

RESPONSE OF THE WEST AUSTRALIAN CHIEF MENTAL HEALTH ADVOCATE TO THE PRODUCTIVITY COMMISSION DRAFT REPORT INTO MENTAL HEALTH – JANUARY 2020

The WA Chief Mental Health Advocate is the head of the Mental Health Advocacy Service (MHAS) which assists all patients on involuntary treatment orders, as well psychiatric hostel residents, people referred for psychiatric assessment, people subject to custody orders and required to undergo treatment, and some voluntary patients in Western Australia.

Its functions and powers are set down in Part 20 of the *Mental Health Act 2014* (the Act), which requires the Chief Mental Health Advocate to ensure advocacy services are delivered to the above groups of people – who are called ‘identified persons’ in the Act, and referred to as ‘consumers’ throughout this report.

The Act requires the Chief Advocate to be notified by mental health services of every person made involuntary, and Mental Health Advocates must contact all adults within seven days of them being made involuntary, and all children within 24 hours. Advocates also make contact at the request of consumers or others acting on their behalf. Involuntary treatment orders comprise community treatment orders (CTOs) (form 5As), involuntary inpatient treatment orders on an authorised mental health ward (form 6As) and involuntary inpatient treatment orders on a general medical ward (form 6Bs).

The Advocates’ functions include ensuring consumers are aware of their involuntary status, and their rights under the Act, and assisting consumers in protecting and exercising those rights. Advocates also seek to resolve complaints by consumers, facilitate their access to other services, and assist them in Mental Health Tribunal and State Administrative Tribunal hearings.

The Chief Mental Health Advocate’s comments on a number of the draft recommendations (DR) are set out below.

11.2 DR – The Australian, State and Territory Governments should collectively develop a national plan to increase the number of psychiatrists in clinical practice, particularly outside major cities and in sub specialities with significant shortages, such as child and adolescent psychiatry. This should be done in collaboration with the Royal Australian and New Zealand College of Psychiatrists, and form part of the broader National Medical Workforce Strategy which is currently being developed.

The WA Chief Mental Health Advocate (Chief Advocate) strongly supports DR 11.2 that a plan be developed to increase the number of psychiatrists. Advocates in regional areas are constantly dealing with locum doctors who come for a couple of weeks and then leave. A regional mental health service in WA has been without a permanent clinical director for years and only recently managed to get a psychiatrist to take the position on a time-limited contract.

The continuity of care is compromised as is the therapeutic relationship when doctors are constantly changing or not available. Often the locum doctors are from another jurisdiction and do not know the WA Act which means consumer rights are breached. Sometimes the locum psychiatrist will avoid making a decision because of their short stay; others will change the diagnosis or medication causing confusion and distress for the patient. Issues are also caused in Mental Health Tribunal hearings as the medical report required by the Tribunal is not produced because the previous psychiatrist has left and the new psychiatrist has not yet seen the patient.

Even in Perth metropolitan hospitals there can be significant use of locums and non-availability of psychiatrists, especially in school holiday periods such as January. In some mental health services there is no back-fill for doctors on leave and other psychiatrists have to pick up extra patients.

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16.6 DR – State and Territory Governments should adequately resource legal aid services to assist people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation. This could be addressed through broader legal aid funding or providing a specific legal aid grant.

The WA Chief Advocate strongly supports the recommendation that legal aid services should be better resourced to assist people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation.

In WA significant rights are regularly removed from people who are involuntarily detained on mental health wards or who have chronic and severe mental illness by the State Administrative Tribunal pursuant to the *Guardianship and Administration Act 1990* without the person being represented (or personally present) in the hearing. They may lose control over their finances, where they live, their medical treatment and even who they can see and talk to.

MHAS Advocates (who are not lawyers but who receive significant training) used to be able to provide this representation but due to its funding constraints have not been able to continue this work. Matters are referred to the Mental Health Law Centre (MHLC) but very often they do not have capacity and they need at least 10 days' notice which is not always available.

In relation to Mental Health Tribunal (MHT) hearings, the Chief Advocate is strongly of the view that every person who wants representation in a MHT hearing should have ready access to representation, and preferably it should be representation by a lawyer who has had additional training in mental health issues and engagement and who has time to get to know the person and ready access to the person's medical files.

In 2018-19 MHAS Advocates represented people in 838 (36.1%) of hearings while the MHLC represented people in 212 (9.1%) of hearings. Apart from the low level of representation by the MHLC, they regularly use para-legals for such hearings and have struggled to attract and retain lawyers due to the low level of funding. They also have difficulties and delays getting access to the medical files of patients (whereas MHAS Advocates can access medical files under the WA Act). It is not uncommon for the lawyer or para-legal to only meet the person on the day of the hearing. Significantly more funding and longer term funding (so it is not year to year) is required.

It should be noted that due to MHAS funding constraints Advocates do not attend MHT hearings if a lawyer is attending. Advocates will work with lawyers and give them information in the lead-up to the Tribunal hearing where a lawyer has been engaged early and has time.

16.7 DR – State and Territory Governments should ensure that non-legal individual advocacy services are available for all individuals subject to involuntary treatment under mental health legislation. In particular, services should:

- focus on facilitating supported decision-making by individuals subject to orders
- be resourced to provide assistance to all individuals who require it
- integrate with rather than replace legal advocacy services.

The WA Chief Advocate strongly supports this recommendation - with a proviso (or clarification) and two recommendations for amendment - noting that the Commission's recommendation is in part based on the MHAS. The proviso is that the advocacy service does not have to be 'integrated' physically or organisationally with a legal advocacy service, if this is what is meant by the draft recommendation. The Chief Advocate agrees that the advocacy service should not replace legal services and is also of the view that such a service should have a lawyer employed within it or ready access to legal advice. The Act does not require that the Chief Advocate be a lawyer but the current

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incumbent is a lawyer. Advocates receive considerable training in the Act and it would not be possible for them to carry out their job without this and access to advice on legal interpretation of the Act. MHAS also works closely with the MHLC in WA which is a separate not for profit non-government organisation.

The Chief Advocate also proposes that the Productivity Commission's draft recommendation 16.7 be expanded as follows:

1. That such advocacy services be established in legislation and provide the advocates with clear functions and powers as is the case in WA:
 - a. The functions and powers of MHAS Advocates include the right to attend wards at any time, ask and require staff to answer questions, view medical files, attend meetings with clinicians on behalf of the patient, provide general support to patients to help them enforce their rights and get access to other services. Except in very extreme circumstances the MHAS Advocates cannot be denied access to a patient and they have investigation powers as well.
 - b. These powers mean the Advocates must be taken seriously and can be much more effective at an individual level but also at a systemic level. With such powers comes responsibilities too, which is why the Chief Advocate favours a statutory agency rather than a funded non-government organisation. Funding is also likely to be more consistent (albeit still never enough) for a statutory agency which must be funded.
2. That such advocacy services should be available to any person on a locked ward or otherwise detained under mental health legislation (for example, in an emergency department) and not limited to those 'subject to involuntary treatment':
 - a. All child and older adult wards in WA are locked but most patients are not detained or treated under the involuntary mental health legislation – technically they are 'voluntary' patients but they are not free to leave the ward. Either they are told if they insist on leaving they will be made involuntary, and/or families/carers/guardians are making decisions. The person's voice is often not heard and they have no access to the protective rights under the Act of a tribunal hearing or second opinion, for example. Children are often in the guardianship of child protection or have parents who are dealing with their own issues and unable to advocate for the child. In the case of the elderly, the person may be 'compliant' but this is because they do not know their rights to leave or to refuse or question treatment.
 - b. People are regularly detained in emergency departments (ED) under the Act (sometimes for days) but this is prior to being 'subject to involuntary treatment' so the recommendation should make clear that they are also included. Advocates can make a big difference to the outcome of whether a person becomes distressed and agitated in the ED and also may be the difference between them being made involuntary or not, and discharged with appropriate follow-up or not.

20.3 DR - Traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. In the medium term (2-5 years):

- **The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people.**
- **This evaluation should incorporate the knowledge and views of Aboriginal and Torres Strait Islander people and seek to improve the evidence about how a partnership between traditional healers and mainstream mental healthcare can most effectively support Aboriginal**

and Torres Strait Islander people with mental illness and facilitate their recovery in their community

The Chief Advocate supports this recommendation. MHAS has recently conducted an *Inquiry into Services for Aboriginal and Torres Strait Islander People and Compliance with the Mental Health Act 2014*. Concerns had been raised by MHAS Advocates about whether mental health services were consistently offering Aboriginal consumers their rights under the Act to have assessments, examinations and treatment provided in collaboration with Aboriginal mental health workers and/or significant members of the person's community.

A draft report with 15 recommendations has been sent for feedback and comments to relevant stakeholders including the Acting Mental Health Commissioner and the Director General of the Department of Health, and the Chief Executives of the five health service providers in WA.

In short summary, based primarily on data from the health service providers and consumer feedback to Advocates, it appears that the Act is not being complied with in many cases and overall Aboriginal consumers are not consistently being offered their rights. The MHAS Inquiry Report remains in draft so may be amended but of particular relevance to DR 20.3 the preliminary findings included the following:

- There did not appear to be a common collaborative approach of treating teams working in partnership with traditional healers, elders and other significant community members in the mental health assessment, examination and care of Aboriginal people.
- Very few mental health services could point to examples of elders and traditional healers being involved with consumers and there was little data collected or available.
- Problems were reported in identifying and accessing traditional healers, and there was no clear or uniform practice for the payment of traditional healers or elders involved in assessment, examination or treatment.
- It appears that there is no procedure in most mental health wards to guide clinical teams on the process for collaboration in assessment, examination and treatment required under the Act.

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