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# Submission

## Exposure Draft Mental Health Bill 2010

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**Psychiatric Disability Services of Victoria's (VICSERV) role**

VICSERV is a membership-based organisation and the peak body representing community managed mental health services in Victoria. These services include housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self-help, respite care and Prevention and Recovery Care (PARC) services.

Many VICSERV members also provide Commonwealth funded mental health programs.

VICSERV welcomes the opportunity to make a submission regarding the exposure draft of the Mental Health Bill 2010. The submission focuses on the practical implications of the draft proposals on community managed mental health services and people who use these services.

## 1) Advance statements

VICSERV is pleased to see the recognition of advance statements in legislation. However of concern is it is not entirely clear who is eligible to certify the making or revocation of advance statements. For instance, one category of professionals that can certify is health professionals employed by a mental health service provider however the draft Bill does not contain a definition of the term 'health professional' unlike other legislation such as the *Child and Wellbeing and Safety Act 2005* (Vic). This lack of definition leaves the term open to wide interpretation which may jeopardise the validity of the advance statement or the withdrawal.

1. That the term 'health professional' be defined.

## 2) Nominated Person Scheme

As with advance statements, a clear definition of which health professionals are able to witness the making or withdrawal of nominations is lacking.

Users of community managed mental health services will invariably rely on staff to assist in the drafting of these documents. Therefore, there will be a need for training to ensure that staff are aware of advance statements and nomination documents as well as the ethical considerations when assisting in the drafting of these documents. For example, it would inappropriate for staff to accept to become a service user's nominated person or to influence what is written in an advance statement.

Another key consideration is how advance statements and nominations will be stored to ensure that the most up-to-date version can be accessed. With people accessing more than one service at any one time, ensuring all involved in their treatment and care are aware of the current advance statement and nominated person is vital. The exposure draft does mandate that a mental health service provider record particular information about the nomination on a departmental information system. This system however can only be accessed by a declared health service provider.

That a person who is nominated fully understands the implications of the role in accepting the nomination is crucial. The draft currently does not have a requirement for ensuring that the nominated person is properly informed about their rights and what the role entails. The legislated provision of an information sheet or communicating what the role demands could go some way in addressing this issue.

Additionally, the definition of 'person' under the *Interpretation of Legislation Act 1984* (Vic) includes a body politic or corporate as well as an individual which on strict interpretation would

mean that organisations may be nominated persons. It is unclear whether the drafters intend for organisations to be able to take up the role of nominated person considering that there is an age limitation on who can be appointed which would presuppose that it is natural persons which can be nominated.

There also appears to be a lack of ability to nominate more than one person at any one time. This may be problematic as there is no capacity for a 'back-up' nominated person unlike say Powers of Attorney.

It is of concern that the situation still remains unclear for those who do not have a nominated person with the current status quo appearing to remain. In practice, this will continue to create misunderstandings resulting in the withholding of information.

**Recommendations**

1. That a person is able to nominate more than one person at one time to be their nominated person.
2. That information sharing provisions where a person does not have a nominated person be clarified in the draft.
3. That there is a central repository for nominations and advance statements to ensure that the most accurate information is relied upon.
4. That there be a requirement that information is provided to the person proposed to be nominated about the scope, responsibilities and implications of the role in a manner that is understood by that person.
5. That the draft be clarified as to whether a nominated person can only be a natural person.
6. That training is provided to ensure that nominations and advanced statements are made properly and ethically.

### 3) Assessment Order

There has been some expressed concern that in order to assess a person, they must be detained an authorised mental health service. This poses some practical difficulties, particularly where the nearest authorised mental health service is far away from the person's home and support network.

Further, the definition of 'mental health practitioner' does not include occupational therapists, meaning that they will not be able to make an assessment order or transport the person to an authorised mental health service.

It is also unclear whether it was the drafters' intention that any person who practices in one of the professions listed under 'mental health practitioner' is able to make an assessment order or must they also be employed by a declared mental health service in order to do so.

**Recommendations**

1. That occupational therapists be included in the definition of mental health practitioner.
2. That it is clarified whether anyone who is a registered psychologist, registered nurse or social worker is able to do anything that a mental health practitioner is empowered to do under the draft or must they also be employed by a declared mental health service.
3. There be included a capacity for assessments to take place in the community rather than necessitating transportation to an authorised mental health service.

## 4) Changed criteria for community treatment orders

Of interest is the proposed criterion for community treatment orders which requires that services for the provision of appropriate treatment exist in the community, are available, and will be provided to the person.

It is unclear what this section will mean for the person about to be placed on a community treatment order if specific community treatments are not available or there is a waiting list for services. Further, the implications for community managed mental health services with respect of service demand remains unclear.

**Recommendations**

1. That s.71(e) is clarified with respect to what it means for the person if services are not available in the community.
2. That the terms 'available' and 'will be provided' are clarified, particularly from a temporal aspect.

## 5) Collaborative planning and case coordination

Section 131 of the draft has the title 'collaborative planning' which provides for the ongoing planning process for treatment in consultation with the person receiving mental health services, their nominated person and with their consent, their family/guardian. Missing from this is other mental health service providers who may be involved in the treatment and care of a person. Ideally, they too should be involved in the collaborative planning process.

Further, the draft assumes that everyone has a clinical case manager which is not always the case. This assumption has implications on communications between the consumer and those involved in provision of mental health and ancillary services such as housing, employment. The draft is not entirely clear how services will be working together and communicating in relation to a person's treatment and care.

Whilst it appears that one of the aims of the draft is for a more collaborative approach between clinical and community services in the provision of treatment and care, it is not explicitly stated in the draft. Of concern is how this will play out in practice so as to ensure there is a balance of philosophy and approach without the chance of one model dominating the other. On current reading, the draft has appeared to subsume all services into one even though arguably clinical services and community managed mental health services differ in terms of philosophy and service model.

1. That there is a clear distinction between community managed mental health services and clinical services.
2. That there is provision for community managed mental health services who will be or are involved in the recovery of the person to be party to the collaborative planning process.
3. That there is an explicit recognition that community managed mental health services and clinical services will be working in an equal partnership in the provision of care and treatment.

## 6) Review Officers

VICSERV is disappointed as to the scope of the proposed role of Review Officers. Largely an administrative position, supplanting to some extent the initial review process offered currently by the Mental Health Review Board, it offers little in terms of remedies or rights protections. There is considerable concern that even though the main role of Review Officers is to ensure that proper processes have been followed and to communicate to a person their rights, Review Officers will not have a capacity to discharge a person from a compulsory order or, in any case, advocate for the person. The Review Officer role as proposed will be a basic a 'rubber stamping' and a safety net for omissions by service systems. There is concern that this will lead to complacency in mental health services in not properly considering a person's rights and following due process when putting someone on a compulsory order.

VICSERV sees this as an opportunity to redefine the role, so that there is a strong advocacy component and that Review Officers, act as a conduit for information gathering, sharing and understanding.

Further, what is lacking in the draft is a position which assists persons with a mental illness to navigate the service system from beginning to end. The redefinition of the role could include such an aspect.

**Recommendations**

1. That the Review Officer role be redefined to give it a strong advocacy base for people with a mental illness throughout the treatment process.
2. A component of the role should be to coordinate information gathering and sharing as well as ensuring that information is being understood by the person receiving treatment and their carers/nominated person.
3. Review Officers should be made available to voluntary patients and not be limited to people on compulsory orders.
4. That there is an aspect of care and service coordination to the role of the Review Officer.

## 7) Mental Health Tribunal

VICSERV is pleased to see the proposed establishment of a Mental Health Tribunal and the more regular review of compulsory powers. However, it is disappointed that the initial review process has been relegated to Review Officers who have no power to discharge a person from an order.

The inability to lodge an appeal during the assessment order stage is of concern as it strips away the rights of a person to appeal his or her detention. VICSERV would like to see the initial review process occur within a short period and be conducted by the Mental Health Tribunal.

In addition, whilst the current notice of hearing provisions mandate that notice be given to nominated persons and interested persons, often in practice it is found that case managers or other non-clinical professionals involved in the treatment process will only know of an impending hearing through their client.

**Recommendations**

1. That initial reviews be conducted by the Mental Health Tribunal within 7 days of making a compulsory order.
2. A person or someone on their behalf, have the ability to lodge an appeal to the Mental Health Tribunal upon the making of an assessment order.

## 8) Mental Health Commissioner

Whilst VICSERV welcomes the proposed establishment of a Mental Health Commissioner, it is disappointed that the role does not encompass advocacy for service users, ensuring effective funding for services and the provision of quality services.

VICSERV would have liked to have seen the Mental Health Commissioner position be modelled upon the New Zealand equivalent as well as including the complaints component currently proposed.

**Recommendation**

1. That the Mental Health Commissioner's role be expanded to include advocacy for service users, ensuring effective funding for services and the provision of quality services.

## 9) Role of Chief Psychiatrist

VICSERV's understanding is that the Chief Psychiatrist's proposed main functions are to provide clinical leadership and to monitor the standard of mental health services provided by private, government as well as community-managed mental health services. This includes the development of guidelines and standards as well as provision of direction with respect of those services. Further, the Chief Psychiatrist will be able to conduct practice audits of some services.

The definition of 'mental health services' is not clear. As it currently stands, it will cause confusion in practice as to whether it includes particular community managed mental health services.

Further, there is some concern that there will be additional standards which will need to be complied with, building upon the current regulatory burden experienced by services. VICSERV would like to explore ways in which these standards can be developed and streamlined to avoid possible duplication.

**Recommendation**

1. That the definition of 'mental health services' is rephrased so that it is clear which community managed mental health services are included.

## 10) Codes of Practice

VICSERV is pleased to see provision for the making of codes of practice and the benchmarking of what is considered to be good practice. It is hoped that the Department seeks to partner with key stakeholders, particularly consumers and peak bodies such as VICSERV, in the development of codes of practice.

Whilst the current list of issues which codes will address is a good start, it does not include issues such as:

- Guidance on partnerships: how community managed mental health services and clinical services will be working together under the proposed Act.
- Cultural sensitive practices.
- Gender sensitive practices.

**Recommendations**

1. That there is a requirement for the Minister to consult with key stakeholders such as consumers and peak bodies in the development of the codes of practice.
2. That the issues to which the codes can pertain include guidance on partnerships, gender and cultural sensitive practices.