STATUTORY REVIEW OF THE MENTAL HEALTH ACT 2014

ORYGEN SUBMISSION

EXECUTIVE SUMMARY

Orygen welcomes the proposal to enact new legislation to replace the *Mental Health Act 2014*. The development of a new legislative regime provides an opportunity to build the structure of a new mental health system in Western Australia that promotes wellbeing and provides a prompt and wide-ranging set of early interventions for mental ill-health.

The proposals within the discussion paper are generally supported. However, there is scope for considering the following amendments to those proposals:

- involving people with lived experience in the review and consideration of complaints against breaches of the Act
- shortening the detention period for people detained under the provisions of the Act
- expanding the situations in which an explanation of rights occurs
- clarifying when a practitioner may make a decision contrary to an advance health statement
- providing an upper-time bound on when a further opinion must be provided
- reducing the time by which mental health advocates must make first contact with a person
- enshrining lived experience voices within the Mental Health Executive Committee, the Community Mental Health, Alcohol and Other Drug Council, and Mental Health Tribunals.

If you wish to discuss anything with Orygen's submission please contact Cameron Boyle, Senior Policy Analyst at Cameron.Boyle@orygen.org.au.

ABOUT ORYGEN

Orygen is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people. At Orygen, our leadership and staff work to deliver cutting-edge research, policy development, innovative clinical services, and evidence-based training and education to ensure that there is continuous improvement in the treatments and care provided to young people experiencing mental ill-health.

Orygen conducts clinical research, runs clinical services, supports the professional development of the youth mental health workforce and provides policy advice relating to young people's mental health. Our current research strengths include: early psychosis, mood disorders, personality disorders, functional recovery, suicide prevention, online interventions, neurobiology, and health economics.

ABOUT THIS SUBMISSION

Orygen welcomes the opportunity to provide a submission on the development of the Mental Health Act 2014 (the MH Act).

Orygen's submission is focused on opportunities to optimise the MH Act to ensure accessible, appropriate, effective and evidence-based mental health supports for young Western Australians (aged 12 to 25 years). This submission is based on Orygen's experiences as a research and knowledge translation organisation focused on youth mental health. The structure of this submission reflects the order of the relevant provisions in the MH Act, not a prioritising of suggested ammendments.

CHARTER OF MENTAL HEALTH CARE PRINCIPLES - COMPLIANCE

RELEVANT PROVISIONS

- Part 4 of the MH Act
- Part 19 of the MH Act

ORYGEN RESPONSE

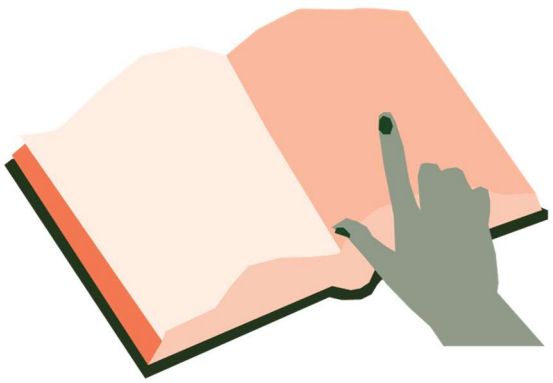
Orygen supports the continuing provision of the Charter of Mental Health Care Principles within the MH Act. Providing such a clear statement of the rights of peoples helps protect the wellbeing of all those within WA's mental health system.

Orygen would like to submit with respect to the investigation of complaints against potential contraventions of the Charter. It is important that the entity with oversight responsibility for complaints should be free of concerns about service delivery and funding in order to enable both actual and perceived independence. The Health and Disability Services Complaints Office (HaDSCO) has that independent character, and accordingly a body akin to HaDSCO should continue as the primary investigator of complaints.

However, Orygen would like to ensure that people with lived experience are involved in the determination and investigation of complaints. Currently Part 19 of the MH Act seems to provide that investigations by HaDSCO are primarily undertaken internally with little reference to external stakeholders. While a more streamlined process allows for relatively prompt consideration of complaints, Orygen considers that this priority is outweighed by the need to reflect a lived experience voice within HaDSCO.

Accordingly, Orygen considers that there could be value in providing a provision in the proposed MH Act to provide that the Director of the Complaints Office at HaDSCO must have regard to the views of at least one person with relevant lived experience to the subject matter of the complaint. In determining what is 'relevant lived experience', consideration must be given to age to ensure that young people with lived experience are consulted in matters relevant to young people. It's recognised that 'relevant lived experience' could be a challenging concept to interpret, as it may also capture factors as broad as demographics, mental health condition, and service location. Regardless, we still consider there is value in providing for such a concept in order to enshrine lived experience within the complaints process.

In order to strengthen this provision, HaDSCO should employ a range of people with lived experience of the Western Australian mental health system to assist in the determination and investigation of complaints.



DETENTION UNDER A TREATMENT ORDER

RELEVANT PROVISIONS

- Part 7 of the MH Act

ORYGEN RESPONSE

LENGTH OF DETENTION PERIOD

Section 87 of the MH Act provides that an involuntary inpatient can be detained for a maximum of 21 days if an adult, or 14 days if a child. Orygen considers that these periods of detention are too long due to the potentially significant impacts for a young person if they are left under an ill-considered, hastily provided or misapplied detention order for such a length of time.

There are examples of shorter review periods for detention orders in interstate legislation. In the *Mental Health Act 2007* (NSW), a review of a community treatment order can be heard in a minimum of three days if the person is detained in a mental health facility, and a minimum of 14 days if they are not detained in a mental health facility. Under the *Mental Health Act 2013* (Tas), an initial compulsory assessment order (which has effect for 24 hours) can only be extended for a maximum of four days prior to the Tasmanian Mental Health Tribunal considering whether a treatment order should be issued.

Orygen does not consider that a review period of less than seven days is necessarily viable as it can take this long to examine and review the impacts of treatment. Instead, we propose that the assessment period in the *Mental Health Act 2014* be lowered to somewhere between 14 days for adults, and 10 days for a child. This time period balances the risk of harm to a compulsory order being in place too long while providing sufficient time to understand the impact to a person's mental health.

Orygen is mindful of the potential impacts of such a proposed change and suggests consultation be undertaken with consumers and mental health practitioners to understand the impacts of shortening the maximum time for detention period.

PROTECTION OF PATIENT RIGHTS

RELEVANT PROVISIONS

- Part 2, Division 3 of the MH Act
- Part 13, Division 2 of the MH Act
- Part 16 of the MH Act

ORYGEN RESPONSE

EXPLANATION OF RIGHTS – EXPANSION

The MH Act is currently quite comprehensive in outlining where and how a person is to have their rights under the act explained to them. However, the current section 243 of the MH Act is largely limited to situations where a person is either involuntarily admitted to the mental health system, or appearing voluntarily at a hospital.

Orygen suggests that the explanation of rights should be expanded to occur at all entry points to the mental health system. This incorporates consumer's rights into the language of treatment from the earliest stages and will increase consumer literacy in those rights.

If there is to be a focus on understanding statements of rights and improving consumer literacy, then Orygen's view is that this should start as soon as possible. While not strictly a legislative issue, Orygen supports the benefits of delivering mental health awareness courses in secondary schools. Such an approach would help decrease the stigma of mental ill-health, in addition to improving awareness of the mental health system.(1)

REGISTER OF ADVANCE HEALTH DIRECTIVES

In both the MH Act and the *Guardianship and Administration Act 1990*, there does not seem to be any mandatory provision requiring that advance health directives be registered. One of the key issues that came out of the Victorian Royal Commission into Mental Health was the suggestion that advance statements be made accessible for service practitioners through a central register.

In a similar vein, it is worth considering the enshrining such a central register in legislation to ensure that mental health practitioners are readily able to access advance health directives.

SUBSTITUTED DECISION MAKING

For consumers who make an advance health directive, one of the main concerns is that their wishes as outlined in the directive will not be considered, or be overridden.

The MH Act currently provides, through sections 7, 8 and 179, how a psychiatrist must consider a person's wishes as demonstrated through statements such as an advance health directive.

However, the MH Act is not clear in outlining the circumstances in which a person's wishes may be overridden. While a psychiatrist is required to provide written records of any decisions that were inconsistent with a person's wishes, Orygen considers there is value in the proposed act giving some guidance as to when this could occur.

A possible option for how this could look can be seen in section 73 of the *Mental Health Act 2014* (Vic). This provision gives two circumstances in which a person's wishes may be overridden:

1. If the patients wishes are not clinically appropriate; or
2. If the treatment requested in the patients wishes are not ordinarily provided by the relevant mental health service.

Orygen supports the inclusion of this first criteria in any updated legislation, as there are circumstances where a person's wishes may not be clinically appropriate. However, Orygen does not necessarily support the requirement that a person's wishes be overridden if the services are not ordinarily provided by the relevant mental health service.

The risk with this requirement is that it could lead to equity issues depending upon service availability. If a consumer is in a region with a comparatively lower level of service availability, then there is an increased chance that their needs as specified in the advance statement may not be able to be met. In that situation, the 'treatment ordinarily provided' language would enable substitution, where a consumer in a region with greater access to services would be able to have their needs met.

One option is to instead use language akin to 'treatment reasonably provided by a designated mental health service.' This would limit issues of service equity and instead become a more objective examination of whether the treatment is ordinarily provided by Western Australian service providers.

INFORMATION SHARING

Currently, sections 249(2) and 577(1)(g) of the MH Act provide that a person has the ability to consent to the use or disclosure of their personal information.

For the purposes of this legislation, there needs to be consideration of what occurs when a person does not have the capacity to consent. There potential circumstance in which a person's mental health has declined to the point where they can no longer have sufficient capacity to make such decisions.

It is worth examining whether these information sharing provisions could be adapted to provide for a nominated person to provide consent to the use or disclosure of personal information. Currently the powers of a nominated person under section 266 of the MH Act are primarily centred around making treatment-related decisions. It is not an undue expansion of these powers to provide that the nominated person can also make decisions with respect to information.

FURTHER OPINIONS

Section 182(4) of the MH Act provides that a further opinion must be provided 'as soon as practable' after receiving the request for a further opinion.

The language 'as soon as practicable' provides for a subjective examination of the circumstances of the psychiatrist. If they are busy or otherwise unavailable, this could potentially justify the further opinion not being provided for an extended period of time.

One option to reduce the waiting period for further opinions is to provide an upper time-bound on when requests must be responded to by the second psychiatrist. Due to the often time-specific nature of mental health care, it is vital that any second opinion be accessed promptly. Orygen doesn't have any feedback on the length of such an upper time-bound for second opinions, yet suggests that any period os set following consultation with service practitioners and people with lived experience of mental ill-health.

If such a change were introduced, it would lessen the time taken to access a second opinion. Such a change should only occur following due consideration of the resourcing needs of the mental health sector. If such a change were bought in without proper resourcing, it would significantly impact currently practising psychiatrists.

MENTAL HEALTH ADVOCATES – DUTY TO CONTACT

RELEVANT PROVISIONS

- Part 20, Division 2 of the MH Act

ORYGEN RESPONSE

Section 357 provides that an identified person who is detained under the MH Act must be visited by a mental health advocate 'as soon as practicable', or within a certain period of time following the making of the request. The period of time varies depending on the circumstances of the patient. For an adult under an involuntary treatment order, the initial contact for a mental health advocate must occur within seven days.

Orygen is concerned about the risk that patients will not be seen until the end of their respective waiting period. Using the language 'as soon as practicable' provides for a subjective examination of the circumstances of the mental health advocate. If advocates are busy or otherwise unavailable, this could potentially justify a consumer not being attended until the end of the waiting period. This is important as there are potentially significant impacts that can occur to a consumer in that period.

There are further concerns regarding the equity of these provisions. Under the current provisions a 17 year old is classed as a child, and only therefore has to wait a maximum of 24 hours before being seen by a mental health advocate. However, once that person turns 18, they are now classed as an adult and potentially have to wait up to seven days to see a mental health advocate. For young adults, the risk of harm from an involuntary treatment order is functionally similar to that of an adolescent.

Accordingly, Orygen proposes that the maximum time for a mental health advocate to visit an adult be reduced. Ideally, there would be equity between children and adults, meaning that mental health advocates must make first contact within 24 hours.

An alternative is that the legislation provide for a definition of 'children and young people' for the purposes of this section which classifies all people 25 years and younger as 'children and young people'. This would provide support for young people while miniminsing the risk of over-burdening mental health advocates by providing for a 24 hour contact requirement for all patients.

It is recognised that such proposed changes would place an increased burden upon mental health advocates. However, this may be managed with increased investment in the advocacy program.

LIVED EXPERIENCE

RELEVANT PROVISIONS

- Part 21, Division 14 of the MH Act

ORYGEN RESPONSE

Orygen recognises the engagement of people with lived experience in the Mental Health Executive Committee (MHEC) and the Community Mental Health, Alcohol and Other Drug Council (CMC). Lived experience voices need to be involved at all levels of the new governance framework. However, it is also important to recognise the value in including representation of different lived experience backgrounds and experiences.

Accordingly, it is it is recommended that young people's voices are enshrined at all levels of the new mental health governance system. Young people are a cohort that is uniquely impacted by mental ill-health. The onset of mental ill-health generally occurs in young people, with 50 per cent of mental ill-health onset occurring before the age of 15 years and 75 per cent by the age of 24 years.(2)

Orygen proposes two primary options to reflect youth lived experience within the proposed MH Act. The first is to prescribe the membership of the Mental Health Executive Committee (MHEC) and the Community Mental Health, Alcohol and Other Drug Council (CMC) within the Act. Including lived experience within these governance structures is in line with the recent recommendations of the Victorian Royal Commission into Mental Health who (in recommendations 4 and 44) provided that people with lived experience must be involved in mental health governance.

In a similar vein to the language in section 211(2)(a) of that Act, there could be provision in the MH&W Act that at least two members of the MHEC and the CMC must be a young person (aged between 18 to 26 years) with experiences of mental ill-health. The reason for two young people is that there is an increased risk that a single young person will be isolated within a greater group setting, so having two young people enables them to support each other.

The second option is to amend the existing section 476(2)(c) to provide that the non-lawyer/non-psychiatrist member of the mental health tribunal must be a person with relevant lived experience. While the current provision does not prevent a person with lived experience being appointed to the tribunal, there is value in enshrining lived experience directly in the Act.

REFERENCES

1. Hampson ME, Watt BD, Hicks RE, Bode A, Hampson EJ. Changing hearts and minds: The importance of formal education in reducing stigma associated with mental health conditions. Health Education Journal. 2018;77(2):198-211.
2. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of general psychiatry. 2005;62(6):593-602.