treatments such as ECT.⁶

This chapter discusses a number of issues currently associated with ECT use in Victoria, particularly as it relates to patients who are unable to consent. It also examines whether licensing of ECT services is an effective and efficient way to regulate the safe performance of ECT.

5.2 The Victorian context

The Act has regulated the provision of ECT since 1986. It sets out the circumstances under which a patient may give informed consent to ECT and under which the authorised psychiatrist may provide substitute consent to ECT for involuntary patients. The Act also requires any public or private mental health service administering ECT to be licensed, comply with certain procedures and standards, and report regularly on ECT use.⁷

1 It may also be used in treatment of other serious mental illnesses such as mania, schizophrenia, catatonia and other neuropsychiatric conditions. Where ECT is prescribed, it forms part of a treatment plan in combination with other therapies. See: Department of Human Services 2000, *Electroconvulsive therapy manual: Licensing, legal requirements and clinical practice guidelines*, Victorian Government, Melbourne, p.1.

2 See, for example: UK ECT Review Group 2003, 'Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis', *The Lancet*, 361, pp.799–808, as noted in The Royal Australian and New Zealand College of Psychiatrists 2007, *Clinical memorandum #12 Electroconvulsive therapy: Guidelines on the administration of electroconvulsive therapy (ECT)*, available at <<http://www.ranzcp.org/resources/clinical-memoranda.html>>.

3 For a comprehensive examination of law, history and practice relating to ECT see: Wilson B and Freckelton I 2001, 'Electroconvulsive therapy: law, history and practice', *Journal of Law and Medicine*, vol.8, p.389.

4 Royal Australian and New Zealand College of Psychiatrists 2005a, pp.1, 9.

5 See chapter 2 for an overview of the rights engaged by the Act.

6 Disabilities Convention, art 17; See: McSherry B 2008, 'Opening minds not locking doors', paper presented at Monash University Educate 08 50th Anniversary Public Lecture, October, Melbourne, p.14.

7 The Act, Part 5 Division 2.

5.2.1 Consent to ECT

The Act recognises that an involuntary patient can give informed consent to ECT. Where a person is capable of giving informed consent to ECT, it must be given in writing.⁸ The person must have been provided with a detailed written statement of rights including their right to obtain legal advice and a second psychiatric opinion.⁹ The person may refuse or withdraw consent and discontinue treatment at any time.¹⁰ Unless urgently needed, the Act does not permit ECT to be given to a person who has capacity to consent but refuses.¹¹

A person who has given informed consent under the Act is taken to have consented to a course of ECT treatment and to the administration of an anaesthetic to enable the ECT to be performed.¹² A course of treatment is described as not more than six treatments given over a period, with not more than seven days elapsing between any two treatments.¹³ If consent is withdrawn at any stage during the course of the ECT treatment, the treatment must be ceased unless urgently needed.

Where an involuntary patient is *unable* to give informed consent to ECT, consent may be provided under the Act by the authorised psychiatrist.¹⁴ The authorised psychiatrist must be satisfied that the ECT has clinical merit, is appropriate, and if the ECT is not performed the person is likely to suffer a significant deterioration in his or her physical or mental condition.¹⁵ In these circumstances consideration must also be given to any benefits, discomforts or risks and any beneficial alternative treatments. All reasonable efforts must have been made to notify the person's guardian or carer of the proposed ECT.¹⁶

The *Electroconvulsive therapy manual* developed by the Chief Psychiatrist recommends that the authorised psychiatrist obtain a second psychiatric opinion in circumstances where a patient is not capable of consenting to ECT.¹⁷ Other jurisdictions in Australia and internationally provide for external review by a tribunal or a mandatory independent second psychiatric opinion prior to the provision of ECT where a patient cannot consent. While the Act articulates a right to a second psychiatric opinion, it does not require any form of oversight of the authorised psychiatrist's decision to provide substitute consent before ECT is administered.

5.2.2 Licensing

In Victoria, the premises where ECT is provided must be licensed by the Secretary to the department (the Secretary).¹⁸ Victoria's licensing regime enables inspection of premises, regulation of the suitability of licence holders, regulation of the standards and conditions of premises and equipment, and examination of the qualifications of clinicians providing ECT. There are currently 36 premises licensed to provide ECT in Victoria; 28 of these are public services and eight are private. Twenty-five of the licensed premises are located in metropolitan Melbourne and 11 in regional areas.

8 The Act, s 53B(1).

9 The Act, ss 53B, 53B(2)(a)(i). Statements of patients' rights are considered in chapter 4.

10 The Act, s 53B(2)(a)(ii).

11 The Act, ss 73(1), 73(4).

12 The Act, s 72(3). In practice, anaesthetists would seek this consent as a matter of course.

13 The Act, s 72(2).

14 The Act, s 73(3)(a).

15 The Act, s 73(3)(a).

16 The Act, s 73(3)(b).

17 Department of Human Services, 2000 p.16.

18 The Act, s 74(1). This function is delegated by the Secretary to the Chief Psychiatrist.

Administering ECT in unlicensed premises is an offence.¹⁹ Licences can be granted for up to five years and may be cancelled in certain circumstances.²⁰ Licence holders must submit a monthly return to the Chief Psychiatrist on ECT performed at the premises.²¹ Aggregate non-identifiable data on ECT use across Victoria is included each year in the Chief Psychiatrist's annual report.²² As a condition of their licence, clinicians and administrators of licensed services must also comply with the requirements of the Chief Psychiatrist's *Electroconvulsive therapy manual*.²³

5.2.3 Use of ECT

The following data shows that during 2007–08, 17,682 ECT treatments were provided to 1798 patients in public and private mental health services in Victoria.²⁴ The average number of treatments administered to these patients was 9.8.²⁵ Approximately 63 per cent of ECT was provided in public services.

Approximately 74 per cent of all ECT was provided to inpatients, with the remainder to outpatients. Of those who received ECT during this period, approximately 79 per cent had a diagnosis of major affective disorder or other affective disorder such as depression or bipolar disorder. Of the total ECT treatments, 35 per cent (or 6197 treatments) were provided to involuntary patients and of those, 95 per cent (or 5890 treatments) were consented to by the authorised psychiatrist on the basis that the involuntary patient was unable to consent to the treatment.

In examining rates of ECT use, some commentators have described higher comparative rates of ECT in Victoria than in other similar jurisdictions.²⁶ However, meaningful comparison between jurisdictions is difficult and can be undermined by differences in data reporting, collection, definitions, legislative requirements and service configuration.²⁷

5.3 Rethinking ECT

5.3.1 Licensing

Victoria and the Northern Territory are the only Australian jurisdictions that require premises to be formally licensed to provide ECT. Licensing creates a mechanism by which standards can be set and monitored, thereby promoting the safe and expert provision of ECT. It can also provide patients with reassurance that clinicians and administrators of licensed services are required to comply

19 The Act, s 74(2).

20 The Act, ss 76(1)-(2).

21 The Act, s 80.

22 See: Department of Human Services 2008, *Chief Psychiatrist's annual report 2006*, Victorian Government, Melbourne. This data does not identify individual service use of ECT but collates total treatments across Victoria.

23 Department of Human Services, 2000. These guidelines set out requirements for licensing, resource and equipment standards and clinical practice guidelines for the provision of ECT.

24 All references to data in this chapter are derived from: Department of Human Services 2008, Operational Data Store, Unpublished data.

25 Female patients receive 68 per cent of all ECT administered.

26 Melding P 2006, 'Electroconvulsive therapy in New Zealand: terrifying or electrifying?', *New Zealand Medical Journal*, vol.119, no.1237, p.67. Melding describes rates of 19.7 patients per 100,000 in Scotland, 22 per 100,000 in Wales and 44 per 100,000 in Victoria.

27 For further discussion of Victorian rates of ECT and the challenges posed in interpreting and comparing them, see Wood D and Burgess PM 2003, 'Epidemiological analysis of electroconvulsive therapy in Victoria, Australia', *Australian and New Zealand Journal of Psychiatry*, vol.37, no.3, pp.307–311.

with certain legal and procedural requirements. The Victorian scheme is strongly supported by licensees who consider it an important tool for standard-setting and monitoring and a mechanism for responding to patient or carer concerns about ECT regulation.²⁸

The government is required to ensure that the regulatory burden imposed by licensing schemes is justified to achieve its purpose, is not duplicated in other statutory or non-statutory regimes and is not unnecessarily burdensome. In terms of the potential detriments of licensing, it could potentially be argued that licensing is not necessary because these premises are subject to broader regulation or accreditation and that clinicians are subject to separate health practitioner regulation. In response, Victorian licensees have indicated they do not consider the current arrangements burdensome, nor do they consider that other health service accreditation processes or regulatory requirements duplicate the licensing process.²⁹

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

5.3.2 External review of ECT or mandatory second psychiatric opinion

Patient advocates in Victoria have argued for some time that the authorised psychiatrist's decision to consent to ECT should be subject to external review.³⁰ There is concern that current safeguards in the Act are insufficient and that more effective appeal and oversight mechanisms and greater public accountability are required.

In circumstances where the patient does not wish to have ECT, it has been argued he or she may feel powerless to convince the authorised psychiatrist of the contrary position.³¹ Some patients consider that there is little point in having informed consent requirements in the Act when there is no effective forum for challenging the authorised psychiatrist's decision.³²

Increased oversight may therefore provide stronger protection for patients and enhance transparency of decision making. It may also ensure consistency in the quality and nature of information provided to patients in these circumstances. If supported, this form of oversight would be patient focused. As such, it would not duplicate or overlap with licensing that regulates the operational and clinical standards of health services providing ECT.

28 These views were articulated at a departmental forum on ECT licensing in May 2008.

29 Such as those undertaken by the Australian Council on Health Care Standards or the private hospital accreditation process.

30 Mental Health Legal Centre Inc. 2000, *A position paper on the law and electroconvulsive therapy in Victoria*, p.v, viewed 12 September 2008, <www.communitylaw.org.au/clc_mentalhealth/cb_pages/mental_health_act_reform.php>.

31 Mental Health Legal Centre Inc., 2000 p.15.

32 Mental Health Legal Centre Inc., 2000 p.15.

Schemes operating in New South Wales and Queensland require the external review of ECT provision.³³ Under these schemes, the board (or its statutory equivalent) is required to review an application for administering ECT to involuntary patients.³⁴ It can consent, or refuse consent, to a course of treatment where the person is unable to consent. In 2006 the tribunal in New South Wales determined ECT was necessary and desirable in 472 cases and not necessary and desirable in six.³⁵ While the number of tribunal refusals is low, this is only one indicator of the impact and potential benefits of oversight. The benefits of increased transparency and rigour in decision making, the provision of quality information to patients and increased opportunities for patient participation in decision making, are harder to quantify.

In England and Wales, a different approach is taken to ECT where a person cannot consent. In these circumstances, ECT can only be given if a statutory 'second opinion doctor' agrees and the ECT does not conflict with any advance statement. The second opinion doctor is independent of the mental health service and government departments.³⁶

It could be argued that introducing an additional 'check' on clinical discretion in these circumstances would delay necessary treatment, be unduly administrative and place an unnecessary burden on clinicians by requiring them to document their opinions on a patient's capacity to consent in these circumstances. It could also be argued that a hearing-based process by a board could be distressing to involuntary patients who are severely unwell.

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

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

5.3.3 Emergency ECT

The Act provides that ECT can be given without informed consent if it is considered to be urgently needed.³⁷ No further guidance is provided concerning how to determine whether ECT is urgently needed, such as the seriousness of harm that will result if the ECT is not provided. The potential consequence is that ECT can be performed on a person who is capable of consenting but refusing, without safeguards. This provision is rarely, if ever, used.

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

33 *Mental Health Act 2007* (NSW), ss 88, 89, 94, 96; *Mental Health Act 2000* (Qld), ss 139–140, 229.

34 *Mental Health Act 2007* (NSW), s 94; *Mental Health Act 2000* (Qld), s 229.

35 Mental Health Review Tribunal 2007, *Mental Health Review Tribunal Annual report 2006*, New South Wales Government, Sydney, p.28. Forty patients were considered capable and provided consent. The percentage was higher in Queensland, with approximately 5.1 per cent of applications for ECT refused: Mental Health Review Tribunal, 2007 p.16. (334 applications for ECT were granted and 18 applications were refused.)

36 *Mental Health Act 1983* (England and Wales), s 57.

37 The Act, s 73(4).

5.3.4 Supporting patient participation

In addition to potential oversight, when a patient is unable to consent to ECT they may require further support. The new Act could require information to be provided to a person nominated by the patient. This may help patients to participate more effectively in decision making about their treatment and to raise any concerns they may have about the treatment. This would be in addition to the current provision requiring all reasonable efforts to be made to inform a patient's carer concerning proposed ECT.³⁸

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

5.3.5 ECT and young people

The provision of ECT to young people is rare, but there are some clinical circumstances where it may be considered. The Act is silent on age in relation to ECT. The Chief Psychiatrist recommends that where ECT is being considered for a young person, a second opinion should be sought from a specialist child and adolescent psychiatrist. Nevertheless, further specific safeguards may be appropriate when ECT is being considered for a young person. Such safeguards could apply irrespective of the young person's capacity to consent to treatment. This could ensure that all relevant developmental issues have been fully taken into account and require appropriate carer or family consultation.

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

38 The Act, s 73(3)(b).

6. Restraint and seclusion

6.1 Introduction

Restraint and seclusion are extremely restrictive interventions that are regulated in most contemporary mental health legislation. Restraint may be physical or mechanical. Physical restraint involves skilled hands-on immobilisation or physical restriction of a person to prevent the likelihood of harm to self or the endangerment of others, or to ensure the provision of essential medical treatment. Mechanical restraint involves the application of devices (including harnesses or straps) on a person's body to restrict movement. Seclusion involves the sole confinement of a person in a room of which the doors and windows are locked from the outside.

Restraint and seclusion can be traumatic for the patient and, where problems occur, the consequences can be profound. Tragically, restraint and seclusion have been associated with deaths in Victoria and elsewhere over recent years. In recognition of the gravity of these interventions and their impacts for patients, significant work is underway nationally and at a state level to reduce and, wherever possible, eliminate their use.¹ This work is consistent with the National Safety Priorities in Mental Health that describe restraint and seclusion as a safety measure of last resort.²

Restraint and seclusion clearly raise charter and Disabilities Convention rights and protections, such as the protection from cruel, inhuman or degrading treatment or punishment.³ The Disabilities Convention requires respect for physical and mental integrity and arguably aims to limit, where possible, the use of restraint and seclusion.⁴ This chapter will examine these issues and explore whether further or different regulation of restraint and seclusion is required.

6.2 The Victorian context

The Act contains detailed provisions regulating the use of mechanical restraint and seclusion. Physical restraint is regulated under the Act for the purpose of transporting a person safely to a public mental health service, but is otherwise governed by the common law.⁵

In addition to the policy work occurring nationally, the Victorian Creating Safety: Addressing Seclusion and Restraint Practices project was established in 2007.⁶ Consistent with national goals, the project aims, wherever possible, to reduce the number of patients subject to restraint and seclusion, as well as the frequency and duration of these interventions, through establishing alternative strategies. It draws on international best practice in reducing restraint and seclusion rates. Pilot programs have already commenced in a number of Victorian mental health services trialling new therapeutic approaches to managing acutely disturbed patients. A statewide best-practice training curriculum will be implemented as a result of the project to support practice change and improvement.

1 ACT Health 2007, *National Mental Health Seclusion & Restraint Project*, viewed 12 September 2008, <<http://www.nmhsrp.gov.au/c/mh?a=da&did=1005829>>. See also: Department of Human Services 2007, *Creating Safety: Addressing Seclusion and Restraint Practices*, viewed 12 September 2008, <<http://www.health.vic.gov.au/creatingsafety/overview.pdf>>.

2 National Mental Health Working Group 2005, *National safety priorities in mental health: a national plan for reducing harm*. Department of Health and Ageing, Canberra, p.17

3 The charter, s 10(b).

4 Disabilities Convention, art 17; See: McSherry B 2008, *Opening minds not locking doors*, paper presented at Monash University Educate 08 50th Anniversary Public Lecture, October, Melbourne, p.14.

5 The Act, s 9B(2).

6 Department of Human Services, 2007.

6.2.1 Use of mechanical restraint and seclusion

The following data shows that during 2007–08, 174 patients (1.3 per cent) in public inpatient services were mechanically restrained one or more times during their admission.⁷ These patients experienced 936 episodes of restraint of which 91.5 per cent were for less than four hours and 1.9 per cent were for longer than 12 hours. Sixty-eight per cent of restraint episodes involved patients over the age of 65 while 29 per cent involved patients between the ages of 18 and 65. The majority of restraint and seclusion episodes occurred during the process of making an involuntary treatment order.⁸

During the same period, 1913 patients (14 per cent) admitted to public inpatient services were secluded one or more times during their admission. These patients experienced 6681 episodes of seclusion of which 63 per cent were for less than four hours and 16 per cent were for longer than 12 hours. Ninety-three per cent of seclusion episodes involved patients between the ages of 18 and 65.

6.2.2 Regulation of mechanical restraint and seclusion

Mechanical restraint has been regulated under the Act since 1986. It is defined as the application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict movement.⁹ Involuntary, forensic, security and voluntary patients may be mechanically restrained in limited circumstances. These are: if it is necessary for the purpose of the person's medical treatment; to prevent a person causing injury to themselves or any other person; or to prevent a person from persistently destroying property.¹⁰

Seclusion is defined in the Act as the sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside.¹¹ Under the Act a person receiving treatment and care in a public mental health service can be secluded if it is necessary to protect them or others from an immediate or imminent risk to their health or safety or to prevent them absconding.¹² Further guidance to clinicians on the practical implementation of these provisions is provided in the *Chief Psychiatrist's guidelines*.¹³

6.2.3 Authorisation of mechanical restraint and seclusion

Mechanical restraint and seclusion must be approved by the authorised psychiatrist for a specified period.¹⁴ In an emergency, mechanical restraint and seclusion may be authorised by the senior nurse on duty and notified to a medical practitioner without delay.¹⁵ The senior nurse must also notify the

7 All references to data in this chapter are derived from the Department of Human Services 2008, Operational Data Store, Unpublished data.

8 In the case of seclusion 51 per cent of episodes and in the case of restraint 78 per cent of episodes: Department of Human Services, 2008.

9 The Act, s 81(1A). Mechanical restraint does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture.

10 The Act, s 81(1)(a).

11 The Act, s 82(1).

12 The Act, s 82(2)(a).

13 See Department of Human Services 2006, *Chief Psychiatrist's guideline on mechanical restraint*, Victorian Government, Melbourne; Department of Human Services 2006, *Seclusion: Chief Psychiatrist's guideline*, Victorian Government, Melbourne.

14 The Act, ss 81(1)(b)(i), 81(1)(c), 82(2)(b)(i), 82(2)(c). In the case of mechanical restraint the type of mechanical restraint must also be approved by the authorised psychiatrist.

15 The Act, ss 81(1)(b)(ii), 82(2)(b)(ii).

authorised psychiatrist as soon as practicable.¹⁶ The Act is silent on the subsequent responsibilities of the medical practitioner and authorised psychiatrist and there is no requirement for the authorised psychiatrist to subsequently review and authorise emergency restraint or seclusion.

The Act currently permits mechanical restraint and seclusion of voluntary patients without any further restriction on the circumstances in which this can occur. Once seclusion and mechanical restraint are authorised, the Act does not specify who can undertake the actual process of restraining or secluding a patient or whether that person should have particular qualifications or experience.

6.2.4 Monitoring of mechanical restraint and seclusion

The Act requires that a person who is mechanically restrained must be under continuous observation by a medical practitioner or nurse.¹⁷ In contrast, where a person is in seclusion, they are not required to be under continuous observation.

Under the Act, a mechanically restrained or secluded person must be clinically reviewed by a nurse as clinically appropriate to his or her condition at intervals of not more than 15 minutes.¹⁸ A medical practitioner must conduct an examination of the person at not more than four-hourly intervals.¹⁹ The authorised psychiatrist may vary the interval for the medical examination if they think it is appropriate to do so.²⁰ The Act does not give any direction as to appropriate grounds for variation. The Act requires that if the senior nurse on duty, a medical practitioner or the authorised psychiatrist believes that the mechanical restraint or seclusion is no longer necessary, it must be ceased without delay.²¹

Monthly reports on mechanical restraint and seclusion use must be made to the Chief Psychiatrist by the authorised psychiatrist of the service.²² The practices of mechanical restraint and seclusion are not subject to further external review, appeal or monitoring processes. Some services have introduced internal quality monitoring processes of the use of seclusion to assess the appropriateness of its use, the impact on the person and to inform practice improvement.

6.2.5 Regulation of physical restraint

As stated above, the use of physical restraint in circumstances other than safe transport to a mental health service is governed by common law. Services and clinicians have a well-established duty of care to patients. Fulfilment of this duty requires clinicians to take reasonable care in when providing treatment and care to patients. The duty requires clinicians and services to avoid harm, damage or injury that is reasonably foreseeable. Consistent with this duty, the use of physical restraint must be the minimum necessary to keep the patient or others safe and must be used for the least amount of time required to fulfil this purpose.

16 The Act, ss 81(1B), 82(2A).

17 The Act, s 81(1D)(a).

18 The Act, ss 81(1D)(b), 82(3)(a).

19 The Act, ss 81(1D)(c), 82(3)(b).

20 The Act, ss 81(1E), 82(3A).

21 The Act, ss 81(1F), 82(3B).

22 The Act, ss 81(3), 82(5). Where variation occurs, this must be reported to the Chief Psychiatrist at the end of each month: ss 81(3)(f), 82(5)(e).

6.3 Rethinking regulation of restraint and seclusion

6.3.1 Physical restraint

Most Australian states and territories regulate mechanical restraint but do not regulate physical restraint to any significant degree.²³ The Chief Psychiatrist has observed the emerging use of physical restraint as a discrete intervention used to hold patients until their behaviour calms, separate from processes of mechanical restraint, seclusion or transport.²⁴ Given the intrusive nature of physical restraint and risks associated with its use, it may require greater statutory regulation, guidance and monitoring. Such a scheme could be broadly consistent with the scheme for mechanical restraint as described in this chapter.

It could be argued that effective regulation of physical restraint may be difficult given the need to respond urgently in a range of circumstances where there is a serious and imminent risk of harm to the patient or others or where necessary for providing essential medical treatment. Further, regulating physical restraint may result in clinicians and support staff in emergency departments having different legal and reporting obligations depending on whether they are restraining a patient subject to some form of assessment or order under the Act, compared with other people.

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

6.3.2 Grounds for mechanical restraint and seclusion

Current national and state policy development suggests that restraint should only be used as a last resort when other less restrictive options have been tried, or considered and excluded. This work reflects an intention, consistent with overarching human rights principles, to limit the use of restraint and seclusion, and to drive changes in clinical practice. Further limiting the grounds for restraint and seclusion would be consistent with these approaches. For example, use could be limited to circumstances where it is necessary to protect the person or others from an *immediate or imminent serious* risk to health or safety.

Currently the Act justifies the use of mechanical restraint and seclusion in a broader range of circumstances. For example, mechanical restraint may be used in order to prevent the persistent destruction of property.²⁵ Seclusion may currently be used to prevent absconding.²⁶ If use of mechanical restraint and seclusion were limited to the circumstances described above, services would be unable to seclude or mechanically restrain a person unless the absconding risk or persistent property destruction posed an immediate or imminent serious risk to either the patient's health or safety or that of others.

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

²³ See, however, the *Mental Health Act 1996* (Tas) that defines bodily restraint in section 3 as 'a form of physical or mechanical restraint that prevents the free movement of the limbs' and provides grounds for use in section 34; The Australian Capital Territory also provides for 'involuntary restraint' and attaches certain reporting requirements to its use: see *Mental Health (Treatment and Care) Act 1994* (ACT), s 35(4).

²⁴ This point has been made in consultation with the Chief Psychiatrist in relation to the development of new clinical guidelines.

²⁵ The Act, s 81(1)(a)(iii).

²⁶ The Act, s 82(2)(a).

6.3.3 Authorisation of mechanical restraint and seclusion

As stated above, mechanical restraint or seclusion can only be applied where it has been approved by the authorised psychiatrist or, in the case of an emergency, authorised by the senior nurse on duty. These provisions are problematic because in an emergency the authorised psychiatrist is not required to subsequently review and endorse the decision to use the intervention. One proposal is to tighten these provisions so that the authorised psychiatrist must subsequently review and endorse *all* incidents of restraint and seclusion regardless of how they have been initiated.

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

6.3.4 Monitoring of restraint and seclusion

Review of a secluded person by a nurse is currently required ‘as clinically appropriate’ to the person’s condition at intervals of ‘not more than’ 15 minutes. The Act does not specify the nature or purpose of the review. Unlike the requirements for mechanical restraint, a secluded person is not required to be monitored continuously.²⁷ Given the seriousness of the seclusion intervention and the risks associated with it, continuous clinical observation of a secluded person could be an appropriate further safeguard.²⁸

Examination by a medical practitioner is currently required at intervals of ‘not more than’ four hours.²⁹ In order to improve safeguards, medical examination could be required ‘as soon as practicable’ after commencement of seclusion or restraint (and thereafter at intervals of no more than four hours) as well as following cessation of the intervention. Potential changes to the monitoring of seclusion and medical examination of secluded or restrained persons would have immediate impacts on the clinical workforce and would require significant changes to current operational protocols and procedures.

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

6.3.5 Ending an episode of restraint or seclusion

The Act requires the authorised psychiatrist or senior nurse, at the commencement of mechanical restraint or seclusion, to authorise the length of time the intervention will be used.³⁰ These provisions are problematic and may contribute to extended use of the interventions because the authorised period appears to be interpreted as a default or ‘set’ period. One proposal to address this would be to instead require that the intervention be ended immediately when a person ceases to meet the grounds for the intervention rather than ‘without delay’. The purpose of the mandatory clinical review procedures that are currently required during restraint and seclusion could also be clarified to ensure restraint and seclusion are ended immediately that the person ceases to meet the grounds for their use.

²⁷ The Act, s 82(3)(a).

²⁸ Section 154 of the *Mental Health Act 2000* (Qld) requires the continuous observation of patients in seclusion unless a medical practitioner states in the seclusion order that this is not clinically necessary.

²⁹ The Act, ss 82(3)(b), 81(1D)(c).

³⁰ The Act, ss 81(1)(c), 82(2)(c).

Amendment of these provisions would remove any potential flexibility or clinical discretion from the operation of these provisions. In order to give effect to such a requirement in relation to seclusion, it could be argued that continuous clinical observation would be required (as discussed above) rather than the 15-minute observations currently required in the Act.

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

6.3.6 Regulating who can apply physical restraint

As already discussed, physical restraint is not regulated by the Act except in relation to transport of a person to an approved mental health service. In practice, physical restraint may be used to transfer a highly disturbed patient safely to a seclusion room or to administer medication. However, the Act does not specify who can apply physical restraint or accompany the person to seclusion. This may lead to undesirable practices where the interventions are not performed by people with appropriate qualifications, experience and training. Additional regulation in this area may further reduce risks associated with using physical restraint and seclusion and strengthen accountabilities for their use. However, policy and procedural variations across the service system may mean that statutory or other regulatory restrictions are considered too rigid or inflexible to meet diverse and frequently changing operational needs.

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

6.3.7 Restraint and seclusion of voluntary patients

Restraint and seclusion of voluntary patients raise a number of issues, primarily whether these interventions should be permitted in relation to voluntary patients at all. If permitted, the use of these interventions in such circumstances should arguably be limited to the shortest possible period necessary to determine whether the person meets the grounds for an involuntary order. Prescribed processes to ensure urgent review of the patient’s voluntary status could be a further safeguard in these circumstances.

**Q43. If the physical restraint, mechanical restraint and seclusion of voluntary patients is considered necessary in the new Act: (a) On what grounds?
(b) For what duration? (c) Subject to what safeguards?**

6.3.8 Other potential safeguards

Currently there is no obligation for a carer, nominated person or external monitoring body to be notified when a patient is restrained or placed in seclusion, nor is there is formal oversight of the legality and appropriateness of the use of restraint or seclusion and potential alternatives. In the Australian Capital Territory, the authorised psychiatrist must inform the Public Advocate in writing within 24 hours of placing a patient in restraint or seclusion.³¹ Similarly, if a patient is placed in seclusion in Western Australia, the board must be notified in writing as soon as practicable.³²

A legislative obligation to notify a carer, nominated person or external monitoring body when a patient is restrained or secluded may assist the patient to challenge the use of the intervention. Another way to ensure that patients' views are heard is through advance statements. An advance statement could contain a person's preferences for their treatment and care, and who to notify in the event of a crisis.

Children and young people may require the additional assistance of a nominated person or carer to act on their behalf in their best interests. This could include involving the child or young person's nominated person or carer in any planning for the management of disturbed behaviour, together with the child or young person.

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

31 *Mental Health (Treatment and Care) Act 1994 (ACT)*, s 35(4)(b).

32 *Mental Health Act 1996 (WA)*, s 120(d).



7. External review and appeals

7.1 Introduction

An external body to conduct reviews and appeals of involuntary orders is a key feature of most contemporary mental health legislation and an essential safeguard for the rights of involuntary patients. The World Health Organization recommends that every involuntary order be reviewed by an external body.¹ Many jurisdictions require that every person recommended for involuntary admission should appear before an external body during an assessment period and prior to an order being made. In some jurisdictions it is an external body that makes involuntary orders.

The introduction of the charter and Disabilities Convention encourages reconsideration of when external reviews are held in Victoria and the need for greater patient involvement. The Disabilities Convention requires effective access to justice for people with disabilities on an equal basis with others.² It also requires that involuntary orders apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. This chapter outlines the current arrangements in the Act for external reviews and appeals of involuntary orders. Consideration is given to how to achieve greater oversight of involuntary orders.

7.2 Current Victorian context

7.2.1 Board hearings

The board is a quasi-judicial body established in 1987 to provide external review of involuntary orders and to hear appeals. Its introduction represented a departure from a purely medical model for involuntary treatment.³ Its introduction also reflected a desire for greater accountability and transparency in the treatment and care of involuntary patients, and a much greater focus on the protection of the rights of people with a serious mental illness.⁴ Under the previous *Mental Health Act 1959* (Vic) there was no automatic external review of the decision to treat a person involuntarily.

The board must conduct reviews of involuntary orders within eight weeks of the orders being made and at least once every 12 months thereafter.⁵ It must also conduct reviews of the extension of a community treatment order within eight weeks.⁶ In addition, the board hears appeals against involuntary orders and must commence the hearing of appeals without delay.⁷ At each hearing, the board must review whether all of the five grounds for an involuntary order in the Act continue to apply to the person and review the treatment plan.⁸

1 World Health Organization 2005, *WHO resource book on mental health rights and legislation*, WHO, Geneva, p.68.

2 Disabilities Convention, arts 12(4), 13(1).

3 Grundell E 2005, 'Psychiatrists' Perceptions of Administrative Review: A Victorian Empirical study', *Psychiatry, Psychology and Law*, vol.12, no.1, p.68.

4 Grundell E 2005, p.68.

5 The Act, ss 21, 22(1)(b), 30(3), 30(5). Under s 30(1) of the Act the board must review the following orders: an involuntary treatment order, restricted involuntary treatment order, assessment order, diagnosis, assessment and treatment order, hospital transfer order, hospital security order or restricted hospital transfer order.

6 The Act, s 30(4).

7 The Act, ss 22(1)(a), 29(4). Pursuant to sections 22(1)(c)-(d) of the Act, it also hears appeals against the refusal of the Chief Psychiatrist to grant special leave of security patients and appeals against transfers including interstate transfers.

8 The Act, ss 35A, 36(2)-(3), 36C(2)-(3). The Act is silent in relation to the status of orders following any failure of the board to conduct or finalise an appeal or review within required timeframes. This issue is currently under consideration in a matter before VCAT.

The board currently comprises a full-time president and 105 part-time members. Hearings usually involve three members: a legal member (chairperson), a psychiatrist member and a person representing the views and opinions of members of the community.⁹ Hearings of the board are held at mental health services throughout Victoria.¹⁰ In 2006–07 the board conducted 5447 hearings.¹¹ In conducting hearings, the board is bound by the rules of natural justice.¹² Hearings of the board are informal and the board can inform itself in whatever manner it chooses, such as by asking questions of people in attendance.¹³

7.2.2 Board powers

The board has powers to: confirm an involuntary treatment order; order the authorised psychiatrist to make a community treatment order; discharge a person from an involuntary treatment order; and confirm, vary or revoke a community treatment order.¹⁴ Further, the board may order that the authorised psychiatrist revise a treatment plan if the board is satisfied that the treatment plan has not been made and revised in accordance with the requirements of the Act, or if the plan is not capable of being implemented.¹⁵ The obligation of the board to consider a second psychiatric opinion obtained by an involuntary patient is unclear. The Act does not require the board to take a second psychiatric opinion into account when deciding whether to direct the authorised psychiatrist to revise a treatment plan.¹⁶

7.2.3 Participation by involuntary patients at board hearings

As discussed in chapter 4, the Act provides involuntary patients with the following rights to participate in board hearings:

- **Right to information:** An involuntary patient must be: given notice of an appeal or a review of their involuntary order by the board; given access to their file and other documents to be given to the board; provided with a statement of reasons for the board's determination within 14 days of a request; and informed if the board revokes or varies a community treatment order.¹⁷
- **Right to appeal:** Under the Act a person may appeal their involuntary order to the board at any time.¹⁸

9 The Act, Sch 2, cl 1. A single member may conduct certain hearings including the periodic review of an involuntary treatment order, the extension of a community treatment order, and the review of an interstate transfer: The Act, Sch 2, cl 1A(a)(i)–(iii).

10 The Act, Sch 2, cl 5(1)(b).

11 Of those hearings, 2277 were reviews within eight weeks (31.4 per cent), 2119 reviews within 12 months (29.2 per cent), 1707 community treatment order extensions (23.5 per cent), 72 reviews listed by the board (1.0 per cent) and 1081 appeals (14.9 per cent): Mental Health Review Board 2007, *2007 annual report*, MHRB, Melbourne, p.42.

12 The Act, s 24(1)(b).

13 The Act, s 24(3).

14 The Act, ss 36C(2)–(4), 36(2)–(4). In 2006–07 the board discharged 249 patients from their involuntary status (3.4 per cent): Mental Health Review Board, 2007 p.42.

15 The Act, ss 35A(2)(a)–(b).

16 Second psychiatric opinions and treatment plans are discussed in chapter 4.

17 The Act, ss 32(1), 26(7), 27(1), 36C(5)(a), 36C(6).

18 The Act, ss 29(1)(a)–(b). Section 29(1A) of the Act allows for appeals by others on behalf of an involuntary patient or security patient.

- **Right to appear:** At any hearing an involuntary patient has the right to appear in person.¹⁹ The Act provides a right for involuntary patients to authorise any person, including a lawyer, carer or support person, to be their representative before the board.²⁰ In practice there are a number of services that can assist and represent involuntary patients, including the Mental Health Legal Centre, Victoria Legal Aid and other independent legal advisers. However, unlike in some jurisdictions, there is no requirement in the Act that involuntary patients are legally represented or that they receive advocacy support.²¹
- **Right to appeal to the Victorian Civil and Administrative Tribunal (VCAT):** An application for review of a determination of the board may be made to VCAT within 28 days of the determination.²² Decisions of VCAT can be appealed to the Supreme Court of Victoria but only on questions of law.²³

7.2.4 Psychosurgery Review Board

Psychosurgery can only be performed on a person who has provided informed consent to the procedure and where the Psychosurgery Review Board has also provided consent. The Psychosurgery Review Board is established under the Act.²⁴ Between 1988 and 1997 it dealt with 14 applications for psychosurgery for voluntary patients but it has considered only two since 1997.²⁵ Applications for psychosurgery are heard by a panel of five members, including three who must be medically trained, as well as others representing particular organisations.²⁶

7.3 Rethinking external review and appeals

7.3.1 External review of involuntary orders

7.3.1.1 Timing of external review of involuntary orders

Patient advocates argue that the length of time before involuntary orders are externally reviewed in Victoria, as required by the Act, is unacceptable. The World Health Organization has suggested that involuntary orders should be automatically externally reviewed within three days after they are made and every six months thereafter.²⁷ The purpose of external reviews is to monitor whether involuntary patients continue to meet the grounds for involuntary treatment and where a person is found to meet all five grounds, ensure that the order is discharged. In Victoria, an involuntary patient may be on an involuntary order for up to eight weeks before an external review. This is the longest

19 The Act, s 26(1). Pursuant to section 26(5) of the Act, this right may be limited by the board in circumstances where it is satisfied that the appearance of the involuntary patient would be detrimental to the patient's health.

20 The Act, s 26(3).

21 As is the case in jurisdictions including the Northern Territory, South Australia, England, Wales and Scotland.

22 The Act, s 120. In reviewing a determination of the board, VCAT reviews the merits of the board's decision. In 2006–07, 23 applications were made to VCAT for a review of a board's decision, 14 proceeded to full hearing before VCAT and in all matters the board's decision was affirmed. Mental Health Review Board of Victoria, 2007 p.39.

23 The Act, s 118(1). Where a question of law arises in proceedings before the board, the board may reserve the question for the opinion of the Supreme Court.

24 The Act, s 56.

25 Psychosurgery Review Board of Victoria 2008, *2007 annual report*, PRB, Melbourne, p.72.

26 The Act, Schedule 3, cl 2(1).

27 World Health Organization 1996, *Mental health care law: ten basic principles*, WHO, Geneva.

period in Australia.²⁸ As a result, a large number of involuntary patients are not reviewed by the board because they are discharged by the authorised psychiatrist during the eight-week period.²⁹ Further, most states in Australia require more frequent external reviews.³⁰

As described in chapter 3, some jurisdictions achieve oversight of involuntary orders by separating the involuntary treatment process into stages. These typically include an assessment order, a second stage order and a third stage order. The assessment order is usually made by a clinician. The second and third stage orders are usually made by an external body; however, in Victoria they are made by an authorised psychiatrist.³¹ In comparison with Victoria, the second and third stage orders in other jurisdictions are shorter in length, thereby triggering more frequent external reviews. For example, in New South Wales the second stage involves an external review by a magistrate that must occur as soon as practicable after a person has been examined for involuntary treatment purposes.³² The magistrate attends at mental health services to conduct hearings. The third stage in New South Wales involves an inpatient order made by a tribunal that is externally reviewed by the tribunal at least every three months for the first 12 months of the order, and six monthly thereafter.³³ An involuntary order requiring a person's treatment in the community is reviewed externally every 12 months.³⁴

7.3.1.2 Manner in which external reviews of involuntary orders are conducted

There are a range of approaches to the manner in which second and third stage orders are reviewed and made, both in terms of the clinician or body that makes and reviews the orders and whether or not a hearing is required. An external body making a second stage order can ensure that external review occurs as soon as practicable after an assessment order. Alternatively, if made by an authorised psychiatrist, the second stage order can operate to limit the duration for which a person

28 In Western Australia reviews must also be conducted not later than eight weeks after they are made. However, unlike Victoria, in Western Australia there is an added requirement that reviews be conducted 'as soon as practicable'. In addition, the Western Australian Government has made a public commitment to reduce this period. Reviews must be conducted within six weeks in Queensland; 45 days in South Australia; 28 days in Tasmania; seven days in Northern Territory; five days in the Australian Capital Territory; and as soon as practicable in New South Wales.

29 In 2007–08 approximately 70 per cent of involuntary patients were discharged from their order without having a board hearing: Department of Human Services 2008, Operational Data Store, Unpublished data.

30 Victoria, South Australia and Queensland require periodic reviews within 12 months. The remaining states conduct more frequent periodic reviews. In the Australian Capital Territory, Tasmania and Western Australia periodic reviews are conducted every six months. In the Northern Territory periodic reviews are conducted every three months for involuntary inpatients and every six months for involuntary patients in the community. In New South Wales reviews of involuntary patients must occur at least every three months for the first year and at least every six months thereafter.

31 World Health Organization 2005, *WHO resource book on mental health rights and legislation*, WHO, Geneva, p.68. For example, the Australian Capital Territory, New South Wales, Northern Territory, South Australia, and internationally in New Zealand and Scotland. Further, in Victoria guardianship orders are made in the first instance by VCAT: *Guardianship and Administration Act 1986* (Vic), s 22.

32 *Mental Health Act 2007* (NSW), s 27.

33 *Mental Health Act 2007* (NSW), ss 37(1)(b)-(c), 38(4).

34 *Mental Health Act 2007* (NSW), s 53.

can be treated involuntarily prior to external review. In Scotland, a clinician makes a 28-day second stage order that can be extended.³⁵ Third stage orders are generally made by a tribunal for a duration of six months in the first year, and 12 months thereafter.³⁶ Consistent with the duration of the orders, external reviews in Scotland occur every six months in the first year and every 12 months thereafter.³⁷

Some jurisdictions achieve oversight of involuntary orders by having a more flexible external body. The type and membership of the external body that reviews involuntary orders varies across jurisdictions. For example, in New South Wales the external body is a magistrate in some situations and a tribunal in others.³⁸ Similarly in many jurisdictions it is a mental health tribunal or a tribunal with a broader mandate that conducts external reviews and makes involuntary orders.³⁹ In Victoria, VCAT makes orders in other administrative law areas such as guardianship.

There is considerable debate about the most appropriate membership of tribunals or other bodies for the purposes of conducting external reviews of involuntary orders. Currently, the Act requires an external review hearing to be conducted within eight weeks of the making of an involuntary order by a three-member panel. A single board member, whether a lawyer, psychiatrist or person representing the views and opinions of members of the community, may conduct external review hearings required within every 12 months.⁴⁰

7.3.1.3 Participation by involuntary patients

Commentators have questioned whether a hearing similar to that currently required under the Act is necessary.⁴¹ It has been argued that a hearing involving the attendance of all parties at the same time has the potential to create tension between clinicians and involuntary patients.⁴² The challenge is to conduct informal proceedings that are fair, inclusive of involuntary patients, that promote recovery,⁴³ and enable involuntary patients to feel that their position has been ‘fully and clearly articulated’.⁴⁴

35 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), ss 44(1), 44(5)(b). Further, under section 68(2)(a) this second stage order can be extended for a period of five days pending an application for a third stage order.

36 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 64(4)(a).

37 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), ss 64(4)(a)(i), 86(2).

38 *Mental Health Act 2007 (NSW)*, s 27.

39 For example, in Western Australia review hearings are conducted by the State Administrative Tribunal that also deals with a broad range of administrative, commercial and personal matters.

40 The majority of hearings are conducted by a three member panel: See: Mental Health Review Board of Victoria, 2007 p.24.

41 See, for example: Rees N 2007, ‘Learning from the past, looking to the future: Is Victorian mental health law ripe for reform?’, *Proceedings of the Mental Health Review Board of Victoria 20th Anniversary Conference*, Mental Health Review Board, Melbourne, pp.17–19.

42 Rees, 2007 p.19.

43 A three year Australian Research Council study ‘Mental health tribunals: balancing fairness, freedom, protection and right to treatment?’ led by Professor Terry Carney and Dr David Tait is currently underway. The focus of the study is on the ‘fairness and justice’ of mental health tribunal hearings in New South Wales, Victoria and the Australian Capital Territory. The findings are soon to be published and will inform this review.

44 Diesfeld K and McKenna B 2007, ‘The unintended impact of the therapeutic intentions of the New Zealand Mental Health Review Tribunal? Therapeutic jurisprudence perspective’, *Journal of Law and Medicine*, vol.14, no.4, p.570; See also: Freckelton I 2005, ‘Mental Health Review Board decision-making: A therapeutic jurisprudence lens’, *Psychiatry, Psychology and Law*, vol.10, no.1, p.45.

In Victoria, despite the right to appear before the board, attendance by involuntary patients at hearings remains low.⁴⁵ The number of involuntary patients represented at external review hearings (whether by a lawyer or support person) is also low.⁴⁶ In considering ways to enhance participation by involuntary patients in external review, representation by a lawyer or advocacy by a support person has been identified as increasing the likelihood that people will view hearings positively, even when their order is maintained.⁴⁷ Representation or advocacy may also increase the level of participation and engagement with treatment.⁴⁸ In some jurisdictions mental health legislation establishes a funded scheme for legal representation, which is available to all patients.⁴⁹ In other jurisdictions, rather than legal representation, a support person advocates on behalf of involuntary patients, enabling more active participation.⁵⁰

A support person or nominated person may also assist involuntary patients to challenge their involuntary treatment by assisting them to institute an appeal or by accessing review mechanisms on their behalf. In New Zealand district inspectors may assist involuntary patients to apply for an external review. A district inspector first visits an involuntary patient at the end of a five day assessment and treatment stage.⁵¹ District inspectors have a statutory duty to talk to involuntary patients to ascertain whether or not an application should be made for an external review.⁵²

A more flexible approach to oversight may require rethinking the manner in which external reviews are conducted. Introducing a staged involuntary treatment process, with some orders made by clinicians and others made externally, could ensure oversight of higher proportion of involuntary orders. Limiting the duration of involuntary orders, for example to six months, could also ensure that involuntary orders are reviewed more frequently. Introducing a more flexible model of external review in terms of the body, membership and type of hearings required, may overcome current difficulties in recruiting large numbers of part-time members to the board.

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

Q46. What type of external body, what kind of proceeding, and what powers should the new Act contain for: (a) External review soon after the making of an involuntary order? (b) Subsequent external reviews of involuntary orders?

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

45 Of the hearings conducted under the Act in 2006–07, 52.2 per cent of patients attended, 47.8 per cent of patients did not attend: Mental Health Review Board of Victoria 2008, p.28.

46 Of the 5447 hearings conducted under the Act in 2006–07, 5.6 per cent involved legal representation (69.4 per cent by Victoria Legal Aid, 29.1 per cent by Mental Health Legal Centre, 7 per cent by a private lawyer and 0.3 per cent representation by the Office of Public Advocate). Family members attended 8 per cent of hearings: Mental Health Review Board of Victoria, 2008 p.27.

47 Diesfeld and McKenna, 2007 p.570.

48 Diesfeld and McKenna, 2007 p.571.

49 For example, in the Northern Territory pursuant to section 131 of the *Mental Health and Related Services Act 1998* (NT), and for appeals in South Australia pursuant to section 27 of the *Mental Health Act 1993* (SA).

50 For example, in England and Wales, and Scotland.

51 New Zealand Ministry of Health, 2003, *Guidelines for the Role and Function of District Inspectors*, New Zealand Ministry of Health, Wellington, pp.iv, vii.

52 *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), s 12(8).

7.3.2 Participation by others

Another key issue is how to ensure the external body obtains sufficient information about the involuntary patient to make an informed decision. Currently under the Act the board can inform itself in whatever manner it chooses, such as by asking questions of people in attendance. The authorised psychiatrist is required to attend hearings, however there is no requirement in the Act for the board to notify family members, carers or nominated persons of hearings. While the involuntary patient's wishes regarding the attendance of families, carers or nominated persons would need to be respected, such notification could enable a carer or nominated person to attend hearings in a support role. Their attendance could also assist the external body in fulfilling its requirements to consider the involuntary patient's medical and psychiatric history and social circumstances.⁵³ Increased involvement by case managers may also be of assistance.⁵⁴ Although case managers must be notified by the authorised psychiatrist of the hearing, there is no requirement for the case manager to either attend or provide a written report.⁵⁵ Some commentators argue for the mandatory attendance or presentation of reports by case managers and other members of the treating team, which could enable staff to participate more fully in external review.⁵⁶

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

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

7.3.3 Psychosurgery Review Board

The number of applications for psychosurgery in Victoria over recent years has been low.⁵⁷ However, research into the use of deep brain stimulation as a treatment of last resort for certain treatment-resistant mental illnesses, particularly major depressive disorders, may see this trend change.⁵⁸ This research may justify the retention of the current regulatory function of the Psychosurgery Review Board, although it should be noted that a number of jurisdictions in Australia have prohibited psychosurgery.⁵⁹ To enable the sharing of administrative resources, it may be more appropriate for this function to be performed by the same external body that reviews involuntary orders.

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

53 The Act, s 22(2).

54 Brophy L, Campbell J and Healy B 2003, 'Dilemmas in the case manager's role: Implementing involuntary treatment in the community', *Psychiatry, Psychology and Law*, vol.10, no.1, p.154.

55 Mental Health Review Board of Victoria, 2007 p.27.

56 Brophy et al, 2003 p.161.

57 Psychosurgery Review Board of Victoria, 2007 p.72.

58 Psychosurgery Review Board of Victoria, 2007 p.71.

59 *Mental Health Act 2007* (NSW), s 83(1)(c).



8. Monitoring patient wellbeing

8.1 Introduction

Mechanisms to monitor treatment and care are a feature of most contemporary mental health legislation.¹ Monitoring mechanisms are a key way of ensuring that the wellbeing and rights of patients are respected. Monitoring is particularly important in relation to involuntary patients as it can help ensure that treatment and care is provided in accordance with legal requirements. Monitoring functions commonly include frequent visits by specialist mental health monitoring bodies to mental health services. They can also involve investigating any unresolved complaints, legislative compliance issues and breaches of patients' rights.² Robust monitoring processes can also promote service improvement.

This chapter discusses the monitoring functions performed under the Act by the Chief Psychiatrist and community visitors. It also considers the monitoring mechanisms used in some other jurisdictions. In these jurisdictions specialist mental health monitoring bodies have a range of robust processes to oversee patient wellbeing, review patient deaths and promote service improvement. This chapter also examines clinical leadership roles as well as the potential need to recognise codes of practice and clinical guidelines in the Act.

8.2 Monitoring of treatment and care in Victoria

Since 1986 the Chief Psychiatrist and community visitors have performed the role of monitoring the treatment and care provided to patients. The Chief Psychiatrist is a senior departmental officer appointed by the Secretary with the responsibility to oversee patient care and welfare, as well as a range of monitoring functions under the Act. The Chief Psychiatrist is supported by departmental staff with clinical expertise in mental health.³

Community visitors are volunteers from a wide range of backgrounds who report to the Minister through the Public Advocate. Their primary function under the Act is to visit public mental health services regularly to monitor the adequacy, appropriateness and standard of facilities.⁴

8.2.1 Role of Chief Psychiatrist in recent years

The overarching responsibility of the Chief Psychiatrist in the Act has not altered since 1986, despite fundamental changes to the mental health service system. However, the focus of the Chief Psychiatrist's role has changed over time.⁵ When the department directly managed services, the focus of the Chief Psychiatrist's role was on recruiting and training psychiatrists, and providing clinical leadership to the sector.⁶ In the late 1990s its focus broadened to include monitoring functions more applicable to the service environment at that time. In 1999 the Act was amended to create a quality assurance committee (QAC), including the Chief Psychiatrist, to oversee and monitor standards of mental health services.⁷

1 World Health Organization 2005, *WHO resource book on mental health, human rights and legislation*, WHO, Geneva, p.67.

2 The World Health Organization suggests that independence in these functions is crucial: World Health Organization, 2005 p.67.

3 Pursuant to section 106 of the Act, staff are authorised by the Chief Psychiatrist to exercise powers of inquiry and investigation.

4 The Act, s 109.

5 Department of Human Services 2004a, *Office of the Chief Psychiatrist annual report 2003*, Victorian Government, Melbourne, p.5.

6 Department of Human Services, 2004 p.5.

7 The Act, s 106AC. Note that the QAC is subject to strict confidentiality and privilege controls preventing publication of identifiable information.

In recent years the Chief Psychiatrist has taken an increasing role in responding to large numbers of patient, family and carer complaints, facilitating effective collaboration between public mental health services and providing clinical advice to the sector. In addition the Chief Psychiatrist occupies a valued clinical leadership role. This is vital to a sector facing high levels of service demand, increasing numbers of patients with comorbid mental illness and substance abuse as well as growing patient, carer and community expectations.

8.2.2 Monitoring functions of Chief Psychiatrist

The Chief Psychiatrist performs the following monitoring functions under the Act:

Receiving reports: The Act requires that public mental health services report to the Chief Psychiatrist on the use of mechanical restraint and seclusion, and the performance of ECT.⁸ The Act does not state the purpose for which this information is collected by the Chief Psychiatrist. In practice, the office publishes aggregate data on these practices and treatments in its annual report.⁹

Reviews of clinical incidents: The Chief Psychiatrist's office participates in departmental reviews of certain types of clinical incidents known as sentinel events.¹⁰ This process enables the Chief Psychiatrist to provide expert advice to services but it does not enable the Chief Psychiatrist to respond immediately to any issues of concern. Where the Chief Psychiatrist's office independently becomes aware of a clinical incident, the office may review the matter. However, there is no requirement in the Act for clinical incidents to be reported directly to the Chief Psychiatrist, nor does this routinely occur.¹¹

Death reviews: The Act requires mental health services to provide a report to the Chief Psychiatrist on the death of any person receiving treatment and care for a mental illness, as defined in the Victorian *Coroners Act 1985*.¹² The Act does not state the purpose for which this information is collected.¹³ In practice the Chief Psychiatrist's office reviews each report submitted with the aim of identifying any issues of concern at a local or systemic level. If the circumstances surrounding the death cause particular concern, the Chief Psychiatrist may conduct an investigation under the Act.¹⁴ In recent years the Chief Psychiatrist's office has made informal enquiries following some deaths and has conducted one formal investigation into a death.¹⁵

Issuing clinical guidelines: The Chief Psychiatrist's office issues clinical guidelines on appropriate standards of practice and service delivery in a range of areas, including the use of mechanical restraint and seclusion.¹⁶ Although the clinical guidelines are not recognised in the Act,¹⁷

8 The Act, ss 81(3), 82(5).

9 This data does not identify individual service use of mechanical restraint, seclusion or ECT but collates total use across Victoria.

10 Defined for the purpose of the department's sentinel event program as serious events that occur within health services that are: relatively infrequent; are clear cut events that occur independently of a patient's condition; commonly reflect hospital system and process deficiencies; and result in unnecessary outcomes for patients.

11 The Chief Psychiatrist's office may become aware of a clinical incident via complaints. The Chief Psychiatrist's complaint handling role is considered in chapter 9.

12 The Act, s 106A. Section 3 of the *Coroners Act 1985* (Vic) defines reportable deaths. A review of the *Coroners Act 1985* (Vic) is currently underway.

13 Note that the role of the Chief Psychiatrist does not extend to determining the cause of death. This is the role of the State Coroner's Office. See: *Coroners Act 1985* (Vic), ss 3, 19(1).

14 The Act, s 106(4).

15 Pursuant to the Chief Psychiatrist's enquiry and investigation powers in section 106 of the Act.

16 Clinical guidelines issued by the Chief Psychiatrist are available at <<http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>>.

17 With the exception of section 43A of the Act that relates to clinical guidelines for the discharge of security patients.

public health services are required to incorporate them in local policies and procedures as a condition of their funding.¹⁸

Systemic improvement: Between 1997 and 2004 the Chief Psychiatrist (and from 1999 under the auspices of the QAC) conducted a statewide clinical review program. During the program, senior clinicians from the sector visited each public mental health service in Victoria (under the direction of the Chief Psychiatrist) to evaluate standards of clinical practice and procedures. Under the Act the Chief Psychiatrist is able to authorise senior clinicians from the sector to participate in visits, to inspect and obtain documents, and interview staff.¹⁹

The intention of the program was to proactively promote improvement in clinical practice. The subsequent reports and recommendations were not disseminated publicly; however, broad systemic findings were published in the Chief Psychiatrist's 2003 annual report.²⁰ There is no requirement in the Act for the Chief Psychiatrist to publish the outcome of clinical reviews or investigations into deaths or clinical incidents.²¹ To date, the Chief Psychiatrist's investigation reports have not been made publicly available.

ECT licensing: As discussed in chapter 5, the Chief Psychiatrist performs ECT licensing functions on behalf of the Secretary.²²

8.2.3 Powers to investigate and respond to clinical incidents and deaths

The Chief Psychiatrist's office has powers to visit mental health services in certain circumstances: where there are concerns that a patient's medical care and welfare is at risk; where there are broader concerns about standards of practice; and to monitor standards of clinical practice.²³ As described above, the Chief Psychiatrist is able to authorise experts from the sector to assist in conducting investigations.

Following an investigation the Chief Psychiatrist has powers to make treatment decisions including to direct a service to treat a person, change a practice, procedure or treatment, and to admit a person as an involuntary patient.²⁴ These powers are infrequently exercised as the Chief Psychiatrist often addresses issues informally through liaison and discussion rather than by making formal directions to mental health services. The Chief Psychiatrist may also recommend that the department prosecute a clinician or mental health service following any failure to comply with the Act, although this has not occurred in practice.²⁵

18 Department of Human Services 2008, *Victoria Public hospitals and mental health services policy and funding guidelines 2008-09*, Victorian Government, Melbourne, p.94; Department of Human Services 2006, *An introduction to Victoria's specialist clinical mental health services*, Victorian Government, Melbourne, p.8.

19 'Authorised officers' may only conduct clinical reviews at the direction of the Chief Psychiatrist and do not participate in clinical reviews of services in which they are employed. See: Department of Human Services 2004b, *The protocol for clinical review of area mental health services 1997-2003*, Victorian Government, Melbourne, p.1.

20 Department of Human Services, 2004a p.17.

21 Department of Human Services, 2004a p.17.

22 The Act, Part 5, Division 2.

23 The Act, s 106(4).

24 The Act, ss 106-106AB.

25 Pursuant to Department of Human Services 2005, *Prosecutions guidelines*, Victorian Government, Melbourne.

8.2.4 Chief Psychiatrist leadership functions

In addition to monitoring functions the Chief Psychiatrist conducts various activities to facilitate practice and service development, including providing education, training and advice to the sector. Unlike other similar statutory departmental officers, the Act does not directly refer to any of the clinical leadership functions of the Chief Psychiatrist.²⁶

The Chief Psychiatrist also responds to requests for advice from clinicians in relation to mental health policy and service system issues. Advice is often sought on the application of the Act in complex or uncommon situations such as interstate transfers.²⁷

8.2.5 Monitoring functions of community visitors

Under the Act community visitors have functions to visit certain public mental health services to enquire into:

- the adequacy, appropriateness and standard of facilities
- whether people are being given the best possible treatment and care appropriate to their needs in the least restrictive environment and least intrusive manner possible
- any failure to comply with the Act
- complaints.²⁸

The Act requires community visitors to visit each public mental health service at least once a month, as otherwise directed by the Minister or as requested by patients.²⁹ In 2006–07, community visitors conducted 1251 visits to 106 public mental health services.³⁰ The majority of these visits were unannounced and a significant number were conducted in response to complaints referred from the Public Advocate's Advice Service.³¹ The Act requires that community visitors report biannually to the Public Advocate and Minister, and annually to Parliament.³²

26 For example, the leadership functions of the Senior Practitioner are contained in section 24 of the *Disability Act 2006* (Vic).

27 Department of Human Services, 2008 p.19.

28 The Act, s 109. Under section 107 of the Act, they have powers to visit mental health services providing residential services and 24 hour nursing care.

29 The Act, ss 111(2), 111(4).

30 Office of the Public Advocate 2007, *Office of the Public Advocate Annual Report 2007*, OPA, Melbourne, p.44.

31 Office of the Public Advocate, 2007 p.44.

32 The Act, ss 115, 116A. Community visitors can also make recommendations to the Public Advocate, Chief Psychiatrist and the Minister following visits: The Act, ss 113(3), 115(2).

8.3 Rethinking monitoring of treatment and care

8.3.1 Specialist mental health monitoring body

Commentators and patient advocates argue that a specialist mental health commission is essential to safeguard the rights of the mentally ill and, in particular, those subject to involuntary treatment.³³ Currently there is no body of this type in Australia.³⁴ However, the Western Australian Government has recently announced the establishment of a Mental Health and Wellbeing Commissioner.³⁵ In many international jurisdictions, particularly those with human rights charters, the Chief Psychiatrist and community visitor functions are performed by independent commissions with multidisciplinary expertise, or by lawyers employed for this purpose.

These bodies routinely attend public mental health services to ensure that involuntary patients are being treated appropriately and within the law, and to provide them with rights advice and other support. Examples of these specialist mental health bodies include district inspectors in New Zealand, MHAC in England and Wales, and the Mental Welfare Commission for Scotland (MWC).³⁶

District inspectors are lawyers appointed by New Zealand's Minister of Health with specific statutory functions to advise involuntary patients of their rights, support them in exercising their rights, and receive and investigate complaints of breaches of their rights.³⁷ England and Wales' MHAC is an independent multidisciplinary commission. It was established in 1983 to monitor the operation of the legislation as it relates to involuntary patients.³⁸

Scotland's MWC is also an independent multidisciplinary commission with a broader responsibility to monitor the operation of the Scottish Act and promote best practice in relation to its operation.³⁹ Similar to district inspectors, these commissions also perform complaints and advocacy functions. Both the MWC and MHAC employ staff from a variety of disciplines, including clinical experts.⁴⁰ In addition, MHAC provides an additional safeguard through a death review service.⁴¹

33 See: Delaney S 2003, 'An optimally rights recognising mental health tribunal – What can be learned from Australian jurisdictions', *Psychiatry, Psychology and Law*, vol.10, no.1, p.74; See: Rees N 1990, 'Bringing law to psychiatric hospitals – Can it be done and is it worth the effort', Unpublished paper, pp.6–7; Lesser J 2007, *Review and decision making for persons with a serious mental illness: achieving best practice, A cross-jurisdictional evaluation of involuntary mental health review and decision-making systems*. Report prepared for The Winston Churchill Memorial Trust of Australia, p.48.

34 The Chief Psychiatrist role is replicated in mental health legislation in the Australian Capital Territory, Tasmania and Western Australia.

35 Western Australian Government, 2008, 'WA's suicide prevention and Commissioner for mental health, under Liberals', viewed 11 November 2008, <http://www.wa.liberal.org.au/index.php?option=com_content&view=article&id=551:was-first-suicide-prevention-plan-minister-and-commissioner-for-mental-health-under-liberals&catid=54:loop-news-category&Itemid=109>.

36 Established by the *Mental Health Act 1983* (England and Wales), *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), and the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), respectively. Note that MHAC is due to be subsumed into the Care Quality Commission established by the *Health and Social Care Act 2008* (England and Wales) which received Royal Assent on 22 July 2008.

37 *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), ss 75, 94; New Zealand Ministry of Health, 2003, *Guidelines for the role and function of district inspectors appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*, Wellington, p.vii.

38 *Mental Health Act 1983* (England and Wales), s 121.

39 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 5.

40 Other disciplines include social work, nursing, general practice, psychologists, lawyers, patients and carers.

41 *Mental Health Act 1983* (England and Wales), s 121(2); See also MHAC's website: <www.mhac.org.uk>.

A fundamental feature of specialist mental health monitoring bodies is their mandate to proactively visit mental health services on a frequent and unannounced basis to meet with patients.⁴² Such visits are focused on informing and assisting patients to exercise their rights and assisting service and system improvement rather than on inspector-type regulatory functions. Specialist mental health monitoring bodies also have powers to conduct investigations and they report publicly on the results of their findings.

The focus of visits is to meet with individual patients in private to hear about their experiences. Medical records and registers of the use of restrictive practices are scrutinised and relevant factors, including environmental, organisational and human rights issues, are assessed to ensure treatment and care complies with legislative requirements.⁴³ The aim of these visits is to improve the experience for individual patients and to check for patterns that may indicate the need for service improvement or systemic change.⁴⁴ A wide range of powers are used to help resolve issues at a local level, investigate unresolved complaints, ensure compliance with legislation and investigate breaches of patients' rights.

In order to achieve service and systemic improvement, specialist bodies in other jurisdictions publish their findings and recommendations following investigations and visits. In England and Wales, annual reports are produced based on information collated from individual service visits made throughout the year. The reports are service specific and are published annually on the MHAC website.⁴⁵ The purpose of these reports is to provide feedback to mental health services and other interested parties on the key issues that have arisen during visits and whether they have been addressed. Typically, such reports also contain a list of actions required.⁴⁶ Publishing service-specific annual reports is one of the many advantages to a commission, as is the ability to perform a range of coordinated functions designed to improve patients' rights and wellbeing.

- Q51. (a) What monitoring functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these monitoring functions and powers?**
- Q52. If publishing of information obtained through monitoring functions is considered necessary: (a) What publishing requirements should the new Act contain?
(b) In what other ways should the new Act require that information obtained through monitoring is used to improve patient wellbeing and achieve service improvement?**

42 For example, in 2007–08 in MHAC commissioners conducted 6109 meetings with involuntary patients in England and Wales, in Scotland MWC representatives visited 2294 patients, and in New Zealand district inspectors aimed to visit every person made an involuntary patient within the first week of the process and every voluntary patient: Mental Health Act Commission 2008, *Annual report and operating accounts 1 April 2007 – 31 March 2008*, London, p.67; Mental Welfare Commission for Scotland, 2007, *Our annual report 2006–2007 Key messages and challenges*, p.4; *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s 12.

43 See: Mental Health Act Commission, 'About Us – Visit Activity', <www.mhac.org.uk>; *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), ss 96–97; New Zealand Ministry of Health, 2003 p.10.

44 See: Mental Health Act Commission, 2008 p.5.

45 Mental Health Act Commission 2007, *Service provider reports – Reports introduction*, MHAC, viewed 16 October 2008, <<http://www.mhac.org.uk/>>; In Scotland, MWC publishes individual investigation reports on the internet. See: <http://www.mwscot.org.uk/newpublications/investigation_and_inquiry_reports.asp>.

46 In England and Wales, a response from the mental health service is expected within 28 days and these are also published on MHAC's website: <<http://www.mhac.org.uk>>.

8.3.2 Monitoring patient deaths

In addition to the above reporting functions, some specialist bodies also publish information about the deaths of involuntary patients. For example, in England and Wales, MHAC reviews the deaths of involuntary patients to establish whether good practice, as defined in a code of practice, has been followed and whether improvements can be made to practice or policy.⁴⁷ In response to each unnatural death, a trained MHAC commissioner reviews the death notification and any local action plan.⁴⁸ The intention is not to duplicate the local or coronial investigation but to act promptly to prevent similar deaths or other problems occurring within the mental health service or elsewhere.⁴⁹ Recommendations for action are made to the mental health service and published in its biennial reports on its website.⁵⁰ MHAC's commissioners may follow up recommendations during future visits or undertake a more detailed investigation.⁵¹

In recent years a death review role has been created in other Victorian legislation. A Child Safety Commissioner (CSC) was recently established to review the death of any child currently or recently under protection pursuant to the *Children Wellbeing and Safety Act 2005* (Vic).⁵² The objective is to promote continuous improvement and innovation in policies and practices relating to child protection and safety.⁵³ Reports are reviewed by a multidisciplinary ministerial advisory committee that examines the death of each child individually, and then in aggregate, to identify common themes and emerging trends. The Advisory Committee also recommends service responses in an annual report to Parliament.⁵⁴

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

8.3.3 Senior clinician

The Chief Psychiatrist occupies a clinical leadership role, which is vital to a sector facing high levels of service demand, increasing complexity in patient presentations and growing patient, carer and community expectations. However, as noted above the Act does not refer to the clinical leadership functions performed by the Chief Psychiatrist. In recent years clinical leadership roles have been established in other in Victorian legislation. For example, a Senior Practitioner role was recently created in the *Disability Act 2006* (Vic) with the general responsibility to ensure the rights of people with disabilities subject to restrictive interventions and compulsory treatment. The Senior Practitioner role is also designed to ensure that disability services comply with appropriate standards, in particular in relation to restrictive interventions and compulsory treatment.⁵⁵

47 For further information, see MHAC's website: <www.mhac.org.uk>.

48 The death reviewer may attend the coronial inquest or may undertake a 'death review visit': Mental Health Act Commission 2008, *Deaths of detained patients policy and procedure 2008*, MHAC, Nottingham, pp.5,8.

49 Mental Health Act Commission, 2008 p.3.

50 Mental Health Act Commission, 2008 p.5.

51 Mental Health Act Commission, 2008 pp.3–5.

52 The Child Safety Commissioner is required to conduct an inquiry and prepare a report: *Child Wellbeing and Safety Act 2005* (Vic), s 33(1).

53 *Child Wellbeing and Safety Act 2005* (Vic), s 33(2).

54 Victorian Child Death Review Committee, 2008, *Annual report of inquiries into the deaths of children known to Child Protection 2008*, Office of the Child Safety Commissioner, Melbourne, p.v.

55 *Disability Act 2006* (Vic), s 23(2)(a).

The Senior Practitioner is appointed by the Secretary and has a range of leadership and other functions. These include to: develop guidelines and standards; provide education, advice, information and directions to service providers to improve practice; develop professional and academic links and facilitate knowledge and training to the disability sector; and research and provide information to service providers on practice options.⁵⁶ The Senior Practitioner does not receive complaints about disability services; these are received by the Disability Services Commissioner, appointed by the Governor in Council.⁵⁷ The advantages of a establishing a statutory clinical leadership role include the ability to provide guidance to the Minister, the Secretary and the sector to improve patients' rights and wellbeing.

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

8.3.4 Clinical guidelines or codes of practice

The World Health Organization emphasises the importance of clinical guidelines in minimising intrusive treatments such as restraint and seclusion for both involuntary and voluntary patients.⁵⁸ The Chief Psychiatrist issues clinical guidelines, however, these are not recognised under the Act. Anecdotal evidence suggests that many clinicians are unaware of the content and effect of the clinical guidelines.

In the United Kingdom, guidance to clinicians on how to interpret and apply the legislation is provided in codes of practice issued by Parliament. Those performing functions under the legislation are required to have regard to the codes.⁵⁹ In addition, MHAC and MWC have each issued guidelines on clinical practice areas,⁶⁰ and MWC has a specific statutory responsibility to publish guidelines.⁶¹ Detailed guidelines or a code of practice may provide guidance to clinicians, particularly regarding respecting patients' rights.

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

56 *Disability Act 2006* (Vic), s 24(1).

57 These bodies were established by the Victorian *Disability Act 2006*.

58 World Health Organization, 2005 p.69.

59 *Mental Health Act 1983* (England and Wales), s 118(2D); *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 274.

60 Mental Health Act Commission 2007, Guidance notes list, p.1; viewed 17 October 2008, <http://www.mwscot.org.uk/newpublications/good_practice_guidance.asp>

61 *Mental Health Act (Care and Treatment) (Scotland) Act 2003* (Scot), s 10.

9. Complaints

9.1 Introduction

Most contemporary mental health legislation contains many safeguards to ensure that patients' rights are respected. In order to ensure that such safeguards achieve this purpose, these laws also establish specialist bodies to support patients or others on their behalf, and enable complaints about their treatment and care to be effectively and efficiently dealt with. These bodies have a range of powers to resolve complaints and promote service improvement.¹

An effective and efficient complaints system is essential to ensure that patients are able to voice any concerns about breaches of their rights, as articulated in the charter and Disabilities Convention. This chapter will examine the adequacy of the current Victorian complaint handling system for patients and their families and carers. In response to long-standing concerns expressed by patients and their advocates, this chapter explores ways the current system could be improved, as well as some of the features that are essential to an effective and efficient complaints system.

9.2 The Victorian context

In Victoria, some mental health services have a local complaints system for patients while others utilise the broader complaints system within general hospitals. The Act has no provisions for how local complaint mechanisms should operate and does not establish a complaint mechanism independent from mental health services for complaints that are not resolved at a local level. However, some mental health complaints are received by the Chief Psychiatrist and bodies established under other legislation such as the Victorian *Health Services (Conciliation and Review) Act 1987*.

9.2.1 Complaint handling under the Act

Although not established for this principal purpose, the Chief Psychiatrist's office receives many complaints relating to mental health service delivery.² In their role as volunteer advocates, community visitors resolve some patient complaints in person during their routine visits to inpatient mental health services.³ Community visitors also receive some telephone complaints via the Public Advocate's enquiry line.⁴ However, unlike the Chief Psychiatrist, community visitors do not have powers under the Act to resolve complaints.

The Chief Psychiatrist responds to complaints as part of the statutory responsibility for the medical care and welfare of patients.⁵ Most complaints to the Chief Psychiatrist's office are from involuntary patients who disagree with their diagnosis and the need for involuntary treatment. Voluntary patients can also make complaints to the Chief Psychiatrist's office. Many families and carers also contact

1 The World Health Organization argues it is crucial that involuntary patients have access to a specialist mental health complaints mechanism that is independent both from mental health service providers and government departments: World Health Organization 2005, *WHO resource book on mental health, human rights and legislation*, WHO, Geneva, p.71.

2 In 2007 the Chief Psychiatrist's office received 394 complaints about a range of mental health service delivery issues: Department of Human Services 2008, Chief Psychiatrist's complaint database, Unpublished data.

3 Pursuant to section 111(2) of the Act, community visitors are required to visit public mental health services at least once a month to enquire into the adequacy, appropriateness and standard of facilities. They also have specific statutory functions to enquire into complaints made by patients under section 109(g).

4 Further enquiries are managed by the Public Advocate: Office of the Public Advocate, 2007, *Office of the Public Advocate annual report 2007*, OPA, Melbourne, p.44.

5 The Act, s 105(2)(a).

the Chief Psychiatrist's office, often to express concern about the difficulty in accessing services or about treatment and care issues for a relative. Complaints are received by telephone and in writing.⁶ In responding to complaints the Chief Psychiatrist is assisted by departmental staff with clinical mental health expertise.⁷

The Chief Psychiatrist has statutory powers to make enquiries regarding patients' treatment and care, and regularly liaises with public mental health services to resolve complaints for patients, carers and families.⁸ The Chief Psychiatrist also has statutory powers to conduct investigations where there are concerns that a patient's medical care and welfare is at risk or where there are broader concerns about standards of practice.⁹

In recent years, the Chief Psychiatrist's office has conducted a small number of formal investigations in response to complaints.¹⁰ Following an investigation the Chief Psychiatrist prepares an investigation report for service management, summarising findings and making recommendations for action. As described in chapter 8, the Chief Psychiatrist has powers following an investigation to make treatment decisions.¹¹ These powers are infrequently exercised as the Chief Psychiatrist often addresses issues informally through liaison and discussion rather than by making formal directions to mental health services. The Chief Psychiatrist may also recommend that the department prosecute a clinician or mental health service following any failure to comply with the Act although this has not occurred in practice.¹²

Historically the Chief Psychiatrist's investigation reports have not been published. There is no requirement in the Act to provide the patient or complainant with a copy of the report and this does not routinely occur in practice. There is also no requirement in the Act for the Chief Psychiatrist to publish information about complaints. Although not required by the Act, in recent years the Chief Psychiatrist has initiated a practice of publishing an annual report containing information about the Chief Psychiatrist's activities including aggregate non-identifiable complaints data.¹³

9.2.2 Other complaints bodies

The HSC is an independent statutory authority established under the Victorian *Health Services (Conciliation and Review) Act 1987*. The primary function of the HSC is to receive and resolve complaints about general health services and health information privacy.¹⁴ As part of this role, the HSC receives some complaints about mental health services; however, it is not a primary mental health complaints body.¹⁵ The suitability of the HSC as a mental health complaints body must be

6 Of the 394 complaints received by the Chief Psychiatrist's office in 2007, 276 were made by telephone and 118 were written: Department of Human Services, 2008.

7 See: The Act, ss 105(2), 105(5), 106(1).

8 The Act, s 106(5)(b).

9 The Act, s 106(4).

10 Section 106(1) of the Act enables the Chief Psychiatrist to investigate the treatment and care provided to involuntary and voluntary patients, by both public and non-government services.

11 The Act, s 106AB.

12 Pursuant to: Department of Human Services 2005, *Prosecutions guidelines*, Victorian Government, Melbourne.

13 This data does not identify complaints made about individual services.

14 The HSC receives complaints about health information privacy under the *Health Records Act 2001 (Vic)*, and complaints about health services pursuant to the *Health Services (Conciliation and Review) Act 1987 (Vic)*.

15 In 2006–07 the HSC received 98 complaints relating to mental health services: Office of the Health Services Commissioner, 2007 p.30.

assessed against the following: the HSC does not generally receive complaints from families and carers unless they are nominated by the patient;¹⁶ the HSC requires that complaints be confirmed in writing;¹⁷ and the primary expertise of the HSC's office is in relation to general health rather than clinical mental health. Further, due to clinical mental health expertise in the Chief Psychiatrist's office, complaints made by involuntary patients are referred by the HSC to the Chief Psychiatrist or to the board.¹⁸ Unlike the Chief Psychiatrist the HSC has powers of conciliation, investigation and enquiry but has no powers to make treatment decisions.¹⁹

In addition, there are a number of other statutory bodies that may currently receive complaints about matters related to the treatment and care provided by mental health services. Guardianship-related complaints are received by the Public Advocate. Complaints about health practitioners are received by professional registration boards. Complaints about discrimination, sexual harassment or vilification are received by the Victorian Equal Opportunity and Human Rights Commission, and complaints about actions or decisions taken by government departments and statutory bodies are received by the Ombudsman.²⁰

Further, involuntary patients have a right under the Act to appeal to the board at any time if they wish to challenge their involuntary order.²¹ Despite a requirement under the Act that involuntary patients are informed of their rights, anecdotal evidence suggests that many involuntary patients are unaware of their right of appeal. This is discussed in further detail in chapter 4.

9.3 Rethinking complaint handling in Victoria

9.3.1 Mental health complaints at a local level

Complaints systems within Australia and internationally recognise that, ideally, most complaints will be resolved promptly at a local level. Patient advocates argue that complaints made by patients at a local level are often not dealt with in a transparent or rigorous manner.²² In response to concerns about the inconsistency of local complaint mechanisms for patients, the Minister has engaged the Consumer and Carer Subcommittee of the Ministerial Advisory Committee to review mental health complaints systems at a local level. It will examine complaint management policies and processes across selected adult mental health services and PDRS services. The subcommittee is due to report its findings later this year. The findings will inform this review.

Patient advocates argue that local-level complaints information is not made publicly available to inform service system improvement. There is no requirement that mental health services report or publish information on the number of complaints they receive or the action they have taken in

16 Pursuant to section 15 of the *Health Services (Conciliation and Review) Act 1987* (Vic), the HSC does not generally receive complaints from other family members or carers unless of the opinion a patient is unable to complain or choose a representative to complain and that the person seeking to represent the patient has a sufficient interest in the subject matter of the complaint:

17 *Health Services (Conciliation and Review) Act 1987* (Vic), s 17(2).

18 Office of the Health Services Commissioner, 2007 p.31.

19 Pursuant to section 11 of the *Health Services (Conciliation and Review) Act 1987* (Vic), the HSC can also name persons in reports in order to prevent or lessen the risk of a serious threat to a person or the public.

20 Pursuant to the *Guardianship and Administration Act 1986* (Vic), *Health Professions Registration Act 2005* (Vic), *Equal Opportunity Act 1995* (Vic), and *Ombudsman Act 1973* (Vic) respectively.

21 The Act, s 29(1).

22 Victorian Mental Illness Awareness Council December 2007, *VMIAC newsletter*, vol.11, no.4, p.2.

response to complaints.²³ In the Northern Territory, mental health services are required to report bi-annually about complaints received and any changes made to prevent recurrence.²⁴ They are also required to establish complaint procedures that aim to resolve complaints wherever possible and promote quality improvement.²⁵ In addition, they have obligations to notify complainants about their complaint procedures and about the progress of a complaint at regular intervals.²⁶

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

9.3.2 Mental health complaints at an external level

9.3.2.1 Specialist mental health complaints body

If a complaint is not resolved at a local level, patients should ideally have access to complaint mechanisms that are independent from mental health service providers and government departments. Commentators and patient advocates argue that a specialist complaint-handling body with mental health expertise is essential to safeguard the rights of the mentally ill and, in particular, those subject to involuntary treatment under the Act.²⁷

In Victoria the broader complaints system is fragmented and confusing for mental health patients, their families and carers. As described above, there is no central location for complaints about mental health services. They are received by the Chief Psychiatrist, community visitors and other bodies. Each of the statutory bodies that receive complaints has a different complaints jurisdiction, processes and powers. This makes it difficult for patients to know where to make a complaint and which body is able to respond.

As discussed above, currently most complaints are received by the Chief Psychiatrist's office. Commentators have questioned the appropriateness and effectiveness of the Chief Psychiatrist receiving complaints.²⁸ This is because the Chief Psychiatrist is part of the government department responsible for funding and administering mental health services in Victoria, giving it a dual role of advising the sector and dealing with complaints from patients.

Two bodies were recently created in the Victorian disability sector to perform the clinical adviser and complaints roles separately. As described above, the Senior Practitioner is employed by the Secretary to provide advice to disability service providers, in particular to monitor restrictive interventions. The Disability Services Commissioner, appointed by the Governor in Council, handles complaints.²⁹

23 Section 105 of the *Disability Act 2006 (Vic)* requires disability service providers to report annually to Disability Services Commissioner specifying the number of complaints received and how the complaints were resolved.

24 *Mental Health and Related Services Act 1998 (NT)*, s 100(9).

25 *Mental Health and Related Services Act 1998 (NT)*, s 100(2).

26 *Mental Health and Related Services Act 1998 (NT)*, ss 100(4)-(6).

27 See, for example: Delaney S 2003, 'An optimally rights recognising mental health tribunal – What can be learned from Australian jurisdictions' *Psychiatry, Psychology and Law*, vol. 10, no. 1, p. 74; Rees N 1990, 'Bringing law to psychiatric hospitals – Can it be done and is it worth the effort', Unpublished paper, pp.6–7; Lesser J 2007, *Review and decision making for persons with a serious mental illness: achieving best practice, A cross-jurisdictional evaluation of involuntary mental health review and decision-making systems*. Report prepared for The Winston Churchill Memorial Trust of Australia, p.48.

28 Mental Health Legal Centre Inc. 2006, *20/20 hindsight: A history of the Mental Health Legal Centre Inc*, MHLC, Melbourne, pp.69–70; Delaney, 2003 p.74.

29 These bodies were established by the Victorian *Disability Act 2006*.

Internationally, there are a number of specialist complaint-handling bodies. For example, in England and Wales, involuntary patients can complain about their treatment and care to the Healthcare Commission and MHAC.³⁰ MHAC provides support to involuntary patients by visiting them to advise them of their rights and, if they make a complaint, by corresponding with the local health service on their behalf.³¹ If a complaint is not satisfactorily resolved locally or by the Healthcare Commission, MHAC may conduct an investigation.³² MHAC also has powers to investigate where there are issues of legal compliance.³³ In addition, MHAC reviews all deaths of involuntary patients and may conduct an investigation where necessary.³⁴

In New Zealand the primary avenue for complaints relating to involuntary treatment is through district inspectors.³⁵ As outlined in other chapters, district inspectors have similar functions to MHAC. District inspectors are required to visit involuntary patients, advise them of their rights, support them in exercising their rights, receive and investigate complaints of breaches of their rights, and ensure that mental health services are improved where required in order for their rights to be upheld.³⁶ Similar to MHAC, in the first instance district inspectors aim to resolve most complaints informally at a local level. They may investigate clinical incidents such as suicides that have not been satisfactorily investigated or resolved locally.³⁷ Complainants who are dissatisfied with the outcome of a complaint to a district inspector or official visitor have the right to appeal to New Zealand's Mental Health Review Tribunal for further investigation.³⁸

9.3.2.2 Responses to mental health complaints

Neither the Chief Psychiatrist's office nor the HSC has sufficient powers to provide a comprehensive range of responses to mental health complaints. Commentators and patient advocates have identified that they are not required to reach determinations or publish rulings, nor do they have the procedural safeguards of a tribunal.³⁹ Further, the Chief Psychiatrist is not intended to be a complaints mechanism, nor is the office sufficiently independent from government.

30 Note that from 1 April 2009 the Healthcare Commission, along with MHAC, is due to be subsumed into the Care Quality Commission established by the *Health and Social Care Act 2008* (England and Wales) which received Royal Assent on 22 July 2008.

31 Healthcare Commission 2004, *Reforming the NHS complaints procedure*, Healthcare Commission, Manchester, p.10.

32 See: Mental Health Act Commission 2007, *About Us – complaints*, viewed 10 October 2008, <www.mhac.org.uk>; See also UK Healthcare Commission, 2004 p.10.

33 *Mental Health Act 1983* (England and Wales), ss 120(1)(b), 121(2)(b).

34 Refer to chapter 8 for a further discussion about MHAC's monitoring and death review functions.

35 *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), ss 75(1), 95(1).

36 *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), ss 75, 94; NZ Ministry of Health, 2003, *Guidelines for the role and function of district inspectors appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*, NZ Ministry of Health, Wellington, p.vii.

37 NZ Ministry of Health, 2003 p.15.

38 *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), s 75(4).

39 See: Delaney S 2003 p.75; Mental Health Legal Centre Inc. 2003, *Mental Health Legal Centre annual report 2002/2003*, MHLC, Melbourne, p.17.

A suitable model in terms of powers might be the Victorian approach to complaints about breaches of health information privacy. These are a subset of the complaints received by the HSC and can also be referred to be heard by VCAT.⁴⁰ The HSC has more extensive powers under the Victorian *Health Records Act 2001* to respond to health information privacy complaints than other complaints about health services. In particular, in relation to health privacy complaints, the HSC:

- must provide appropriate assistance to people wishing to make a complaint and keep them informed of action taken on complaints within specified time limits
- can attempt to resolve health privacy complaints informally, or by conciliation or investigation
- must inform complainants of their right to require the HSC to refer the complaint to VCAT for hearing and must refer a complaint to VCAT if requested to do so
- must certify any agreement reached at conciliation and provide copies to the parties
- following an investigation must publish a ruling regarding any interference with a person's privacy that must specify the reasons for the ruling, any action required to remedy the complaint and the period within which the action must be taken
- may issue a legally enforceable compliance notice following a serious or flagrant contravention of the legislation
- may require persons to attend, and provide documents and information for, conciliation, investigation or compliance purposes
- must publish reports and recommendations in the public interest
- subject to approval from the Minister for Health, can initiate inquiries into broader health care issues arising from complaints.⁴¹

**Q57. (a) What complaints functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these complaint functions and powers?**

9.3.4 Supporting patients to make complaints

Patient advocates argue that more support should be provided to patients and carers to assist them in making complaints.⁴² Internationally, contemporary mental health legislation contains support mechanisms to assist patients to make complaints. As described above, in England and Wales, and New Zealand, patients are assisted by specialist support people who perform visiting functions and receive and resolve complaints. In Victoria, the Chief Psychiatrist's office is not required to conduct routine visits to mental health services.⁴³ This means it is currently left to patients, their families and carers to initiate complaints, often by telephoning the Chief Psychiatrist's office or elsewhere.

40 Delaney, S 2003 p.75.

41 *Health Records Act 2001 (Vic)*, Part 6.

42 See: Mental Health Legal Centre Inc., 2006 p.49; Mental Health Legal Centre Inc, *Mental Health Legal Centre annual report 2004/2005*, MHLCC, Melbourne, p.11; Mental Health Legal Centre Inc., 2004 p.15.

43 Community visitors conduct routine visits, however, they do not have powers under the Act to resolve complaints.

Other legislation specifically provides for carers, family members or a nominated person to complain about treatment and care on behalf of a patient. For example, the Victorian *Health Records Act 2001* allows for health privacy complaints from nominated people and others where an individual is unable to complain personally. Legislation enabling another person to initiate a complaint on behalf of a patient is one way to ensure that patients' needs are addressed. It removes the need for patients to initiate complaints themselves. Another way to ensure that patients do not need to initiate complaints themselves is through an independent support person who could advocate on behalf of the patient.

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

9.3.5 Service improvement and prevention functions

Complaints are an important source of information about patients' experiences of treatment and care. The challenge is how to capture and use this information constructively to identify any changes needed and to avoid the same issues from reoccurring. Currently complaints are not analysed or published to enable prevention and service improvement in Victoria. International approaches to service improvement and prevention include regular visits, the results of which are published on the internet. For example, MHAC publishes a service-specific annual report on every mental health service in England and Wales providing services to involuntary patients based on the data and information collated from its visits.⁴⁴ The annual reports are public documents and are published on MHAC's website.⁴⁵ Their purpose is to provide feedback to mental health services and other interested parties on the key issues that have arisen during visits and whether they have been addressed, such as compliance with the legislation and codes of practice. Typically, annual reports also contain a list of actions required. A response from the mental health service is expected within 28 days and these are also published on MHAC's website.

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

44 Mental health services in England and Wales providing services to involuntary patients are known as 'trusts' and 'independent providers'. See: Mental Health Act Commission, 2007, *Service provider reports – Reports introduction*, MHAC, viewed 15 October 2008 <www.mhac.org.uk>.

45 MHAC provides mental health services with an opportunity to comment on the factual accuracies of annual reports before they are published on the website. See: Mental Health Act Commission, 2007.



10. Confidentiality and information sharing

10.1 Introduction

A key issue in contemporary mental health laws is how to protect the patient's right to privacy as far as possible while providing necessary information to those involved in their treatment and care. Deinstitutionalisation policies have meant families and carers have an increased responsibility to help manage and support the treatment and care of patients in the community.¹ Families and carers now play vital roles in supporting people with a mental illness. They are important partners with mental health services in improving the health and wellbeing of the people they care for, yet the Act requires information to be given to them in only very limited circumstances. The Act also limits the circumstances where information can be given to other services and agencies that are increasingly providing aspects of a person's treatment and care.

The information sharing and confidentiality provisions in the Act are extensive and complex and could be streamlined to make them easier to use. Any changes to the law in relation to confidentiality and information sharing must also be considered in light of the right to privacy in the charter and Disabilities Convention.² This chapter outlines the circumstances in which identified information about patients of mental health services can be lawfully disclosed without their consent. Consideration is given to how to improve information sharing, including with guardians, family members and carers, or to a person nominated by the patient.

10.2 The Victorian context

The Victorian *Health Records Act 2001* is the principal law regulating the *collection and use* of health information by mental health services.³ The Victorian *Mental Health Act 1986* is the principal law regulating the *disclosure* of health information by mental health services.⁴ In limited circumstances, the Act *requires* that clinicians disclose certain identified information about a person *without the person's consent*. A guardian must be notified when a person has become an involuntary patient and of the grounds for it.⁵ Further, reasonable efforts must be made to notify the patient's guardian or carer where a patient is to have ECT with the consent of the authorised psychiatrist.⁶

The Act *allows* (but does not require) the disclosure of identified information *without the person's consent* including in the following circumstances.

- **To a guardian, family member or carer for the purposes of ongoing care.** Under the Act, identified information may be disclosed to a guardian, family member or carer if the information is reasonably required for the ongoing care of the person *and* the guardian, family member or carer will be involved in providing that care.⁷ This provision allows a clinician to disclose information in the circumstances described, but does not require the clinician to do so.

1 Lesser J 2004, 'All care and whose responsibility?', *Psychiatry, Psychology and Law*, vol.11, no.2, p.237.

2 The charter, s 13; Disabilities Convention, art 22.

3 With the exception of collection and use in the electronic information system that is governed by s.120A(3)(e)(ii) of the Act.

4 The Act, s 120A(3)(a).

5 The Act, s 12AE.

6 The Act, s 73(3)(b).

7 The Act, s 120A(3)(ca) permits the disclosure of information to a guardian, family member or carer by a member of the medical staff or other prescribed clinical staff (prescribed by regulation 43 of the Mental Health Regulations 2008 (Vic)).

- **To assist another service or practitioner to treat a person.** Identified information can be disclosed to another service or practitioner for the ‘further treatment’ of a patient.⁸ Examples include the disclosure of information to a general practitioner who is supervising the treatment of a patient subject to a community treatment order.
- **Where the information is about the condition of a current patient and is communicated in general terms.**⁹ Only very limited identified information may be disclosed under this provision. For example, it would extend to telling a telephone caller that an inpatient is well enough to receive visitors.
- **Where necessary to carry out functions or exercise powers under the Act or other legislation.**¹⁰ For example, identified information can be given to a member of the police force or an ambulance officer in order to safely transfer a person to a public mental health service.¹¹
- **Where expressly authorised or permitted under the Act or other legislation.**¹² For example, identified information can be disclosed where there is a significant concern for a child’s wellbeing or where a child is in need of protection.¹³
- **To enable electronic information to be shared between public mental health services.** Employees of public mental health services are required to enter information in a shared electronic records system and can collect and use identified information from the system if it is necessary to enable the treatment of a patient.¹⁴
- **If the Minister considers it to be in the public interest.**¹⁵
- **To the Minister and Secretary.**¹⁶ For example, for incident reporting purposes or for investigating a complaint on behalf of a member of the public.

The Act also allows disclosure of identified health information *without the patient’s consent* in the following circumstances specified in the Health Privacy Principles (HPP) in the *Health Records Act 2001* (Vic).

- **For a purpose related to treatment.**¹⁷ For example, if a patient has a blood test to monitor blood serum levels of their medication, identified information will be shared with the pathology company undertaking the blood testing.
- **For management purposes.**¹⁸ For example, for the purposes of monitoring, improving or evaluating mental health services. However, identified information disclosed for management purposes cannot be published.
- **For legal or equitable claims.**¹⁹

8 Note that under section 120A(2B) of the Act, the giving and sharing of information between employees of a ‘relevant psychiatric service’ to provide treatment to an individual patient, including the sharing of information between inpatient and community-based clinicians of the same service, is regulated by the Health Privacy Principles of the *Health Records Act 2001* (Vic).

9 The Act, s 120A(3)(c).

10 The Act, ss 120A(2)(a)–(b).

11 Where transfer is in accordance with s 9B of the Act.

12 The Act, s 120A(2)(c).

13 See *Children, Youth and Families Act 2005* (Vic), s 36(4).

14 The Chief Psychiatrist, the Secretary, the Mental Health Review Board and the Forensic Leave Panel can also access and use information from the system where it is necessary for the performance of statutory powers, functions or duties: The Act, ss 120A(3B)(ac)–(b).

15 The Act, s 120A(3)(i).

16 The Act, s 120A(3)(j)–(k).

17 The Act, s 120A(3)(ea); *Health Records Act 2001* (Vic), Sch 1, HPP 2.2(a).

18 The Act, s 120A(3)(ea); *Health Records Act 2001* (Vic), Sch 1, HPP 2.2(f).

19 The Act, s 120A(3)(ea); *Health Records Act 2001* (Vic), Sch 1, HPP 2.2(k).

- **When a person is missing or dead.**²⁰
- **Where necessary to prevent a serious and imminent threat to a person or the public.**²¹
- **For research.** This permits the disclosure of identified information for the purposes of medical and social research if approved by an ethics committee.²² Information disclosed for the purposes of research must not be published in a form that identifies any person.

Unlawful disclosure of identified patient information is an offence.²³ It is also an offence for a person to access the electronic records system except as permitted under the Act.²⁴

10.3 Rethinking confidentiality and information sharing

10.3.1 Disclosure to families and carers

The benefits of family and carer participation in treatment decisions are well recognised.²⁵ A key issue is whether the Act provides an appropriate balance between the right to privacy of a patient and the needs of families and carers to access information to enable them to undertake their caring role. If a patient objects to the disclosure of information to their family or carer, this creates a tension that is difficult for clinicians to address. Families and carers frequently contact the Chief Psychiatrist's office to express concern at being excluded from pertinent information about treatment and care. This is particularly an issue around key events such as admission, discharge from hospital, current treatment, including prescribed medication, and significant treatment changes such as discharge from a community treatment order.

The Act permits the disclosure of information only to people who are involved in providing 'ongoing care'.²⁶ It is the clinician who decides whether a person is providing ongoing care and therefore falls into this category. There is anecdotal evidence that some clinicians consider that only family members and carers who live with the person receiving care are providing ongoing care. The department's publication for carers states that family members and carers do not need to be living with the person to be considered as providing ongoing care.²⁷

In practice clinicians are expected to consult with guardians, family members and carers where the patient consents. Further, they must also consult when preparing, reviewing and revising a treatment plan unless the patient objects.²⁸ Some jurisdictions have a legislative obligation to consult with a broader range of people. For example, in New Zealand clinicians are required to consult with 'family or whanau' during involuntary treatment unless it is not in the best interests of the patient or it is not

20 The Act, s 120A(3)(ea); *Health Records Act 2001 (Vic)*, Sch 1, HPP 2.5.

21 The Act, s 120A(3)(ea); *Health Records Act 2001 (Vic)*, Sch 1, HPP 2.2(h).

22 The Act, s 120A(3)(g); *Health Records Act 2001 (Vic)*, Sch 1, HPP 2.2(g).

23 Section 45 of the *Health Records Act 2001 (Vic)* allows some complaints about health information privacy breaches to be dealt with by the HSC.

24 The Act, s 120A(3B). Access to the electronic records system within public sector mental health services is limited to authorised personnel by the use of security measures such as passwords. Authorised personnel are granted different levels of access depending on their responsibilities.

25 Department of Human Services 2006, *Caring together, an action plan for carer involvement in Victorian public mental health services*, Victorian Government, Melbourne, p.3.

26 The Act, s 120A(3)(ca).

27 Department of Human Services 2005, *Information for families and carers of people with a mental illness*, Victorian Government, Melbourne, p.8.

28 Office of the Chief Psychiatrist, Department of Human Services 2005, *Working together with families and carers: Chief Psychiatrist's guideline*, Victorian Government, Melbourne, p.3; The Act, s 19A(2)(b).

reasonably practicable.²⁹ Clinicians are required to consult with this broad range of people when significant treatment decisions are made, at each juncture in the involuntary treatment process and when considering discharge.

Carer and family participation in treatment and care can be enhanced by providing information about key events such as when a patient is admitted to, or discharged from, a mental health service as an involuntary patient,³⁰ when a patient is placed on a community treatment order or when a hearing is listed before the board. A person nominated by a patient could also be notified of key events. In New South Wales, a carer or person nominated by the patient must be notified of a range of events, including details of admission, transfer and discharge.³¹

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

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

10.3.2 Guardians

A guardian requires detailed information about a represented person's treatment and care in order to make informed decisions in the person's best interests. The role of a guardian appointed under the Victorian *Guardianship and Administration Act 1986* is to make decisions in the best interests of the represented person.³² In effect, a guardian stands in the place of the person and makes certain decisions on their behalf. Guardians may have broad powers to make all decisions on behalf of a person or more limited powers to make certain decisions, such as accommodation decisions.³³ The Act allows information to be provided to a guardian *only* where reasonably necessary for the ongoing care of the person and the guardian is involved in providing that care.³⁴

29 *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), s 7A; 'Family/whanau' means a set of relationships a patient defines as family/whanau and is not limited to relationships based on blood ties: New Zealand Government 2006, *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992: Amended Section 7A: requirement to consult with family/whanau*, p.2, viewed 22 September 2008, <<http://www.moh.govt.nz>>.

30 In the Northern Territory carers must be consulted in relation to discharge planning if the patient consents. However, pursuant to section 89 of the *Mental Health and Related Services Act 1998* (NT), if the patient is unable to give consent or unreasonably refuses consent, consultation must still take place with the patient's carer if this is in the best interests of the person.

31 *Mental Health Act 2007* (NSW), ss 75, 78. A notification of initial detention must be made within 24 hours of the person being detained. In other cases the authorised medical officer must provide the notification as soon as practicable after becoming aware of the event.

32 *Guardianship and Administration Act 1986* (Vic), s 28.

33 *Guardianship and Administration Act 1986* (Vic), ss 24(1), 25(1).

34 The Act, s 120A(3)(ca).

It may be more appropriate for a guardian to be given all information given to the patient.³⁵ A related issue is whether the guardian of a represented person should be able to consent to the disclosure of confidential information about the patient to another person or organisation. Currently it is generally only the patient that can consent to disclosure of confidential information under the Act.

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

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

10.3.3 Disclosure of information for other purposes

The Act provides for the disclosure of health information to drug and alcohol services with patient consent. Best practice in the area of comorbid mental illness and substance misuse recognises the importance of an integrated approach to treatment. Accordingly, mental health services and drug and alcohol services may work together towards the recovery of a patient and may wish to develop a joint treatment plan for the patient.

Q64. (a) What service providers, if any, should receive identified information without a patient's consent? (b) If so, in what circumstances should they receive identified information without a patient's consent?

³⁵ Guardians must be informed on the making of an involuntary treatment order, performance of ECT without consent, and non-psychiatric treatment: The Act, ss 12AE, 73(3)(b), 85(a), 85(b).



Appendix 1: List of questions

The following is a list of the questions posed in the consultation paper. Please note that these are not intended to be exhaustive and comments need not be limited to these questions.

2. Background and framework for reform

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

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

3. Involuntary orders

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

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

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

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

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

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

Q9. In what circumstances, if any, should the new Act permit a person to be placed on an involuntary order where the person has capacity to consent and is refusing treatment?

Q10. How should the new Act address the issue of the seriousness and immediacy of risk in the grounds for an involuntary order as they apply to: (a) The person?
(b) Others?

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

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

- Q13. What requirements, if any, should the new Act contain to enable involuntary patients to provide informed consent to a wider range of psychiatric treatment?
- Q14. If a second psychiatric opinion scheme is considered necessary, in what circumstances should the new Act require a second opinion?
- Q15. What additional safeguards, if any, in relation to treatment decisions made by the authorised psychiatrist should the new Act include?
- Q16. Should the new Act include a best interests requirement in relation to treatment decisions made by the authorised psychiatrist?
- Q17. How should the new Act address the issue of children and young people who do not have capacity to consent to treatment due to their mental illness?

- Q18. What requirements, if any, should the new Act contain for clinical reviews of involuntary patients subject to: (a) An involuntary treatment order? (b) A community treatment order?
- Q19. In what circumstances, if any, should the authorised psychiatrist consent to the annual examination of an involuntary patient?
- Q20. What obligations, if any, should the new Act impose in relation to reporting results of annual examinations?

- Q21. If separate grounds for a community treatment order are considered necessary, how should they differ from the grounds for making an involuntary treatment order?
- Q22. What should be the duration of a community treatment order in the new Act?
- Q23. Should there be any restrictions on the type of treatment that can be given under a community treatment order in the new Act?

4. Patient participation in treatment and care

- Q24. What obligations, if any, should the new Act impose in relation to informing a patient's family, carer or nominated person of a patient's rights?
- Q25. If a nominated person scheme is considered necessary, how should the new Act address this?
- Q26. What requirements should the new Act contain to assist patients to understand and exercise their rights throughout the involuntary treatment process?

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

- Q28. What requirements, if any, should the new Act contain to address issues of: (a) Patient involvement in treatment planning? (b) The content of treatment plans?
- Q29. What additional requirements, if any, should the new Act contain to ensure the effectiveness of treatment plans?

- Q30. If an advance statement scheme is considered necessary: (a) What requirements should the new Act contain to ensure their effectiveness? (b) In what circumstances, if any, should the new Act allow an advance statement to be overridden?

5. Electroconvulsive therapy

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

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

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

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

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

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

6. Restraint and seclusion

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

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

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

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

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

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

Q43. If the physical restraint, mechanical restraint and seclusion of voluntary patients is considered necessary in the new Act: (a) On what grounds? (b) For what duration? (c) Subject to what safeguards?

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

7. External review and appeals

- Q45. (a) How soon after the making of an involuntary order should the new Act require external review? (b) How frequently thereafter should the new Act require external reviews of involuntary orders?
- Q46. What type of external body, what kind of proceeding, and what powers should the new Act contain for: (a) External review soon after the making of an involuntary order? (b) Subsequent external reviews of involuntary orders?
- Q47. How should the new Act address issues of patient participation in external review?
- Q48. How should the new Act address issues of participation by families, carers or nominated persons in external review?
- Q49. How should the new Act address issues of participation by members of the treating team in external review?
- Q50. Should the new Act incorporate the functions of the existing Psychosurgery Review Board within the functions of the external body that reviews involuntary orders?

8. Monitoring patient wellbeing

- Q51. (a) What monitoring functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these monitoring functions and powers?
- Q52. If publishing of information obtained through monitoring functions is considered necessary: (a) What publishing requirements should the new Act contain?
(b) In what other ways should the new Act require that information obtained through monitoring is used to improve patient wellbeing and achieve service improvement?
- Q53. (a) What death review functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these death review functions and powers?
- Q54. If the establishment of a clinical leadership role is considered necessary, what functions should the clinical leader perform?
- Q55. If giving legal force to clinical guidelines or codes of practice is considered necessary, what should be the implications of non-compliance?

9. Complaints

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

Q57. (a) What complaints functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these complaint functions and powers?

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

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

10. Confidentiality and information sharing

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

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

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

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

Q64. (a) What service providers, if any, should receive identified information without a patient's consent? (b) If so, in what circumstances should they receive identified information without a patient's consent?

Appendix 2: Overview of the current Act

Broad jurisdiction of the Act

The Act is the principal law governing the treatment and care of people with a mental illness in Victoria. Most of the Act is concerned with the provision of involuntary treatment and care. It sets out the circumstances in which a person can be involuntarily treated, the powers that can be exercised and the safeguards that apply. However, some parts of the Act apply to both voluntary and involuntary patients in both the public and private health care systems, such as the principles of treatment and care, the provisions governing ECT and the confidentiality and information sharing provisions.

Intent and fundamental principles of the Act

A fundamental objective of the Act is to provide for the best possible treatment, care and protection of people with a mental illness who do not or cannot consent to necessary treatment.¹ Other key objectives are to: facilitate the provision of treatment and care to people with a mental illness; protect the rights of people with a mental illness; and ensure all patients are informed about the Act and make use of its provisions.

The Act sets out principles of treatment and care that apply to the provision of treatment and care to all people with a mental illness in Victoria.² They have been developed to ensure high-quality treatment and care and to guide clinicians' day-to-day practice. The principles are:

- People should be provided with timely and high-quality treatment and care in accordance with professionally accepted standards.
- Wherever possible, people should be treated in the community.
- Treatment and care should promote and assist self-reliance.
- People should be provided with appropriate and comprehensive information about their mental illness, proposed and alternative treatments, including medication and services available to meet their needs.
- People should be treated near their homes or the homes of relatives or friends wherever possible.
- When receiving treatment and care the age, gender, religious, cultural, language and other needs of people should be taken into consideration.
- The prescription of medication should meet the best health needs of the person and be given only for therapeutic or diagnostic purposes and never as a punishment or for the convenience of others.
- Appropriately qualified people within a multidisciplinary framework should provide treatment and care.
- Every effort that is reasonably practicable should be made to involve a person in the development of an ongoing treatment plan; and treatment and care should be based on this plan. The plan should be reviewed regularly and revised as necessary.

¹ The Act, s 4(1)(a).

² The Act, s 6A.

The powers in the Act are required to be interpreted and exercised so that:

- all patients are given the best possible treatment and care appropriate to their needs in the least possible restrictive environment and the least possible intrusive manner consistent with the giving of effective care and treatment
- in providing for the care and treatment of patients and the protection of the public, any restriction upon the liberty of patients and any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances.³

The objectives of the department and the functions of the Secretary are also outlined in the Act.⁴

Involuntary treatment

A person can be made an involuntary patient by being placed on an involuntary order. A person on an involuntary order can be treated as an inpatient on an involuntary order or in the community on a community treatment order.⁵ The process and powers for making involuntary orders are set out in appendix 4. The Act sets out five grounds, all of which must be met before a person can be placed on an involuntary order.⁶ One of the grounds is that the person appears to have a ‘mental illness’. Mental illness is defined as ‘a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory’.⁷ The Act also specifies exclusions on which basis alone a person may not be considered mentally ill.⁸

Involuntary inpatient treatment can only occur in approved mental health services. These are public health services that have been proclaimed as approved mental health services.⁹ Every approved mental health service must have an authorised psychiatrist appointed by the board of the relevant health service.¹⁰ The authorised psychiatrist has specific functions under the Act, including the power to consent to treatment on behalf of an involuntary patient.¹¹

Regulated interventions and treatments

The Act sets out the circumstances in which a person can be subject to mechanical restraint or seclusion, or be given ECT or psychosurgery. These interventions are subject to additional safeguards including monitoring and reporting requirements.¹²

The Act also sets out the circumstances in which a person can be given non-psychiatric treatment¹³ and the requirement for every patient’s mental and physical health to be examined at least once a year.¹⁴ The death of any person receiving treatment or care that is a ‘reportable death’ must be reported to the Chief Psychiatrist.¹⁵

3 The Act, s 4(2).

4 The Act, ss 5, 6.

5 The Act, ss 12AA, 14.

6 The Act, s 8.

7 The Act, s 8(1A).

8 The Act, s 8(2).

9 The Act, s 94(1).

10 The Act, s 96.

11 The Act, s 12AD(2).

12 The Act, Part 5, Divisions 1–3.

13 The Act, Part 5, Division 4.

14 The Act, s 87.

15 The Act, s 106A.

Patient rights

As noted above, the objectives of the Act emphasise that individual rights must be protected and respected, and that any intrusion upon or restriction of those rights must be kept to the minimum necessary for the effective giving of treatment and care. The Act requires that involuntary patients receive an explanation of their rights including the right to obtain legal representation before the board and to obtain a second psychiatric opinion.¹⁶

Confidentiality and information sharing

The Act sets out the circumstances in which information relating to a person who is or has received treatment and care can be disclosed without the person's consent, including to families, carers and guardians.¹⁷

Safeguards

The Act contains a range of safeguards including provisions relating to the making, review and discharge of involuntary orders.¹⁸ It establishes the board that is required to review the making of an involuntary order within eight weeks of the order being made and at least once every 12 months.¹⁹ A patient may appeal to the board against their involuntary order at any time.²⁰ As part of any review or appeal the board must review the patient's treatment plan.²¹ The board must discharge an involuntary order if it finds the person does not meet any one of the grounds for an order.²² The board can also direct an authorised psychiatrist to make a community treatment order or revise a treatment plan.²³

The Chief Psychiatrist has overarching responsibility for the medical care and welfare of people receiving treatment or care for a mental illness and broad-ranging powers of investigation, enquiry and direction.²⁴ A further safeguard is the appointment of community visitors who visit bed-based mental health services and who can enquire into the adequacy and appropriateness of services and complaints made by patients.²⁵

Other matters

The Act contains provisions relating to a range of other matters including the interstate application of mental health laws, mentally ill offenders, penalties for breaches of the Act and miscellaneous administrative procedures.

16 The Act, s 18.

17 The Act, s 120A.

18 The Act, Parts 3 and 4.

19 The Act, s 30.

20 The Act, s 29.

21 The Act, s 35A.

22 The Act, s 36(2).

23 The Act, ss 36(4), 35A.

24 The Act, Part 6, Division 4.

25 The Act, Part 6, Division 5.

Appendix 3: Overview of the Victorian mental health service system

Mental health services are provided by a wide range of public and private providers as part of an extended mental health care system.¹ This includes general practitioners, private psychiatrists, psychologists, counsellors, other multidisciplinary therapists and practitioners, support agencies, community health centres, non-government services and self-help groups. Most people with a mental illness will be treated and cared for outside the specialist public mental health service system or have only intermittent contact during a psychiatric crisis or acute episode of illness.

Specialist mental health services

Specialist public mental health services are aimed primarily at people with more severe forms of mental illness whose level of disturbance or impairment prevents other services from adequately treating or managing them. Specialist public mental health services include PDRS services delivered by a wide range of community and non-government agencies. Multiple agencies may now be involved in providing different aspects of an individual's treatment, care and support as part of a comprehensive package of care. People may receive treatment from a specialist public mental health service for varying periods, depending on their needs. Some people will remain with a specialist mental health service for extended periods.

Specialist area mental health services

Mental health services are structured around three main program areas reflecting the different needs of people across the life span: child and adolescent (0–18 years), adult (16–64 years) and aged persons (65 years or older). Delivery of public specialist mental health services is based on defined catchment areas. This differs from the way general medical services are organised where people can present at a hospital or service of their choice. Most people receive treatment and care in their local area. Each area has a spectrum of bed-based and community services designed to respond to the different needs of individuals over time and enable them to move between components of care when needed. PDRS services in each area offer a range of supported accommodation, psychosocial rehabilitation, recreational, respite and recovery programs. Area mental health services also have access to statewide or regional specialist services.

Public mental health service model of care

The Victorian public mental health service delivery model has been articulated in various policy and practice frameworks, and continues to evolve.² Key features of the model include patient-centred care, partnerships with families and carers, partnerships with other services, sectors and the broader community, continuity of mental health care, multidisciplinary care and coordination of care through case management.

1 Department of Human Services 2008, *Because mental health matters, Consultation paper*, Victorian Government, Melbourne, p.34.

2 For further background on Victoria's public clinical mental health services, see Department of Human Services 2006, *An introduction to Victoria's public clinical mental health services*, Victorian Government, Melbourne.

Appendix 4: The process and powers for making involuntary orders

This appendix outlines how involuntary orders are made and the powers enabling a person to be apprehended and taken to a mental health service.

Process for making involuntary orders

Request and recommendation

Under the Act, anyone over the age of 18 can request that a person be examined by a medical practitioner to see if they meet the grounds for an involuntary order. This is known as a 'request'.¹ If a request is made, one of the following can occur:

- **Examination by a medical practitioner:** If the medical practitioner decides the person meets the grounds for an involuntary order, they may make a 'recommendation'.² The person can then be taken to a mental health service for a further examination or may be examined in the community.³
 - **If the person is taken to a service** an involuntary treatment order must be made by a medical practitioner or a mental health practitioner such as a member of a crisis assessment and treatment (CAT) service.⁴
 - **If the person remains in the community** a medical practitioner or a mental health practitioner, must either:
 - make an involuntary treatment order and allow the person to remain in the community⁵
 - take the person, or arrange for the person to be taken, to a mental health service where an involuntary treatment order will then be made for the person.⁶
- **Assessment by a mental health practitioner:** If a medical practitioner is not available, a mental health practitioner may authorise that the person be taken to a mental health service if they consider the person meets the grounds for involuntary treatment. This is known as an 'authority to transport'.⁷ When the person arrives at the mental health service they will be examined by a medical practitioner for the purpose of making a recommendation.⁸ The Act does not state a timeframe in which an authority to transport must be implemented.

1 In accordance with section 9(1)(a) of the Act, the request must be in writing on a prescribed form. See: Sch 1 of the *Mental Health Regulations 2008* (Vic).

2 The Act, s 9(3). Pursuant to section 9(1)(a) of the Act, the recommendation must be in writing on a prescribed form. See: Schedule 2 of the *Mental Health Regulations 2008* (Vic). In accordance with section 9(4) of the Act, the recommendation lasts for 72 hours from the time the medical practitioner examines the person.

3 The Act, s 9(5).

4 The Act, s 12AA(2). A mental health practitioner is a health service provider who is (a) either a (i) registered nurse (ii) psychologist registered under the *Health Professions Registration Act 2005* (iii) social worker or (iv) occupational therapist. They must be employed by a public sector mental health service within the meaning of section 120A of the Act that is an approved mental health service or a community mental health service and engaged in the provision of acute psychiatric assessment and treatment functions in the community. See: r 5(1) *Mental Health Regulations 2008* (Vic).

5 The Act, ss 12(2)(b), 12(3).

6 The Act, ss 12(2)(a), 12AA(2).

7 Pursuant to section 9A of the Act, the authorisation must be in writing on a prescribed form. See: Sch 3 of the *Mental Health Regulations 2008* (Vic).

8 The Act, s 9A(1)(b)(ii).

Examination by authorised psychiatrist

The authorised psychiatrist or their delegate must examine the person within 24 hours after an involuntary treatment order has been made.⁹ The person may be in a mental health service or in the community when the examination takes place. If the authorised psychiatrist believes the grounds for an involuntary order are not met, the person must be discharged from the order.¹⁰ If the person is found to meet all five grounds for involuntary treatment, the psychiatrist will confirm the involuntary treatment order.¹¹ The authorised psychiatrist will decide whether the person needs to be detained and treated as an inpatient or whether the person can be treated in the community on a community treatment order. If the person can be treated in the community, the authorised psychiatrist must make a community treatment order.¹²

Apprehension and transport powers

Transport for examination

The Act sets out the powers that can be used to take a person to a mental health service if subject to a recommendation or an authority to transport. A police officer, ambulance officer or prescribed professional can use reasonable force to enter premises and restrain the person if this is reasonably necessary to take the person safely to the mental health service.¹³ A prescribed medical practitioner can authorise sedation if they believe it is necessary for the safe transport of the person.¹⁴ The practitioner can administer the sedation or direct a medical practitioner or nurse to do so.¹⁵ Where a person cannot be safely transported by any other means Ambulance Services Victoria has primary responsibility for transport. A police vehicle is an option of last resort.¹⁶

9 The Act, s 12AC(1).

10 The Act, s 12AC(2).

11 The Act, s 12AC(2)(b).

12 The Act, s 12AC(4)–(5).

13 The Act, s 9B(2)(a)–(b). The prescribed professionals are listed in regulation 5(2) of the *Mental Health Regulations 2008* (Vic).

14 The Act, s 9B(3). These are prescribed in regulation 5(3) of the *Mental Health Regulations 2008* (Vic).

15 The Act, s 9B(3).

16 Department of Human Services 2002, *Ambulance transport of people with a mental illness*, Victorian Government, Melbourne, pp.1 and 7; Department of Human Services and Victoria Police 2004, *Protocol between Victoria Police and the Department of Human Services Mental Health Branch*, Victorian Government, Melbourne, Part 4.

Apprehension by police

Police have the power in limited circumstances to apprehend and take a person to a medical practitioner or a mental health practitioner to see if the person meets the grounds for an involuntary order. The police officer must believe the person appears to be mentally ill and have reasonable grounds for believing that either:

- the person has recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person
- the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person.¹⁷

The police may enter premises and use reasonable force to apprehend the person.¹⁸ If the person is taken to a medical practitioner, the practitioner can decide that the person should be released or can make a recommendation if the person meets the grounds for involuntary treatment.¹⁹ A mental health practitioner can advise the police to release the person or can authorise the transportation of the person to a mental health service having regard to the grounds for involuntary treatment.²⁰

17 The Act, s 10(1). Pursuant to section 10(1A) of the Act, the police officer must believe the person appears to be mentally ill based on the behaviour and appearance of the person, but is not required to exercise any clinical judgement. Although infrequently used, section 11 of the Act also allows police to enter premises and use reasonable force to enable a medical practitioner 'to visit and examine' a person pursuant to a warrant issued by a magistrate if there is evidence that a person who appears to be mentally ill is incapable of caring for himself or herself.

18 The Act, s 10(2).

19 The Act, s 10(8).

20 The Act, s 10(5).

Appendix 5: Glossary of terms

Advance statement

A document that is created by a person when they are well that sets out the person's wishes and preferences for future treatment and care in the event the person becomes unable to make decisions. It may also contain lifestyle preferences or emergency arrangements to ensure that practical measures are addressed while the person receives involuntary treatment.

Authorised psychiatrist

Every approved mental health service must have an authorised psychiatrist appointed by the board of the relevant health service. The authorised psychiatrist has specific powers and duties under the Act. Consultant psychiatrists may carry out the responsibilities of the authorised psychiatrist under delegation.

Carer

A person involved in the ongoing care and/or support of a person with mental illness.

Charter

The Victorian *Charter of Human Rights and Responsibilities* commenced full operation in 2008 and enshrines a number of rights derived from the *International Convention on Civil and Political Rights*. The charter provides a legislative framework that protects and promotes human rights in Victoria.

Chief Psychiatrist

The Chief Psychiatrist is a psychiatrist appointed by the Secretary with the overall responsibility for the care and welfare of patients. The position and powers of the Chief Psychiatrist are set out in the Act.

Clinical incident

An event or circumstance that could have resulted, or did result, in unintended or unnecessary harm to a person receiving care. A clinical incident can be an *adverse event*: an incident in which harm resulted to a person receiving health care. A clinical incident can also be a *near miss*: an incident that did not cause harm.

Community treatment order

An order under section 14 of the Act requiring a person to obtain involuntary treatment for their mental illness in the community. A person must be subject to an involuntary treatment order before a community treatment order can be made.

Community visitors

Community visitors are volunteers with functions under section 109 of the Act to visit mental health services regularly to monitor the adequacy, appropriateness and standard of facilities.

Consumer

User of public mental health services.

Crisis assessment and treatment (CAT) service

These services operate 24 hours a day and provide urgent community-based assessment and short-term treatment interventions to people in crisis due to a mental illness. CAT services have a key role in deciding the most appropriate treatment option and in screening all potential inpatient admissions.

Deinstitutionalisation

Describes the change from an institutional model of care in stand-alone psychiatric hospitals to a system in which psychiatric treatment is provided by public mental health services in the patient's own community and psychiatric inpatient units in general hospitals. This process has occurred over the past 20 years in Victoria.

International Convention on the Rights of Persons with Disabilities (the Convention)

The Disabilities Convention commenced operation on 3 May 2008 and was ratified by the Australian Government on 17 July 2008. It is an international convention designed to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

District inspectors

Lawyers appointed by the New Zealand Minister of Health under the *Mental Health (Compulsory Assessment and Treatment) Act 1992* with specific functions including advising involuntary patients of their rights and supporting them in exercising their rights.

Electroconvulsive therapy (ECT)

A therapeutic intervention in which modified seizures are induced by the selective passage of an electrical current through the brain. It is performed under general anaesthesia and is most commonly prescribed for treatment of severe depression. It is regulated under Part 5, Division 2 of the Act.

Forensic patient

A person remanded or committed to custody under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

Health Services Commissioner (HSC)

Appointed under the *Health Services (Conciliation and Review) Act 1987* (Vic), the HSC can assist people with a complaint about a health service or about the privacy of their health information.

Individual service plan

A working plan that is put together by a patient and their case manager. It is a written summary of the goals and strategies for recovery, reviewed every six months. Although not required by the Act, it is expected that every patient will have an individual service plan.

Involuntary patient

In this paper 'involuntary patient' refers to a person subject to an involuntary treatment order or a community treatment order.

Involuntary treatment order

An order under section 12 or 12AA of the Act that requires a person to receive involuntary treatment. Treatment can be provided in either a community or inpatient setting.

Mental Health Act Commission, England and Wales (MHAC)

The independent multidisciplinary body that is currently responsible for monitoring the operation of the legislation as it applies to involuntary patients in England and Wales. Its functions are due to be subsumed into a new body with a broader mandate: the Care Quality Commission.

Mental Health Review Board (the board)

A quasi-judicial body established under the Act. Its main purpose is to hear appeals from, and regularly review the involuntary status of, all people subject to involuntary treatment orders in Victoria, including people on community treatment orders.

Mental illness

Defined in section 8(1A) of the Act as being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. The definition covers psychotic disorders such as schizophrenia and non-psychotic disorders such as disorders of mood, severe obsessive compulsive disorder, anorexia nervosa and dementia.

Mental Welfare Commission for Scotland (MWC)

An independent multidisciplinary body whose role is to monitor the operation of mental health law in Scotland and promote best practice in relation to its operation.

Minister

Victorian Minister for Mental Health.

Nominated person

A person nominated by the patient who will look after the patient's interests if he or she is treated under the Act.

Operational Data Store

An electronic records system established and maintained by the Secretary, enabling sharing of patient information between Victorian public sector mental health services to support continuity of treatment and care. Its use is governed by section 120A(3)(e)(ii) of the Act.

Patient

In this paper 'patient' refers to both voluntary and involuntary patients. (Note that in the Act 'patient' is defined differently as meaning an involuntary, security or forensic patient.)

Psychiatrist

A medical practitioner who has undertaken specialised training and registration that qualifies them to diagnose and treat mental illnesses. Some have further specialist training in areas such as child and adolescent psychiatry, aged persons psychiatry or forensic psychiatry. Psychiatrists work in psychiatric inpatient services, community mental health services or in private practice.

Quality assurance committee (QAC)

Established in June 1999 under section 106AC of the Act to oversee and monitor standards of mental health services.

Restraint

Includes physical and mechanical restraint.

- *Physical restraint* involves skilled hands-on immobilisation or physical restriction of the patient to prevent the likelihood of harm to self or endangering of others, or to ensure the provision of essential medical treatment. It is governed under section 9B of the Act to enable safe transport of a person to a public mental health service.
- *Mechanical restraint* means the application of devices (including belts, harnesses, manacles, sheets and straps) on the person's body to restrict his or her movement. It is regulated under section 81 of the Act.

Seclusion

The sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside. It is regulated under section 82 of the Act.

Secretary

Secretary to the Department of Human Services.

Security patient

A person remanded in custody or convicted of an offence who is detained in an approved mental health service under a hospital security order or a restricted hospital transfer order.

Sentinel event

Defined for the purpose of the department's sentinel event program as serious events that: occur within health services that are relatively infrequent; are clear-cut events that occur independently of a patient's condition; commonly reflect hospital system and process deficiencies; and result in unnecessary outcomes for patients.

Statutory

A function, power, duty, authority or jurisdiction set out in an Act of Parliament or in delegated legislation (such as regulations).

Treatment plan

Section 19A of the Act requires that each involuntary patient have a treatment plan. In developing plans the authorised psychiatrist (or delegate) must take into account the wishes of the patient and, unless the patient objects, the wishes of any guardian, family member or carer.

Victorian Civil and Administrative Tribunal (VCAT)

A tribunal that deals with a broad range of disputes including discrimination, guardianship and administration disputes. Under section 120 of the Act, a person can appeal a decision of the board to VCAT.

Voluntary patient

In this paper 'voluntary patient' refers to a patient who receives treatment and care for a mental illness, but not under an involuntary treatment order or community treatment order.