Exposure Draft of the Mental Health Bill 2010 feedback
AMA Victoria

AMA Victoria welcomes the opportunity to provide feedback to the Exposure Draft of the *Mental Health Bill 2010*. Victoria's mental health laws are outdated by national and international standards and need to change to reflect changing views and changing methods of the treatment of mental illness in society. However, it appears that the draft legislation does not recognise the workforce shortages and other pressures facing the public mental health system in Victoria today.

AMA Victoria notes that the new Minister for Mental Health has said that she will be taking another look at the review of the legislation (22 December 2010). There are several aspects of the draft Bill that will need reconsideration.

Principles

In our 2008 review submission, AMA Victoria recommended the revised Bill contain provisions which:

- view the mental health system as a whole;
- treat the right of the individual to privacy as paramount;
- are as least restricting on patients' freedom as possible;
- rethink confidentiality and information sharing;
- implement a thorough series of clinical audits;
- increase the frequency of external reviews of involuntary orders;
- facilitate greater patient input into the development of treatment plans; and
- assess how these principles are being met.

Introduction

AMA Victoria has identified issues with the exposure draft of the *Mental Health Bill 2010* which will compromise patient care and make it more difficult to navigate the mental health system. These include:

- a tendency towards legislating good medical practice;
- the length, complexity and overly prescriptive nature of the draft legislation;
- language issues;
- harsh and unrealistic penalties; and
- onerous red tape requirements.

Critically, the requirements contained in the exposure draft would not be able to be met without a significant increase in the resources directed to mental health care by the Victorian Government. There are not enough people, time or resources to meet the requirements of the proposed legislation. As responsible officials under the proposed legislation, it is possible that medical practitioners would face sanction should the government of the day not resource the sector adequately.

The overly prescriptive nature of the draft legislation is an underlying issue informing AMA Victoria's feedback. Through language, increased administrative requirements, and attempts to legislate good medical practice, the draft legislation is overreaching in several areas. The length of the legislation will make it difficult for clinicians to interpret and apply appropriately.

AMA Victoria recommends that several aspects of the legislation be omitted from the Bill and moved to regulations and Ministerial codes. This will ensure that parts of the legislation that prove too onerous and/or harmful to patient care can be amended without the need for a lengthy Parliamentary process.

Language

The Bill contains language which is absolutist[1], overly complex in parts, and redundant in other parts. Some examples appear to be drafting errors[2] while others appear to be unfortunate choice of wording[3].

For example, an Assessment Order requires that a medical practitioner 'inform the person who is subject to the Assessment Order of their rights under the Act.'[4] AMA Victoria has concerns that the complexity and length of this legislation will make explaining patients' rights in plain English difficult.

The increased complexity of the Bill will make it difficult for registrars and other medical staff to interpret and understand. Treating psychiatrists will be increasingly called upon to interpret, organise and assist in making arrangements as per the legislation. Administrative barriers to treatment may get in the way of doctors serving their patients.

Legislating medical practice

AMA Victoria is concerned that the exposure draft of this Bill attempts to legislate good medical practice. This is a worrying legislative trend where the objectives of best patient care may potentially clash with overly prescriptive legislative requirements.

There should be an assumption that medical practitioners are working in the best interests of their patients, as required by the AMA Code of Ethics, the common law and numerous legislative instruments.

Medicine is one of the most regulated activities in our economy, and there are many overlapping legislative instruments, credentialing processes and common law constraints on activity. The exposure draft of the Bill does not adequately recognise the legal environment, seeking to set up parallel processes at times. For example, should a medical practitioner provide care in a manner that is not clinically appropriate in the circumstances, then they are subject to scrutiny and penalty under the *Health Professions Regulation Act 2009*.

In legislating good medical practice, the Bill does not acknowledge the constantly evolving nature of medical practice and the flexibility required so it may be consistent with individual patient needs. While there is a temptation for legislators to attempt to prescribe good clinical practice, such attempts are likely to fail because every patient is different. What may be right 99.9 per cent of the time may not be in the best interests of the patient in all cases, and thus should not be prescribed in law.

[1] For example, *Exposure Draft of the Mental Health Bill 2010* (Vic) cl.. 123 (1) (b) requires "a description of the benefit, effect and risk associated with the treatment", an impossible task. Other examples include cl. 128 (b)
[2] For example, *Exposure Draft of the Mental Health Bill 2010* (Vic) cl.. 147 (7) (e) requires the medical practitioner to have regard to "if any alternative treatment is available." There is always an alternative, although few of those alternatives may be effective.
[3] For example, *Exposure Draft of the Mental Health Bill 2010* (Vic) cl. 7 (5) (d) uses "as is possible" rather than "as is reasonable." Similar language in cl. 142 (8)
[4] *Exposure Draft of the Mental Health Bill 2010* (Vic) cl. 66 (d)

Over-regulation in medicine means that there is the likelihood that the legislation ends up forcing a doctor to either obey the law, or provide the best possible care for their patient. No doctor should be put in that position.

There are a number of areas where the exposure draft imposes upon clinical areas. Some of these areas include:

- two doctors be in attendance during ECT at all times[5];
- doctors explain treatments in prescribed ways[6];
- families be involved when the patient is under 18[7];
- psychiatrists take into account certain matters[8];
- psychiatrists must undertake a physical exam[9];
- exclusion of trainees and other medical staff[10];
- provide time limits between treatments[11];
- no emergency ECT is available to persons under 18 years[12]; and
- emergency ECT requires a sign off by three doctors[13].

In some of the examples listed there is a possibility, however remote, that the proscribed activity would not be in the best interests of the patient. Others are more practical concerns, while at least one example (psychiatrists to conduct a physical exam) are not good medical practice.

The restrictions around the delivery of electro-convulsive therapy (ECT) are particularly concerning. It would be more appropriate to legislate for a second or third opinion to be required rather than legislate for the outright prohibition[14] of a recognised therapeutic intervention for sections of the population.

More broadly, the scrutiny applied to the use of ECT compared to other forms of treatment only serves to perpetuate the stigma of ECT, rather than acknowledge that it is a psychiatric treatment with a strong evidence base and high rate of effectiveness.

Harsh and unrealistic penalties

The Bill contains many harsh and unrealistic penalties, and appears to assume that medical practitioners are not seeking to act in the best interests of their patients. That the exposure draft envisages gaol or large financial penalties for contraventions of the Act is unjustified given the other forms of regulation in the field.

For example, in the section pertaining to the use of restrictive interventions,[15] the Bill states that a medical practitioner must not use restrictive intervention on a person receiving treatment for a mental illness in contravention of the Act. The penalty for doing so is 60 units. As noted, the administrative requirements are unwieldy and onerous. That a medical practitioner would be subject to large financial penalties for not doing their paperwork correctly every time is unjust.

[5] *Exposure Draft of the Mental Health Bill 2010* (Vic) cl.. 62
[6] *Exposure Draft of the Mental Health Bill 2010* , for example, cl. 9(1)
[7] *Exposure Draft of the Mental Health Bill 2010* cl.. 5(h)
[8] *Exposure Draft of the Mental Health Bill 2010* cl.. 71, 72, 132
[9] *Exposure Draft of the Mental Health Bill 2010* cl.. 77)
[10] *Exposure Draft of the Mental Health Bill 2010* (for example, cl.. 141
[11] *Exposure Draft of the Mental Health Bill 2010* for example, cl. 142, 171
[12] *Exposure Draft of the Mental Health Bill 2010* for example, cl. 145
[13] *Exposure Draft of the Mental Health Bill 2010* , cl.. 145
[14] *Exposure Draft of the Mental Health Bill 2010* for example, cl. 145
[15] *Exposure Draft of the Mental Health Bill 2010* (Vic) Part 8.

There are already penalties for medical practitioners who act in an unreasonable manner. Doctors who initiate treatment beyond their level of competence or who perform treatment on patients without their consent are subject to sanction by the Medical Board of Australia, along with several other disciplinary bodies.

Confidentiality and information sharing

AMA Victoria considers the right of the individual to privacy as paramount. Health care decisions are governed by doctor-patient confidentiality agreements, and this should not necessarily change in the case of mental health decisions.

The Bill contains several instances where 'any other person who has a genuine interest in the welfare of the patient' may act on behalf of a patient.[16] The Bill contains no definition of what constitutes a person who has 'genuine interest', and may end up affecting patients' privacy.

While a refusal to share information can lead to situations of tension between doctors and concerned third parties, the right of the patient to privacy overrides the perceived right of third parties to be privy to this information. There needs to be an exemption to ensure that disclosure is permitted if the treating clinician is of the view that the patient's interests are served by the disclosure, or there is a clear danger to the third party.

Red tape requirements

Mental health services need a measure of accountability that does not compromise a doctor's ability to treat. However, without significantly greater investment into the Victorian public mental health workforce, meeting the proposed increased regulatory requirements without cutting in to clinical time will be extremely difficult.

For example, the requirement of a second opinion[17] will be difficult to fulfil with current workforce shortages. Not only will the second opinion psychiatrist need knowledge of their responsibilities under the new Act, they will also need sufficient seniority to ensure their second opinion is credible.

The Bill does not allow for a medical practitioner to review their patients and waive second hearings. This is unnecessary duplication and an encroachment on the clinical judgement of the treating psychiatrist.

The Bill provides little scope for the engagement of registrars or junior doctors in the treatment of patients will mental illness. Registrars and junior doctors are an invaluable resource in our public health and mental health system, and are training to become the psychiatrists of the future. In order to attract and retain psychiatrists in training in the sector, a much greater importance needs to be placed on their role in providing patient care. For example, the Bill requires the treating psychiatrist conduct an initial physical examination of the patient.[18] Such a role could be taken up easily by a psychiatric registrar or a general medicine registrar.

[16] *Exposure Draft of the Mental Health Bill 2010* (Vic) cl. 81 (4), cl. 87 (2), cl. 83 (2), cl. 87 (2), cl. 95 (2), cl. 103 (7), cl. 119 (2), cl. 170 (2), cl. 179 (2), cl. 185 (2).
[17] *Exposure Draft of the Mental Health Bill 2010* (Vic), cl. 126
[18] *Exposure Draft of the Mental Health Bill 2010* (Vic) cl. 135 (1)

Senior medical staff are currently negotiating the implementation of 20 per cent clinical support time across all Victorian hospitals. This 20 per cent clinical support time, for research, teaching and training purposes will be more important than ever after the introduction of new legislation. This requirement will be difficult to meet with an increase in administrative work for psychiatrists in the public sector.

Resource implications

The administrative requirements of the exposure draft would not be able to be met without a significant increase in the resources directed to mental health care by the Victorian Government. This increase in resources will need to be directed at several areas, including the medical workforce, hospital infrastructure, and hospital ICT systems.

Introducing new legislative requirements without recognising the need for the resources to meet the new requirements would result in resources being diverted from patient care.

Next steps

While AMA Victoria supports a revamp of the Mental Health Act, the exposure draft has a number of key weaknesses that must be addressed. AMA Victoria recommends that following redrafting, a second exposure draft be released for consideration by the sector.