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Mental Health Act Statutory Review
System Development
Mental Health Commission
GPO Box X2299, Perth
Perth Business Centre WA 6847

Submitted via email: statutoryreview@mhc.wa.gov.au

Dear Sir/Madam

RE: Statutory Review of the Western Australian Mental Health Act (2014)

The Australian Psychological Society (APS) welcomes the opportunity to respond to the Statutory Review of the Mental Health Act (2014) (the Act).

The APS is Australia's largest and pre-eminent psychological association with more than 27,000 members. We are dedicated to advancing the scientific discipline and ethical practice of psychology in the communities we serve to promote their mental health and wellbeing. We strive to realise the full human potential of individuals, organisations and their communities through the application of psychological science and knowledge.

We consider the current review timely in terms of the growing demand for mental health services, and the need to ensure their quality and safety - as evidenced by several recent Royal Commissions and Government inquiries across Australia. This submission from the APS does not make comment on all sections of the Discussion Paper. Rather, we have endeavoured to provide a response that highlights the most salient issues from a psychological perspective.

Thank you for the opportunity to provide a response to the current review of the Act. If any further information is required from the APS, I would be happy to be contacted through my office on (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Kind regards,

Dr Zena Burgess, FAPS FAICD
Chief Executive Officer

Statutory Review of the Mental Health Act (2014)

The Australian Psychological Society (APS) is pleased to provide the following response to the Statutory Review of the Mental Health Act (2014) Discussion Paper.

The APS commends the Western Australian Government's intention to revise the Act. We note that the Discussion Paper covers a breadth of topics related to the Act. For the purposes of our response, the APS has only focussed on areas where we believe we have the relevant expertise and/or experience. Therefore, we have not provided input on all chapters and associated questions. Instead, we have limited our response to Chapter 3: Previously Identified Issues; and to only those themes where we believe we can make a useful contribution.

The economic and societal impact of mental illness in Western Australia

Mental ill-health affects all Australians directly or indirectly. It is widespread and has substantial personal, social and economic impact(s). This is well established. For example, the *2007 National Survey of Mental Health and Wellbeing*, conducted by the Australian Bureau of Statistics (ABS), indicated that one in five people aged 16 to 85 experience one of the common forms of mental ill-health (anxiety, affective or mood disorders, and substance use disorders) in any one year. Prevalence rates vary across the lifespan and are highest in the early adult years, the period during which people are usually establishing families and independent working lives¹.

The Western Australian Mental Health Commission's 2020 strategic plan² for mental health notes that the state faces many mental health challenges, including:

- 240 Western Australians suicide annually, well above the annual road toll of 191 people.
- Young Western Australians are particularly vulnerable to developing mental ill-health, with 75% of all serious mental illness occurring before the age of 24 years.
- Over half the defendants in surveys conducted in the Magistrates Court report experiencing mental health problems.
- Indigenous Western Australians comprise five percent of people in specialised mental health inpatient services, and
- An estimated 43% of people in specialised mental health hospital beds could be discharged if housing and other appropriate support services were available³.

Terms of Reference and Guiding Principles

The APS strongly endorses both the Terms of Reference and Guiding Principles for this Review. The former are broad and inclusive. In terms of the latter, the APS supports and reinforces that the intent and implementation of the Act must, first and foremost, serve to protect the human rights and dignity of people with mental ill-health, and their carers and families.

In addition, the focus on broad representation and "substantive equality" for different community groups in the Guiding Principles augers well for the recognition of diversity – both cultural and in terms of experience – and provides a frame for an inclusive approach to the current Review.

Further, the APS commends the Western Australian Government for the flexibility implied in the Guiding Principles around avoiding being overly-prescriptive, minimising the administrative burden associated with legislative change, and ensuring clinical practices are protected.

The APS notes that the Terms of Reference and Guiding Principles for the current Review are consistent with the "Key Principles" outlined in the Commissions 2020 strategic plan⁴.

Chapter 3. Previously Identified Issues

As an over-arching statement, the APS supports amendments which improve patients' rights, quality of care, and access to appropriate support. We note the various Themes identified in Chapter 3. of the Discussion Paper, and offer the following responses to those Themes pertinent to psychology.

THEME 1 - CONSUMERS

Status Identification on forms

1.1 Identifying Aboriginal and Torres Strait Islander status on the Approved forms (**Section of the Act:** Currently not a requirement under the Act.)

- The APS endorses the option to identify persons of Aboriginal and Torres Strait Islander status on all approved forms in use across the mental health system. We do so on the basis that it is essential to appropriately address the needs of this group by not only including this information in treatment planning, but from their first contact with the mental health system. While we acknowledge that there may be some duplication of administrative tasks if this becomes a legislative rather than simply clinical requirement; it is hoped that as a mandatory action required under law, Aboriginal or Torres Strait Islander people will more consistently be offered their rights.
- In addition, the APS emphasises the need to identify other potentially at-risk groups (e.g. Culturally and linguistically diverse [CALD] and LGBTIQ+ communities, and people in economically deprived circumstances, i.e., those who are long term unemployed and/or receiving NDIS support or the Disability Support Pension) to ensure the provision of appropriate support for vulnerable people who come into contact with the mental health system under the Act.

1.5 Voluntary inpatient rights [including older adult patients] (**Sections of the Act:** Part 16, Division 2, Subdivision 2 – Rights of inpatients generally and section 348.)

- The APS endorses the amendment to the Act regarding a “voluntary patient has the right to leave the ward and/or hospital at any time without permission” assuming the over-arching premise is based on the patient’s safety. For older adults who may not fully understand their circumstances, it makes sense that they be “identified persons” under the Act to enable access to assistance from the Mental Health Advocacy Service (MHAS).

1.6 Restraints in non-authorized hospital wards (**Section of the Act:** Part 14, sections 227 and 228.)

- It would seem that the current provisions under the Act that relate to only authorised hospitals wards utilising restraints leave those using these practices in other hospitals and wards open to liability. This clearly needs to be addressed. In so doing however, the APS emphasises the need to ensure that any action taken is in the patient’s best interest in terms of their clinical care. While the APS recognises the necessity to use restraint during naso-gastric feeding of children with eating disorders, the potentially traumatic nature of this action must not be overlooked. For this reason, any legislative change needs to account for the consequences of such actions on the patients they are meant to be serving, and allow for minimisation of harm.

Current literature suggests that the longer term psychological impacts of using restraint during naso-gastric feeding are unknown and more research is needed^{5,6}.

1.7 Private psychiatric hostel definition (**Section of the Act:** Private psychiatric hostels are defined in the Act by reference to the *Private Hospital and Health Services Act 1927*.)

- The APS supports the Act being amended to define hostels in a way that enables consumers to access the MHAS, and views this as an essential option for people staying in places such as step up/step down services and other supported accommodation.

1.8 Definition of ‘mental health service’ (**Section of the Act:** Section 4.)

- The APS endorses the proposed amendment to more broadly define ‘mental health service’ to bring new services under the purview of the Chief Psychiatrist.
- Given that the current definition of ‘mental health service’ includes psychological and psychosocial interventions, the APS suggests that it could be timely to investigate the appointment of a Chief Psychologist to support the work of the Chief Psychiatrist. This would be a beneficial step to accompany the increasing level of responsibility for the Chief Psychiatrist that would result from broadening the definition of ‘mental health service’.

1.9 Referral and detention timeframes back to back use of Forms 1A and 3 (**Section of the Act:** Part 6, various including sections 28, 44 and 45.)

- The issue raised under this point seems to speak to a lack of qualified personnel and resources (including hospital beds). Hence, this concern may not be adequately addressed by legislative change alone. However, the APS agrees that there is a need to examine how this current aspect of referrals to the mental health system are managed. We are particularly concerned about the length of time for which a patient can be detained in places outside of the metropolitan area, and how this might impact people from Aboriginal communities and remote locations. Simply amending the legislation to meet current practices appears to be an inadequate solution, and if the timeframes are extended, could potentially put patients at risk of further deterioration of their mental state.

1.10 Further Opinions (**Section of the Act:** Sections 182, 183 and 184.)

- Again, as above, this issue appears to be potentially caused by a lack of appropriate personnel and may not be adequately addressed by amendments to the Act. However, the APS supports a legislative amendment to enforce an improved time frame for further opinions, along with assurances regarding their independent status.

1.11 Treatment, support and discharge plans (**Section of the Act:** Sections 185, 186, 187 and 188.)

- The APS endorses amendments to the Act that ensure that treatment, support and discharge plans are completed in a timely way and to meet compliance requirements. This is not a purely administrative matter but relates to the necessity to engage patients in their treatment and seek a person-centred, collaborative approach between patient and hospital staff/treating clinicians. The opportunity for this may reduce over time, particularly for a person on an involuntary order who does not agree with being hospitalised, and therefore be resistant to psychiatric intervention.

THEME 2 - PERSONAL SUPPORT PERSONS

2.1 Decision not to notify personal support person (**Section of the Act:** Part9, section 140.)

- The APS agrees with an amendment to the Act to require notification to the Chief Mental Health Advocate within 24 hours. While noting the potential for an increased administrative workload for clinicians, the priority remains ensuring effective recovery based on engagement from, and collaboration with, the patient.

THEME 3 - CHILDREN

3.1. Mandatory notification to Mental Health Advocacy Service when a child admitted as an inpatient to an adult ward (**Section of the Act:** Part 20, section 357.)

- The APS supports an amendment to the Act requiring mandatory notification to the MHAS when a child is admitted as an inpatient, irrespective of whether they are admitted on a voluntary or involuntary basis.

3.2 Restraints of children in non-authorised hospitals (**Section of the Act:** Not covered in the Act. The suggested amendment is to Part 14, section 227)

- Please see our response to: 1.6 Restraints in non-authorised hospital wards.

3.3 Segregation of children from adult inpatients (**Section of the Act:** Part 18, section 303)

- While the APS agrees with the suggested amendment to the Act to exclude youth inpatient mental health units from being required to comply with section 303 reporting requirements, we believe that there may significant developmental disparity between patients in these facilities. A more specific consultation may be required to ensure that the Act adequately accounts for these differences.

3.4 Off-label treatment for children (**Section of the Act:** Part 18, section 304)

- The APS does not agree with the revocation of section 304, and indeed, questions whether it should be extended to include children who are voluntary patients.

We view this as an essential accountability mechanism for children in the mental health system, and a protective measure for clinicians who may be called to justify the use of off-label medication in these circumstances. In addition, the APS believes this data could be useful for research purposes and to understand trends in treatment.

THEME 4 - REGULATION OF CERTAIN KINDS OF TREATMENT

The APS notes that this Theme pertains specifically to electroconvulsive therapy (ECT). Despite the well-known efficacy of ECT for treating depression and other mental health conditions, there are risks associated with this kind of treatment, and therefore, an accompanying need for accountabilities and safeguards for both patients and clinicians.

4.2 Reporting of electroconvulsive therapy statistics (**Section of the Act:** Section 201.)

- Given the potential risks associated with ECT, the APS believes that the current requirement to report death or serious negative outcomes associated with this form of treatment needs to remain as per section 201 of the Act - to ensure that the collection of data pertaining to ECT specifically, is maintained.

4.3 Application to the Tribunal to use electroconvulsive therapy (**Section of the Act:** Part 21, Division 6.)

- The APS supports the suggested amendment that the Tribunal be required to consider whether a patient continues to require an involuntary order at the time of an electroconvulsive therapy application. However, we do not agree that the requirements set out under section 410 be removed altogether, as we consider oversight by the Tribunal a necessary safeguard to protect both patients and clinicians.

THEME 5 - MENTAL HEALTH ADVOCACY SERVICE

5.1 Engagement of advocates (**Section of the Act:** Section 350),

5.2 Chief Mental Health Advocates delegate (**Section of the Act:** Section 350), and

5.3 The term 'financial interest' (**Section of the Act:** Section 373)

- The APS agrees with the change provisions outlined under this Theme as they pertain to improving the employment status of advocates (5.1), the appointment of persons to the role of senior advocate (5.2), and providing clarity around the financial (and any other actual or perceived) conflicts of interest (5.3).

THEME 6 - MENTAL HEALTH TRIBUNAL

6.1 Written reports for hearings (**Section of the Act:** Will require additional provision in Part 21 – Mental Health Tribunal.)

- The APS believes that a balance needs to be struck between the requirement to provide written reports and appearing before the Mental Health Tribunal. Rather than a legislated mandate, the APS suggests a discretionary approach from the Tribunal regarding the grounds upon which it might call for a written report (e.g., where a treating psychiatrist is unable to attend the Tribunal in person), and that this be made clear to all relevant parties.

THEME 7 - INTERSTATE ARRANGEMENTS

7.1 Mutual recognition of mental health orders and interstate arrangements (**Section of the Act:** Part 24.)

- The APS agrees with the propositions outlined in relation to this Theme, and further endorses the need for a nationally consistent approach to the mutual recognition of mental health orders.

THEME 8 - AUDIO-VISUAL COMMUNICATION

8.1 Use of audio-visual communications under the Act (**Section of the Act:** Sections 48 and 79.)

- The APS endorses the amendment of the Act to allow for the use of audio-visual (AV) communications as an alternative to face to face assessment and examinations, under the proviso that this only occurs with the agreement of the patient, and where clinically appropriate and/or necessary.

We completely agree with the premise that audio-visual communication only occurs when a personal support person is available to the patient and when culturally appropriate. Audio-visual communication enables those in regional, rural and remote locations access to assessment and examination where a local psychiatrist may not be available, and avoids the need for unnecessary travel for patients living in these areas.

THEME 9 - SELECT COMMITTEE INTO ALTERNATE APPROACHES TO REDUCING ILLICIT DRUG USE AND ITS EFFECTS ON THE COMMUNITY

9.1 Select Committee – Recommendation 41 (**Section of the Act:** Consideration of how the Act applies in particular situations.)

- The APS acknowledges the complexity of the issue raised by the Select Committee and Recommendation 41. We endorse the recommendation for additional research and work on this issue and believe the need for consistent decision making and inter-relater reliability is critical. Presumably once a patient has received treatment and stabilised, an involuntary order would not be required. However, the issue of whether or not they are mentally ill remains, and needs to be assessed.

THEME 10 - CLINICAL GOVERNANCE REVIEW

10.1 Mental health governance – legislate for Lived Experience partnerships (**Section of the Act:** Requires new provisions.)

- The APS acknowledges that including the voice of people with lived experience is necessary to a well-functioning mental health system. We understand that the suggested amendments to governance arrangements are to increase the responsiveness, efficacy and overall outcomes of the state’s mental health system in order that it best serves the needs of Western Australians with mental illness, their families and carers.

THEME 11 - CULTURE AND SPIRIT OF THE ACT

The APS offers the following responses to the specific questions contained under this Theme.

Question 1. Compared with the 1996 Act, the Act was intended to address the human rights of consumers, families and carers, in the delivery of mental health services. Do you believe that there has been a cultural shift towards addressing human rights since the Act commenced? Why or why not?

- The APS trusts that the 2014 Act represents an improvement on the 1996 Act in responding to the rights of individuals with mental health conditions, their families and carers, and hopes that this has been reflected in the delivery of mental health services.

Question 2. Are the reporting requirements and forms helpful to ensure that consumers’ or their families’ and carers’ human rights are promoted? If not, why not? Can you state which reporting requirements and forms are useful and which are not?

- The APS believes that reporting requirements are essential to measure compliance and changes expected following legislative amendments targeted at improving patient experience and professional practices. We suggest, however, that there exists an essential tension between ensuring reporting requirements are met and the ongoing accomplishment of core functions (in this case the delivery of mental health care).

The APS notes that feedback has already been provided to the Commission in submissions received to date that the forms are too difficult to use⁷. The APS is not able to provide detailed comment on this question without surveying members who work within the mental health system governed by the Act. If it would be helpful, we would be pleased to partner with the Commission to undertake a survey of our Western Australian members, who work under the Act, for this purpose.

Question 3. Have the administration and compliance requirements increased? If yes, how is this impacting on the provision of treatment and care to consumers? Can you identify specific reporting requirements and forms that you think are impacting in this way?

- The APS suggests that it is highly likely that an increase in administration and compliance requirements has occurred. Mental health legislation that seeks to recognise and protect the human rights of individuals requiring mental health care and treatment will inevitably impose an increased administrative burden. The issue is whether there is an appropriate balance between administrative processes and quality and safety standards.

Question 4. What is being done well to ensure that the Objects of the Act and the Charter are being met? and

Question 5. What needs to be done better to ensure that the Objects of the Act and the Charter are being met? What practical suggestions can you make?

The APS notes that one of the primary objects of the Act is “to ensure people who have a mental illness are provided the best possible treatment and care” (p. 15)⁸.

- The APS views the role of psychologists and psychological interventions as critical to achieving this objective. We further believe that a key driver, implicit to the Act, is to ensure that people with a mental illness have access to evidence-based psychological treatment. We emphasise that:
 - Psychological assessment and treatment represents first line, cost-effective interventions for the majority of mental health disorders, and
 - Research has suggested that the majority of mental health care is not based on the best available evidence⁹. This is despite meta-analyses that have demonstrated psychological treatment is both efficacious and efficient - for example, in the treatment of mild-to-moderate anxiety and mood disorders¹⁰ - and systematic reviews that have demonstrated the effectiveness of psychological interventions for a broad range of psychiatric disorders, including schizophrenia PTSD and substance abuse disorders^{11,12,13}.
- Evidence for the effectiveness of psychological treatments for a broad range of mental health disorders is summarised in a systematic review of the literature commissioned by the Western Australian Government Department of Health¹⁴ and clinical guidelines such as those produced by the UK National Institute for Clinical Excellence¹⁵ and Phoenix Australia¹⁶.

Question 6. What are the barriers to implementing any suggested changes?

- The APS perceives several barriers to implementing the changes envisioned. The most prominent of which is insufficient funding. Systemic mental health reform is not possible without adequate funding. Particular when, across Australia, it is well acknowledged that mental health services are struggling to meet current demand.
- In addition, the APS believes that barriers to implementing change inevitably arise when there is a failure to adequately partner with key stakeholders. We note from the available documentation that the Western Australian College of Mental Health Nurses and the Royal Western Australian and New Zealand College of Psychiatrists were specifically consulted in the post-Implementation Review of the Mental Health Act 2014. The APS seeks a similar level of involvement with consultations in the future. We strongly urge the Government to partner with peak bodies for those professions involved in mental health service delivery to facilitate systemic reform and to improve the experience of Western Australians who interact with the mental health system.

Concluding comments

- The APS again expresses our appreciation for the opportunity to provide a submission to the Statutory Review of the Mental Health Act (2014). We underscore the need for the Western Australian Government to continue to recognise and support the delivery of evidence-based psychological interventions to individuals requiring care and treatment related to mental health issues.
- The APS recommends the appointment of a Chief Psychologist to work alongside the Chief Psychiatrist to ensure that state of the art psychological and psychiatric interventions are implemented to produce best practice outcomes for individuals receiving treatment under the Act.
- Further, we encourage the Western Australian Government to actively seek to partner with peak bodies in the mental health field, and the APS in particular, so that best practice clinical services can be delivered in partnerships that will lead to enhanced mental health care for all Western Australians.

References

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