Sub #12 to AHRC OPCAT NGO Consultation from Mental Health Advocacy Service (WA)

Ref: 117453

Mr Edward Santow
Human Rights Commissioner
Australian Human Rights Commission
Level 3, 175 Pitt Street
SYDNEY NSW 2000

By email – humanrights.commissioner@humanrights.gov.au

21 July 2017

Dear Commissioner Santow

RATIFICATION OF OPCAT - DETENTION FOR MENTAL HEALTH TREATMENT IN WA

I am writing in response to the *OPCAT in Australia - Consultation Paper*. As the Chief Mental Health Advocate (Chief Advocate) appointed under the *Mental Health Act 2014* (the Act), I must be notified of every person in Western Australia who is involuntarily detained, being compulsorily treated on a Community Treatment Order, or who is a mentally impaired accused required to be detained in an authorised hospital or "declared place".

Part 20 of the Act further requires that the Chief Advocate engage Mental Health Advocates (Advocates) who must contact every adult within 7 days, and children within 24 hours, of them being put on an involuntary treatment order. The Advocates have a number of functions aimed at providing rights protection, along with powers to enter and inspect mental health services at any time and make inquiries and obtain information and copies of documents.

Currently there are 34 Advocates engaged around WA (in the metropolitan area, Broome, Kalgoorlie, Albany and Bunbury) including two Senior Advocates who supervise and provide support to the Advocate teams. The service is known as the Mental Health Advocacy Service (MHAS) and it replaced the Council of Official Visitors in November 2016. I was previously the Head of the Council of Official Visitors in WA.

This response follows the "questions for discussion" as per the consultation paper and focusses on the experience of MHAS, the Council of Official Visitors and myself, so is primarily limited to the detention of people in the areas of mental health, disability services and child protection.

1. ***What is your experience of the inspection framework for places of detention in the state or territory where you are based, or in relation to places of detention the Australian Government is responsible for?***

1.1. The MHAS is the body responsible for protecting the rights of people in WA who are:

1.1.1. detained involuntarily under the Act

1.1.2. required to be detained in an "authorised" (mental health) hospital under the *Criminal Law (Mentally Impaired Accused) Act 1996* having been found not guilty by reason of unsound mind or not fit to stand trial

1.1.3. detained at the Bennett Brook Disability Justice Centre under the *Declared Places (Mentally Impaired Accused) Act 2015* having been found not guilty by reason of unsound mind or not fit to stand trial due to an intellectual impairment.

1.2. According to MHAS data[1], based on notifications to the Chief Advocate, between 1 July 2016 and 30 June 2017:

- 2,504 people were detained on 3,247 involuntary inpatient treatment orders
- 40 of those were children who were detained on 50 involuntary inpatient treatment orders
- five people were detained in an "authorised" (mental health) hospital under the *Criminal Law (Mentally Impaired Accused) Act 1996*
- two people were detained in the Bennett Brook Disability Justice Centre.

<u>Chief Advocate</u>

1.3. The Chief Advocate is appointed by the Minister for Mental Health for up to 5 years and can only be removed on limited grounds. They must provide an annual report to the Minister which must be laid before Parliament. The Minister may, after consultation with the Chief Advocate, issue written directions about the general policy to be followed by the Chief in performing functions under the Act. The Minister may also direct the Chief Advocate to visit a particular person or facility. In each case the Direction must be laid before Parliament within 14 days.

1.4. MHAS is an "administered item" for budget purposes and reliant on the Mental Health Commission for corporate support services. Public servants are provided to the Chief Advocate to assist in performing his/her functions and, although it is not specified who the employing authority is, this is currently the Mental Health Commission. There are conflict of interest issues which are currently being managed.

1.5. Ideally the Chief Advocate would be appointed by the Governor and report directly to Parliament (though in reality the Minister still controls the appointment) and have corporate support services provided by an agency that does not have any responsibility for mental health services.

<u>Advocates</u>

1.6. The Chief Advocate engages the Advocates on a contract for services (as required by the Act). This must include a specialised Youth Advocate and may include other specialists as the Chief Advocates determines.

1.7. Advocates have the powers and access required by NPM Bodies under the OPCAT. Attachment 1 sets out the functions and powers of Advocates under the Act. The powers are similar under the *Declared Places (Mentally Impaired Accused) Act 2015.*

1.8. There are various offences for not assisting an Advocate or hindering them in the conduct of their functions (s362). While Advocates can make inquiries and demand answers and information of staff, which must be given to them, they cannot see medical files where the involuntary patient objects to them doing so. This is a lower test than consent or capacity but, to properly protect rights, this should be amended in the Act.

1.9. Advocates do not have to have any specific skills but they are almost all tertiary educated and in my view need to be so because of the depth of the legislative knowledge they need and the report writing skills. They are given significant training in the relevant legislation as well as ongoing training and must follow protocols and meet standards set by the Chief

[1] The data is still being verified so may change slightly before publication in the MHAS Annual Report.

Advocate. Perhaps even more importantly they require a strong commitment to human rights, and high levels of people engagement, as well as a thorough understanding of mental health issues and contemporary models of care. While a number of the Advocates have some form of medical training (primarily nursing, OT, social work, or psychology) this is not essential and conflict of interest issues can arise.

1.10. In order to really find out what is happening in a place of detention, the most important skills are the ability to engage with, and gain the trust of, the people detained, particularly when they are also mentally unwell. This requires training and experience. Without the individual and ongoing input from consumers, occasional inspections will never fully uncover all the issues or provide the timely protection envisaged by OPCAT.

Visits/inspections and gaps

1.11. The Act does not legislate for a regular number of inspections or visits to mental health wards. Ideally the Act would provide for a minimum number of inspections of all wards with locked doors in order to ensure it happens and sufficient funding is provided.

1.12. MHAS Advocates do visit locked mental health wards at least weekly (and busy wards much more frequently), however, because of the requirement to contact people within 7 days (and children within 24 hours) of being made involuntary. MHAS protocols set by the Chief Advocate require Advocates to note and report on any issues regarding the health, safety and wellbeing of patients generally on the ward.

1.13. MHAS also currently conducts two "Inquiries" a year pursuant to the function requiring Advocates to inquire or investigate "any matter relating to the conditions of mental health services that is adversely affecting, or is likely to adversely affect the health safety or wellbeing of identified persons" (s352(1)(b) of the Act). The Inquiries usually have a focus area. Currently MHAS is running an Inquiry focussed on patient rights to a Treatment, Support and Discharge Plan. Later this year the Inquiry will be on sexual safety on the wards. This function is limited by funding.

1.14. A notable exception to the weekly visits is older adult wards. While these wards all have locked doors, the patients are rarely held involuntarily under the Act; instead guardians have agreed to them staying on the ward. This is a gap and an area of concern.

1.15. A Ministerial "Direction" relating to voluntary children on locked mental health wards means that these wards are regularly visited even though most of the children are not being formally detained under the Act.

1.16. An area of concern involving children, however, is the Kath French Centre, a secure facility for children run by the Department of Communities in WA. There is no independent oversight of this locked facility although Advocates come into contact with children admitted into, and discharged from, hospital into the Centre.

1.17. It should also be noted that an increasing number of mental health wards are kept locked even though the patients are voluntary. Issues are raised regularly by voluntary patients about this and MHAS has maintained pressure on these facilities to post signage making clear that the patients are free to leave the ward whenever they want. These wards always have some involuntary patients so come within MHAS jurisdiction but potentially are a gap area.

1.18. People are also detained in Emergency Departments under the Act under forms 1A (referral for examination by a psychiatrist) and 3A (detention order). Although people on these orders can request assistance from MHAS, the Chief Advocate does not have to be notified about them and currently MHAS is not regularly visiting or inspecting these facilities.

1.19. Another area of concern is the transport of people on detention orders under the Act (forms 1A and 3). This applies to transport to and between Emergency Departments and hospitals by police and transport services, and between prisons and the forensic mental health service.

1.20. Refugees are occasionally admitted to mental health wards but the Advocates can only assist them while they are an involuntary patient on the ward. It is understood that there is no independent oversight or inspection mechanism at the places on which they are otherwise detained.

Summary of gaps and areas for improvement

1.21. Amendments to the Act providing for:

1.21.1. more independence of the Chief Advocate by appointment through the Governor and Public Service staffing employed by a department unconnected with mental health

1.21.2. Advocates' ability to look at files without needing any form of patient consent

1.21.3. a minimum number of visits per month/year of all wards with locked doors for Inquiry and inspection purposes

1.21.4. a minimum number of visits per month/year of Emergency Departments where people are detained under the Act

1.21.5. independent oversight and inspection in relation to the compulsory transport of mentally ill patients

1.22. amendment to the *Child and Community Services Act 2004* to provide for independent oversight and inspection of secure care facilities under that legislation

1.23. independent oversight and inspection of places where refugees are detained.

2. How should the key elements of OPCAT implementation in Australia be documented?

2.1. A formal agreement between the state governments and the Commonwealth Government, inspection frameworks and methodologies set by the National Preventative Mechanism (NPM), in consultation with the bodies responsible for the inspections, and each NPM Body required to produce an annual report to be laid before its State parliament and the Commonwealth Parliament, would be key elements of OPCAT implementation.

3. What are the most important or urgent issues that should be taken into account by the NPM?

3.1. Transport of mental health patients (and prisoners) is an area of urgent need of oversight. MHAS dealt with a case last week where a young woman was brought into the forensic mental health service from prison in the back of a van naked and handcuffed.

3.2. People being detained indefinitely on a Custody Order under the *Criminal Law (Mentally Impaired Accused) Act 1996,* who are often young and intellectually impaired, is an urgent issue. Although WA has established the 10 bed Bennett Brook Disability Justice Centre pursuant to the *Declared Places (Mentally Impaired Accused) Act 2015* there have only ever been 2 residents and both have now spent more time incarcerated than they would have had they pleaded guilty. *The Criminal Law (Mentally Impaired Accused) Act 1996* urgently needs amending as it fails to provide procedural fairness. People with an intellectual impairment or mental illness can be jailed for many more years in prison than they would have been had they pleaded guilty and prison is not an appropriate place to detain them.

3.3. Another area of immediate concern is the detention of children on locked mental health wards. MHAS data indicates that 40 children were detained in mental health wards in

2016/2017. A current issue facing WA is that 16 and 17 year old youth can be detained on adult mental health facilities. Many more children are detained on locked mental health wards although not made involuntary under the Act. As a result they are detained but without the protections of the Act such as access to Mental Health Tribunal hearings and rights to second opinions, yet they may be restrained and secluded, and their access to communications restricted. By a Ministerial "Direction" requested by the Chief Advocate, they may now be supported by an Advocate. The detention exists because the doors are locked and family or guardians (Department of Communities) have agreed to them being there.

3.4. Children who are detained at the Kath French Centre run by the Department of Communities are also an area of immediate concern because there is no independent, legislated, oversight body for this facility.

3.5. Children in prison are also an area of urgent need. While not in the jurisdiction of MHAS we are aware that many have mental health issues and occasionally a child is detained in the Frankland Centre which is a forensic mental health hospital. There needs to be a facility for young people. The recent report by the Inspector of Custodial Services in WA has highlighted many other issues in the Banksia Hill youth detention centre.

3.6. Sexual safety and gender diversity on mental health wards are issues of major concern to MHAS. There is no female-only mental health ward in WA and MHAS considers this an important issue for those women who have a history of sexual abuse and trauma. There is one male-only ward at Graylands Hospital. It is not uncommon to have one woman patient on a ward in the forensic mental health ward at the Frankland Centre and sexual encounters on that ward are not uncommon. On other wards we have women traumatised by abuse who are forced to share wards with male patients, some of who can be quite agitated and volatile. Women are often in the minority on the wards. There are also issues for people who identify as LGBTQI.

3.7. Older adults (65 and over) on locked mental health wards are another risk area because most are there by agreement of the family or guardians without the protections of the Act. Unlike children, they do not have access to an Advocate. Although a Ministerial "Direction" was sought, funding issues meant it was rejected at this time. Elder abuse is of concern where families refuse to take them home or where family members have been appointed Guardian and/or Administrator and sell the family home, for example. The protections under the *Guardianship and Administration Act 1990* are significantly less than that under the Act.

3.8. Voluntary patients who are told they cannot leave or they will be made involuntary are also an area of concern, particularly when they are on a locked ward. A substantial number of mental health wards in WA have locked doors and voluntary patients have to ask to leave the ward, even for a short time to visit the hospital kiosk or walk in the grounds.

3.9. Emergency Departments where people are detained under the Act and often chemically restrained is also of concern. This is particularly the case in regional hospitals while they wait for the Royal Flying Doctor Service to bring them to Perth. Regional hospitals generally do not have a secure mental health ward so the person is chemically restrained in the Emergency Department and may be shackled to the bed as well.

4. ***How should Australian NPM bodies engage with civil society representatives and existing inspection mechanisms (e.g., NGOs, people who visit places of detention etc.)?***

4.1. There is the risk that inspection bodies can become highly specialised and insular, therefore requirements to consult with interested parties, and particularly the people detained and,

in the case of mental health, any carers, is essential to ensure the protection which OPCAT aims to provide.

4.2. This could be best achieved through the requirement to consult with consumers on an individual basis. Their complaints and issues will feed into the inspection process; no inspection process should be complete without such input. A great many of the systemic issues which MHAS gets involved in come from individuals who have been detained. Without their trust and the very regular visits to the wards by Advocates, many issues and the evidence for those issues, would go unnoticed and unreported.

4.3. At the very least some mechanism needs to be in place to talk to the people detained and consider the issues that have arisen for them during the period under review.

4.4. Holding regular consultation forums or having an advisory committee could also assist or perhaps regular and organised sharing of information and meetings. In the case of mental health though, it can be difficult to get the experience of the people detained except by being on the wards and building a trusting relationship with the patients. Consumers continue to ask for the Board of Visitors (the name of the organisation prior to 1997), the Council of Official Visitors reported a high rate of return of consumers (almost 60% in 2013/2014), and anecdotally consumers are frequently referred to our service by fellow consumers, indicating a high degree of trust in an organisation such as ours.

4.5. MHAS also regularly meets and consults with various consumer and carer groups and other non-legislated advocacy bodies.

4.6. There also need to be clear pathways and mechanisms for people to make "complaints" or provide information to the NPM bodies. MHAS has a freecall number, the usual website and email addresses plus a weekend phone roster to check messages.

5. *How should the Australian NPM bodies work with key government stakeholders?*

5.1. MHAS holds regular meetings with the management of every hospital where people are detained, as well as the CEOs of the health services, and other bodies such as the Mental Health Commission, the Mental Health Tribunal, the Chief Psychiatrist, and various NGO providers. Issues are raised, potential solutions discussed and information is shared at these meetings along with any issues which remain unresolved.

5.2. Prior to Inquiry inspections the hospital management are informed of the focus area although they are not told when the Advocate will be visiting the facility. Separate meeting arrangements may be made later. After Inquiries (inspections) a report is sent to the hospitals and they are given the opportunity to comment and respond. Letters may also be sent raising concerns. Regular feedback is given.

5.3. NPM Bodies should meet at least annually to share information and issues. The experience of MHAS and COV before it is that the issues are common across Australia. Avoidance of "reinventing the wheel" for inspections in every state would be useful.

5.4. The NPM should also meet with the NPM bodies individually on an annual basis.

6. *How can Australia benefit most from the role of the SPT?*

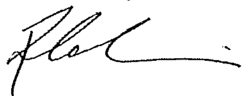
6.1. The SPT clearly has expertise that it could share. The provision of training or training tools would also be useful.

7. *After the Government formally ratifies OPCAT, how should more detailed decisions be made on how to apply OPCAT in Australia?*

7.1. We strongly suggest that direct contact be made with the existing visiting bodies such as MHAS to learn more about their current jurisdiction, capacity and expertise.

If you would like further please contact me or Donna Ayriss, Manager on (08) 6234 6300 or contactus@mhas.wa.gov.au.

Yours sincerely



Debora Colvin
CHIEF MENTAL HEALTH ADVOCATE

cc Minister for Mental Health (WA), Hon Roger Cook MLA
Mr Timothy Marney, Commissioner for Mental Health (WA)

Attachment 1

Extracts from the Mental Health Act 2014 (WA)

352. Functions of mental health advocates

(1) The functions of a mental health advocate are —
- (a) visiting or otherwise contacting identified persons in accordance with section 357; and
- (b) inquiring into or investigating any matter relating to the conditions of mental health services that is adversely affecting, or is likely to adversely affect, the health, safety or wellbeing of identified persons; and
- (c) inquiring into or investigating the extent to which identified persons have been informed by mental health services of their rights under this Act and the extent to which those rights have been observed; and
- (d) inquiring into and seeking to resolve complaints made to mental health advocates about the detention of identified persons at, or the treatment or care that is being provided to identified persons by, mental health services; and
- (e) referring any issues arising out of the performance of a function under paragraph (b), (c) or (d) to the appropriate persons or bodies to deal with those issues, including to the Chief Mental Health Advocate under section 363(2); and
- (f) assisting identified persons to protect and enforce their rights under this Act; and
- (g) assisting identified persons to access legal services; and
- (h) in consultation with the medical practitioners and mental health practitioners responsible for their treatment and care, advocating for and facilitating access by identified persons to other services; and
- (i) any other functions conferred on a mental health advocate by this Act or another written law.

(2) For the purposes of subsection (1)(d), a complaint may be made to a mental health advocate by a person who has a sufficient interest in the identified person concerned.

(3) The performance by a mental health advocate of the function under subsection (1)(e) includes —
- (a) assisting an identified person to make a complaint under Part 19 to —
  - (i) the person in charge of a mental health service; or
  - (ii) the Director of the Complaints Office; and
- (b) being an identified person's representative in respect of a complaint referred to in paragraph (a)(ii) if recognised as the identified person's representative under section 316(2).

(4) The performance by a mental health advocate of the function under subsection (1)(f) includes —
- (a) assisting an identified person in relation to any application made under this Act in respect of the identified person to, and in relation to any proceedings under this Act in respect of the identified person before, the Mental Health Tribunal or the State Administrative Tribunal; and
- (b) if authorised under this Act — representing an identified person in any proceedings under this Act in respect of the identified person before the Mental Health Tribunal or the State Administrative Tribunal.

(5) In performing a function under this section, a mental health advocate engaged under section 350(1) is subject to the general direction and control of the Chief Mental Health Advocate.

353. Powers generally

In addition to the specific powers conferred on a mental health advocate by this Act or another written law, a mental health advocate may do anything necessary or convenient for the performance of the functions conferred on the mental health advocate by this Act or another written law.

359. Specific powers of mental health advocates

(1) The powers of a mental health advocate include these powers —

(a) visiting, at any time and for as long as the mental health advocate considers appropriate, a mental health service at which one or more identified persons are being detained or that is providing treatment or care to one or more identified persons;

(b) inspecting any part of a mental health service that the mental health advocate visits;

(c) seeing and speaking with an identified person unless the identified person objects to the mental health advocate doing so;

(d) making inquiries about any of these things —

(i) the admission or reception of an identified person by a mental health service or other place;

(ii) the referral of an identified person for an examination to be conducted by a psychiatrist at a mental health service or other place;

(iii) the detention of an identified person at a mental health service or other place;

(iv) the provision of treatment or care to an identified person by a mental health service or other place;

(e) requiring a staff member of a mental health service or other place to do any of these things —

(i) answer questions or provide information in response to any inquiry made about a matter referred to in paragraph (d)(i) to (iv);

(ii) make available any document that the mental health advocate may inspect, or take a copy of, under paragraph (f) or (g);

(iii) give reasonable assistance to the mental health advocate in the exercise of a power under this subsection;

(f) inspecting and taking a copy of the whole or any part of the medical record of, or any other document about, an identified person that is held by the mental health service unless the identified person objects to the mental health advocate doing so;

(g) inspecting and taking a copy of the whole or any part of any document, or any document in a class of document, that is held by the mental health service and is prescribed by the regulations.

(2) A mental health advocate cannot exercise a power under subsection (1)(c) or (f) in relation to an identified person who is a voluntary patient without the consent of —

(a) the identified person; or

(b) if the identified person does not have the capacity to consent to the power being exercised in relation to him or her — the person who is authorised by law to consent to the provision of treatment or care to the identified person.

(3) The exercise by a mental health advocate of any power under subsection (1) is subject to the direction of the Chief Mental Health Advocate.