The *Mental Health Act 2014*:
Health Services Information Session

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Welcome

Outline of information session

• Objectives and key principles of the *Mental Health Act 2014*

• Compulsory treatment pathway

• Supported decision-making

• Safeguards in the *Mental Health Act 2014*

• Oversight and service improvement mechanisms

• Preparation of health services for commencement on 1 July 2014
Objectives of the MHA 2014

- assessment and treatment of persons with mental illness
- least restrictive and least possible restrictions on rights and dignity
- enable and support persons to make or participate in decisions about their assessment, treatment and recovery and to exercise their rights
- provide oversight and safeguards
- recognise the role of carers
Mental Health Principles – key messages

The Mental Health Principles guide the provision of mental health services:

- Assessment and treatment provided **in the least restrictive way possible**
- People are supported to **make or participate in decisions** about assessment, treatment and recovery including decisions that involve a degree of risk
- Rights, dignity and autonomy to be respected and promoted
- **Holistic care** (mental and physical health needs including AOD) that is **responsive** to individual needs
- **Best interests** of children and young persons receiving mental health services to be promoted
- **Needs, wellbeing and safety** of children, young persons and other dependents to be protected
- **Carers to be involved** in decisions about assessment, treatment and recovery whenever possible
A mental health service provider must have regard to the mental health principles:

• when providing mental health services

• in performing any duty or function or exercising any power under the Act
The Mental Health Act 2014:

- promotes **voluntary treatment** in preference to compulsory treatment

- seeks to **minimise the use and duration of compulsory treatment** to ensure that the treatment is provided in the least restrictive and least intrusive manner possible

- establishes compulsory treatment orders comprising:
  - Assessment Orders
  - Temporary Treatment Orders
  - Treatment Orders
Criteria for **Assessment Orders:**

- person *appears* to have mental illness

- the person *appears to need immediate treatment to prevent serious deterioration* in the person’s mental or physical health *or serious harm* to the person or another person

- if the person is made subject to an Assessment Order the *person can be assessed*

- there is *no less restrictive means reasonably available* to have the person assessed.
Assessment Order may be made by a registered medical practitioner or mental health practitioner employed or engaged by a designated mental health service.

Mental health practitioner is a registered nurse, registered psychologist, registered occupational therapist or social worker employed by a designated mental health service.

- **Community** – maximum 24 hours
- **Inpatient:**
  - Maximum 72 hours for purpose of transport
  - Max 24 hours when person received at hospital
- An authorised psychiatrist or delegated psychiatrist can extend an Assessment Order up to two times for a total of 72 hours

*See circulated flow chart on Assessment Orders*
Designated mental health service is:

- Albury Wodonga Health
- Alfred Health
- Austin Health
- Ballarat Health Service
- Barwon Health
- Bendigo Health Care Group
- Eastern Health
- Goulburn Valley Health
- Melbourne Health
- Mercy Public Hospitals Incorporated
- Monash Health
- Latrobe Regional Health
- New Mildura Base Hospital
- Peninsula Health
- South West Healthcare
- St Vincent’s Hospital (Melbourne) Limited
- The Royal Children’s Hospital
- Victorian Institute of Forensic Mental Health
Criteria for **Temporary Treatment Order** and **Treatment Orders** (treatment criteria):

- person **has** mental illness

- the person **needs immediate treatment to prevent serious deterioration** in the person’s mental or physical health **or serious harm** to the person or another person

- the **immediate treatment will be provided** if the person is made subject to an Order

- there is **no less restrictive means reasonably available** to enable the person to receive the immediate treatment.
Temporary Treatment Orders: made by authorised psychiatrist
Community or Inpatient (maximum duration of 28 days)

Treatment Orders: made by Mental Health Tribunal
- Community (maximum duration 12 months – adult; maximum duration 3 months person <18 years)
- Inpatient (maximum duration 6 months – adult; maximum duration 3 months person <18 years)

Setting (inpatient or community) may be varied by authorised psychiatrist as clinically appropriate

Authorised psychiatrist must immediately revoke an order when the criteria no longer apply to the patient.
Authorised psychiatrist may delegate:

• any power, duty or function of the authorised psychiatrist to a psychiatrist except power to delegate

• the powers, duties and functions of an authorised psychiatrist relating to Assessment Orders to a registered medical practitioner including:-
  o power to examine a person and extend the duration of an Assessment Order
  o power to assess a person subject to an Assessment Order and to make a Temporary Treatment Order
  o power to revoke an Assessment Order.
The Act has provisions for transition arrangements for patients on recommendation and involuntary treatment orders on 30 June 2014:

- Patients on request and recommendation at time of transition
- Patients on ITOs and CTOs at time of transition
- Security and Forensic patients at time of transition

- *See circulated transition of orders flow chart*

- Clinicians will be provided with information sheets about these provisions to guide discussions with involuntary patients, their families and carers about the new arrangements
Authorised person is an ambulance paramedic, police officer, medical practitioner employed by a designated mental health service and mental health practitioner

Authorised persons under the *Mental Health Act 2014* may:

- **enter** premises
- **apprehend**
- **search**
- use force and **bodily restraint**
- **transport** people to a designated mental health service in prescribed circumstances.
Search powers under MHA 2014

- **Authorised persons** may search a person who is being transported under the Act if they suspect the person is carrying any thing that presents a danger to health and safety of the person or another person.

- Before searching, an authorised person must explain the purpose of the search.

- Search must be least invasive practicable in the circumstances.

- A search includes:
  - ‘pat-down’ search over person’s outer clothing
  - removing and examining jacket/coat/overcoat/hat/gloves/shoes
  - emptying pockets

- Search must be conducted by an authorised person of the same sex as the person searched or by a person of the same sex under the direction of the authorised person.

- Some items must be **given to police** as soon as practicable (s356)
Police powers

- s351 *Mental Health Act 2014* replaces s10 *Mental Health Act 1986* empowering police to **apprehend** a person who appears to have mental illness

- Police must arrange for the person to be **taken** to a registered medical practitioner or mental health practitioner for examination

- The registered medical or mental health practitioner will decide whether to make an **Assessment Order**

- The Act **enables police to release** the person from their custody into the care of a hospital **where it is safe to do so**
Ambulance paramedics

- Ambulance paramedics can now administer **sedation** to mental health patients under the direction of a registered medical practitioner or if it is within their normal scope of practice.

- Arrangements are being made to enable Non-Emergency Patient Transport (NEPT) to be used where reasonable and safe to do so.
• **Supported decision making** is central to recovery-oriented practice

• The *Mental Health Act 2014* enables compulsory patients to make decisions about their treatment and to determine their individual path to recovery

• Practitioners to **support patients to make or participate in decisions about their treatment**
Presumption of capacity and informed consent

• The Mental Health Act 2014 includes a presumption of capacity to make treatment decisions regardless of age or legal status.

• A person has capacity to give informed consent if the person:
  o understands the information he or she is given
  o is able to remember the information
  o is able to use or weigh information
  o is able to communicate the decision he or she makes.
The Mental Health Act 2014 includes principles to provide guidance around determining capacity (s 68(2))

Capacity to give informed consent is specific to the decision that needs to be made.

A person’s capacity to give informed consent may change over time. It should not be assumed that a person lacks capacity to give informed consent based only on their age, appearance, condition or behaviour.

A determination that a person lacks capacity to give informed consent should not be made only because the person makes a decision that could be considered unwise.

A capacity assessment should occur at a time and in an environment in which a person’s capacity can be most accurately assessed.
The Mental Health Act 2014 sets out the elements of informed consent

A person gives informed consent if the person has:

- capacity to give informed consent to the treatment
- been given adequate information to make an informed decision
- been given a reasonable opportunity to make the decision
- given consent freely without undue pressure or coercion
- not withdrawn consent or indicated any intention to withdraw consent
What if the patient does not have capacity or does not give informed consent to a course of treatment?

Authorised psychiatrist can make a treatment decision (except ECT & NMI)

There must be no less restrictive way for the patient to be treated

In determining **least restrictive treatment** authorised psychiatrist must consider:

- patient’s views and preferences (including in advance statement)
- views of nominated person, guardian, carer, parent of patient <16
- likely consequences for the patient if proposed treatment is not performed
- any second psychiatric opinion.
The MHA 2014 promotes supported decision making through:

- **Advance statements**
- **Nominated Person**
- **Second psychiatric opinions**

Other initiatives to promote supported decision making:

- **Advocates**
An **advance statement** enables a person to record their **treatment preferences** in the event that they become unwell and require compulsory mental health treatment.

Advance statements:

- can be made at any time provided a person **understands** what an advance statement is and the consequences of making it
- must be **signed, dated and witnessed** by an authorised witness which includes registered medical practitioner, mental health practitioner, person authorised to witness statutory declarations
- will be flagged on CMI to assist services to locate advance statement
Advance statements

• must be **considered** whenever a substitute treatment decision is made

• can be **overridden** if the preferred treatment is not clinically appropriate or not ordinarily provided by the mental health service
  
  o **written reasons** for overriding an advance statement must be provided within 10 days of a request for such reasons

• can be **revoked** at any time either by:
  
  o making a revocation; or
  o making a new advance statement
A person can nominate a person to receive information and support them while they are a compulsory patient.

A nominated person:

- must be willing, available and able to fulfill the functions and responsibilities of the nominated person
- may be under 18
A nomination:

• can be made or revoked at any time provided the person understands what a nomination is and the consequences of making or revoking it

• must be in writing, signed and dated by the person making the nomination and witnessed by an authorised witness which includes registered medical practitioner, mental health practitioner, person authorised to witness statutory declarations

• must include a statement from the nominated person saying they agree to be the nominated person

A nominated person may decline the nomination at any time.
Second psychiatric opinions

- will promote dialogue between clinicians and compulsory patients about treatment
- can be requested at any time
- written report of the second opinion psychiatrist will be provided to patient, authorised psychiatrist, nominated person and others
- second psychiatric opinions will continue to be provided by psychiatrists working in public mental health services
- **$1m** committed to second opinions from psychiatrists working in private practice to promote access and choice
- practice framework for second psychiatric opinions will be available
Advocacy

Advocates will assist patients to understand and exercise their rights and support them to participate in decisions about their assessment, treatment and recovery.

• Advocates are not prescribed in the Mental Health Act 2014
• Advocacy service is anticipated to commence in 2015
• Consultations are ongoing in the development of the advocacy service
Statement of rights to be provided to:
• patients, nominated person, carer and parent if patient is <16

Restrictive interventions will be subject to improved safety and accountability:

• restrictive interventions are seclusion and bodily restraint (mechanical restraint and physical restraint)
• must only be used after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable
• must report restrictive interventions to Chief Psychiatrist
Mental Health Tribunal will:

- make Treatment Orders
- decide the initial setting where treatment will be provided (inpatient or community)
- decide the duration of the Treatment Order
- comprise a panel of three members (legal, community and psychiatrist or registered medical practitioner)
- general and specialist hearing panels
  - psychiatrist must sit on panel for ECT and neurosurgery for mental illness hearings
Electroconvulsive treatment for adults

- A compulsory patient 18 years and over with capacity can consent to or refuse ECT without Tribunal approval
- Tribunal must determine applications for ECT for compulsory patients without capacity

What must the Tribunal determine?

- Does patient have capacity to give informed consent to ECT?
- Is ECT the least restrictive treatment for the patient?
Electroconvulsive Treatment For People Under 18

**Young compulsory patient** – Tribunal must determine:

- Does the young patient have capacity to give informed consent to ECT?
  
  **Yes:** Tribunal cannot approve ECT without informed consent of young patient
  
  **No:** Is ECT the least restrictive treatment for the young patient?

**Young person (voluntary patient)** – Tribunal must determine:

- Does the young person have capacity to give informed consent to ECT?
  
  **Yes:** Tribunal cannot approve ECT without informed consent of young person
  
  **No:** Has parent provided consent to ECT?

  Is ECT the least restrictive treatment for the young person?
Mental Health Complaints Commissioner

- will be a dedicated specialist complaints body
- will accept, assess, manage, investigate and endeavour to resolve complaints about publicly funded mental health service providers

MHCC will provide guidance to health services about complaint processes and requirements
Oversight and service improvement

**Chief Psychiatrist** – will provide clinical leadership, support and advice to public mental health service providers informed by:

- clinical audits
- clinical reviews
- reportable deaths

**Community Visitors**

- Will continue visiting, providing support and monitoring public mental health services
Disclosure of health information

The *Mental Health Act 2014* mandates when patient’s mental health information must be disclosed and to whom, for example:

- to carers *where a decision will directly affect the carer or the care relationship*
- to *nominated persons, guardians and parents* of patients <16

The *Mental Health Act 2014* also sets out when information may be disclosed, for example:

- to carers - when it is *required for a carer to be able to perform, or prepare for, their caring role*

An *ehandbook* is being developed which will provide guidance on the *Mental Health Act 2014* and its requirements.
Preparing health services for 1 July 2014 commencement

Information and Communication technology reform:
• video conferencing for Tribunal hearings
• CMI/ODS changes
• new case management system for the Tribunal

Forms, ehandbook and guidelines:
• Mental Health Act 2014 forms
• eHandbook and Guidelines

Codes of Practice:
• To be developed
Preparing health services for 1 July 2014 commencement

Nominated Persons, families and carers

• practice framework available May 2014
• train the trainer model and training materials for clinicians
• information resources for consumers, families and carers

Advance Statements

• practice framework available May 2014
• train the trainer model and training materials for clinicians
• information resources for consumers, families and carers
Preparing health services for 1 July 2014 commencement

Second Psychiatric Opinions

• Practice framework being developed by RANZCP and will be available in May 2014

Reducing Restrictive Interventions Project

• Framework for reducing restrictive interventions launched December 2013

• AMHS local action plans under development
Mental Health Tribunal

- e-training is being developed for mental health service staff to understand their role and responsibilities with respect to Tribunal hearings
- scheduling of hearings is being finalised with health services
- the Report on Compulsory Treatment form (currently the Report on Involuntary Treatment) will be available from May 2014.
Evaluation

• An evaluation framework has been designed that includes four focus areas:
  o measuring the level and duration of compulsory treatment
  o project audit and performance monitoring
  o monitoring statutory compliance
  o experience of care

• The evaluation will draw upon existing data sources and those to be established after commencement (including CMI-ODS, MHT, MHCC data), as well as phased implementation of a consumer experience of care data collection

• Options to collect data about carer’s experiences are being considered

• Evaluation will guide ongoing implementation of the Mental Health Act 2014 for both the department and health services
For more information

- Enquiry Line: 1300 656 692
- Email: mhactreform@health.vic.gov.au