



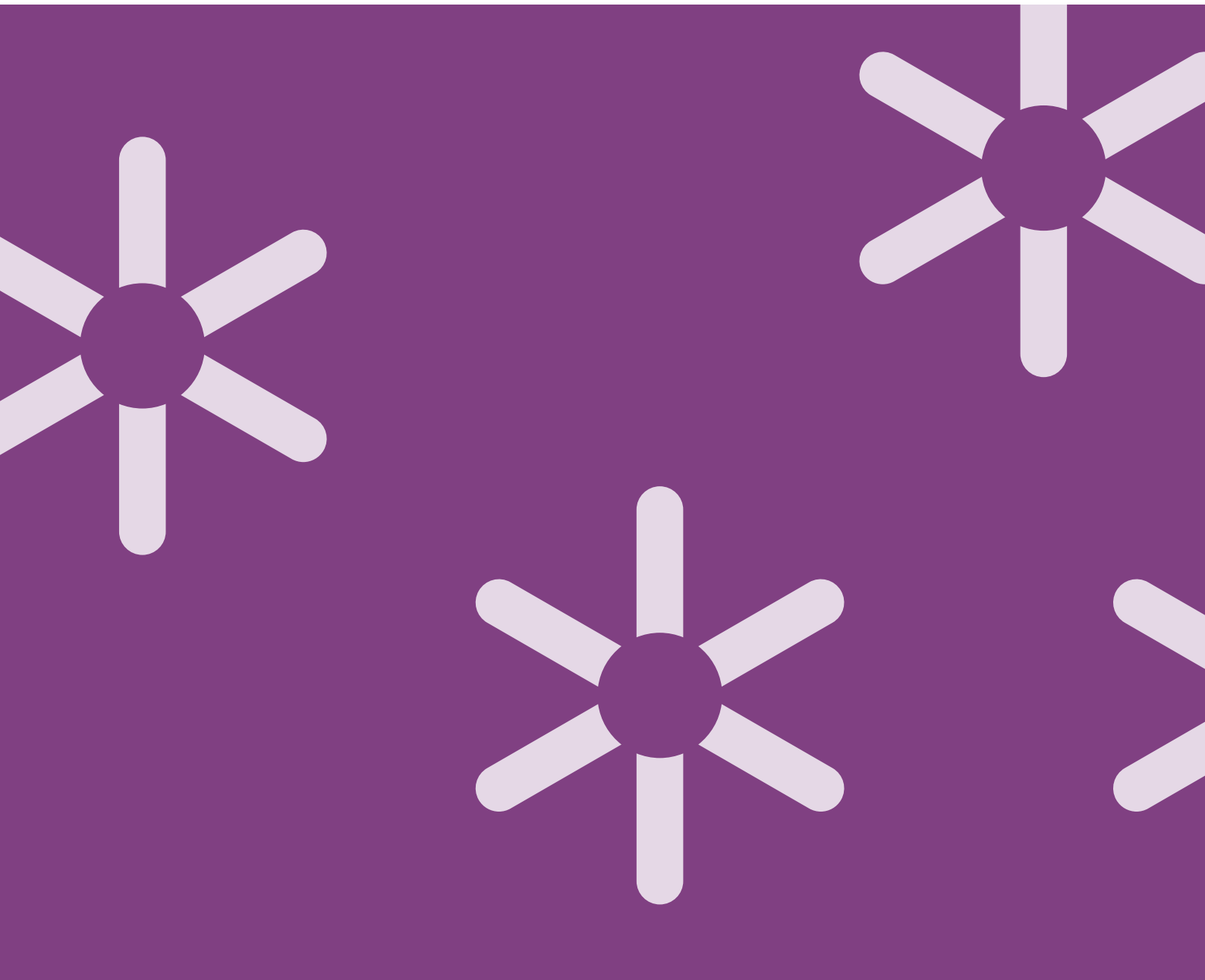
Government of Western Australia  
Mental Health Commission

*We're working for  
Western Australia.*



# Statutory Review of the Mental Health Act (2014): Discussion Paper

August 2021



**This resource was prepared by:**

Mental Health Commission  
GPO Box X2299  
Perth Business Centre WA 6847

**Acknowledgment of Country**

The Mental Health Commission acknowledges the traditional custodians throughout Western Australia and their continuing connection to the land, waters and community. We pay our respects to all members of the Aboriginal and Torres Strait Islander communities and their cultures, and to Elders past, present and emerging.

**Contributions**

The quotes featured throughout the Discussion Paper are attributed to the members of the Statutory Review Steering Group who contributed to the development of the paper.

**Acknowledgement of Lived Experience**

The Mental Health Commission acknowledges the individual and collective expertise of those with a living or lived experience of mental health, alcohol and other drug issues. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

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**Disclosure**

All submissions will be treated as public documents, unless a specific request for confidentiality is made. However, please note that submissions may be subject to release under the *Freedom of Information Act 1992*. Submissions may be quoted from in the final report to be tabled in the Western Australian Parliament or made available online.

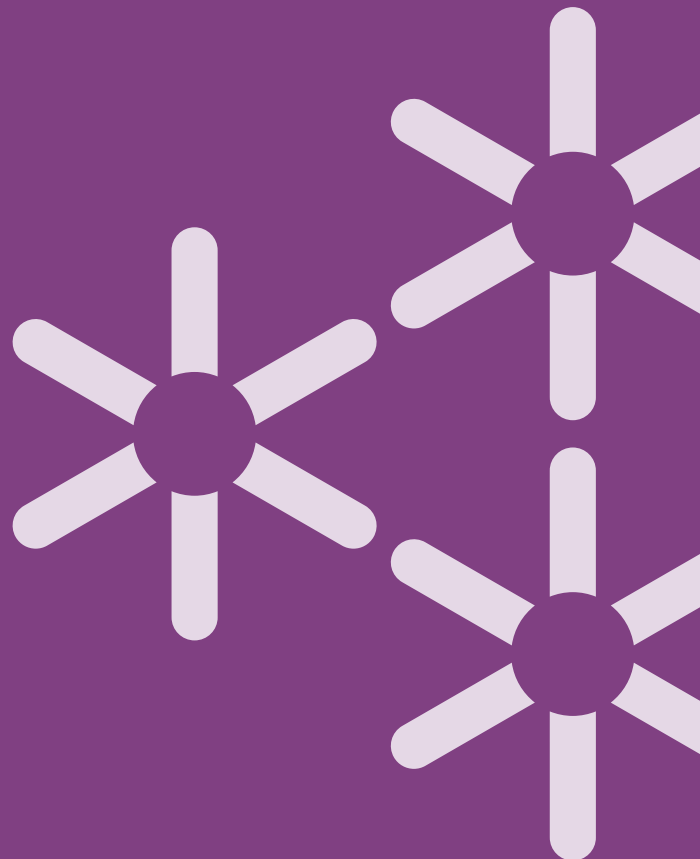
The Commission reserves the right to remove any content that could be regarded as derogatory or defamatory to an individual or agency. Allegations or complaints made through the submission process may be referred to the relevant agency at the discretion of the Commission.

**COVID-19 Context**

This Review commenced in both a State of Emergency Declaration under the *Emergency Management Act 2005* and a Public Health State of Emergency under the *Public Health Act 2015*. Measures have been taken under both of these Acts which have, at various times since early 2020, impacted on people's freedom of movement in Western Australia. These restrictions have been imposed in order to protect and minimise the potential impact of COVID-19 on the community. Whilst it is acknowledged that the restrictions imposed by COVID-19 may impact on people and families who may also be receiving treatment and care under the Act, feedback on the restrictions of COVID-19 more broadly (not related to the Act) is not included in this review.

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# Minister's Foreward

## The Western Australian Government is committed to understanding the needs of, and providing appropriate care, treatment and support to people experiencing mental ill health.

Since the Mental Health Act 2014 (the Act) came into effect in November 2015 our understanding of mental health issues and recovery continues to develop.

The Statutory Review of the Act is an opportunity to comprehensively examine the operations and effectiveness of the Act and consider how the intent of the Act is being applied. Now is the time to consult widely and review what is working well, what can be done differently and how we can better support people to live a contributing and meaningful life. This Review will make a valuable contribution to identifying possible improvements to the Act.

To do this, it is vital for the Government to draw on, empower and be guided by the critical knowledge and strength of people with a lived experience under the Act, as a consumer, carer, family member or other support person; as well as those who administer and work within the legislative framework. It is important that everyone has a seat at the table with representation from across Western Australia and across demographic groups.

I encourage anyone who has had an experience with treatment under the Act to step forward and share your story. I acknowledge that this may not be easy, but your courage in doing so will be greatly valued and respected, and will prove invaluable in understanding how improvements to the Act can be made. The voices of people with a lived or living experience of treatment under the Act, particularly involuntary treatment, need to be heard through this process.

It is also important that those working under, and administering the legislative framework express their views and perspectives of how the intent of the Act is being implemented in practice. To support those in need, we must ensure our mental health workforce is supported to provide compassionate, safe care.

You may feel like yours is but one story, but collectively your experiences tell the story of a community. A community which is entitled to the best practice care and support delivered in a manner which is respectful, maintains dignity and upholds human rights.

Collectively, the experience, knowledge and skill of everyone who contributes to the review will ensure that the final report and recommendations to Government are inclusive, comprehensive and in the best interests of enhancing the lives of those utilising mental health services in our State. Your experience is your expertise; we need to hear your story.



**Hon. Stephen Dawson MLC**  
Minister for Mental Health

# Invitation To Comment

The *Mental Health Act 2014* (the Act) provides for the treatment, care, support and protection of people who have a mental illness; the protection of the rights of people who have a mental illness; and the recognition of the role of families and carers in providing the best possible care and support to people who have a mental illness, in the least restrictive environment.

The Act is an important piece of legislation that at its essence impacts on fundamental human rights, and provides protections to support these rights. However, we need to know that these are working, and if they are not working as well as they could be, we need to know why, and how to change this to ensure that they do.

We want to hear your raw and real-life stories. Your experience is the expertise that will help ensure the Statutory Review of the Act produces the intended outcomes – positive legislative change to benefit the Western Australian Community.

You are invited to provide a submission to the Statutory Review, telling us in your own voice about your personal experiences and interactions with the Act.

You are encouraged to provide comment on the Act as a whole, or on individual parts, and to share which perspective your feedback is from (i.e. consumer, family member, clinician, former involuntary patient).

All submissions will be considered and will help inform a report and recommendations for amendments to the Act which will be tabled in Parliament.

This Discussion Paper has been prepared as a tool to assist you in providing feedback and includes some questions that you may like to include in your response.

Alternatively, you can make any comment in relation to the Act that you wish to be considered.

In addition to general feedback, you are also encouraged to comment on:

- Specific issues that have been raised over the past five years (Chapter 3)
- A set of previously proposed amendments (Chapter 4).

Thank you for contributing to enhancing the *Mental Health Act (2014)* for the Western Australian community.

**Submissions Close:**  
**4:00pm, Monday, 31 January 2022**



A stylized, handwritten signature in black ink, consisting of several loops and a long vertical stroke.

**Jennifer McGrath**

Commissioner  
Mental Health Commission

# Preparing your Submission

To assist in the preparation of your submission, please refer to the below tips and useful questions. You may like to use the suggested questions as headings in a written response, or as a prompt in providing a verbal response.

## General Tips

If comfortable to do so, please detail from what perspective you are providing feedback. This will assist in identifying common concerns raised within and across groups. For example you might say:

- 43-year-old man from Perth with experience of being an involuntary patient on a locked ward;
- Parent of a 15-year-old female child who received treatment in the South-West for an eating disorder;
- Forensic Psychiatrist working in the metropolitan area;
- 60-year woman who identifies as an Aboriginal person and lives in the Kimberley.

Where you can, please include a reference to the section or Part of the Act.

If you are responding to a previously identified issue or previously proposed amendment referred to in this Discussion Paper, please use the number references (i.e. 3.1).

If you are providing comment on a new issue (not addressed directly in this Discussion Paper) please indicate 'new issue' in your comments.

## Useful questions for responding to Chapter 2: The Mental Health Act

- What is working well with the Act... Why do you think this is... How did this impact you?
- What is not working well with the Act... Why do you think this is... How did this impact you?
- If something is not working well, do you think a change to the Act will improve it?
  - » If yes, what change to the Act do you think is required?
    - Can you identify any problems with changing the Act in this way?
    - What experience, knowledge or information supports the changes to the Act that you suggest?
  - » If a change to the Act is not needed, how could change be achieved? i.e policies, procedures, guidelines and/ or education?
- Are your responses based on your perspective/experience as a consumer, family member or carer, clinician or another stakeholder?
- Any other feedback on the Act?



### Useful questions for responding to an issue/s in Chapter 3: Previously Identified Issues

Please indicate in your response (where possible):

- The issue number as indicated in the Discussion Paper (eg 3.3);
- Your view on the issue;
- If you think an amendment would assist, what would you suggest? Why have you suggested this?
- If you don't think an amendment would assist, what would you suggest? Could this issue be addressed through policies, procedures, guidelines and/or education?

### Useful questions for responding to Chapter 4: Previously Proposed Amendments

Please indicate in your response (where possible):

- The amendment number;
- Your view on the issue;
- If you think the suggested amendment should be made, why or why not?

## Providing your Submission

Feedback can be provided via the following methods:



In writing by email to [statutoryreview@mhc.wa.gov.au](mailto:statutoryreview@mhc.wa.gov.au)



In writing, sent to:

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



On the phone by calling **6553 0561** any time and leaving a voice message of up to 5 minutes (this will be transcribed).



By taking part in face-to-face sessions facilitated in the community by individuals, groups and organisations. Information on some of these sessions will be available on the Statutory Review website [www.mhc.wa.gov.au/mhactreview](http://www.mhc.wa.gov.au/mhactreview)

#### Contact Us

For assistance to provide a submission, or to speak to one of the Project Team please contact [statutoryreview@mhc.wa.gov.au](mailto:statutoryreview@mhc.wa.gov.au) or phone 6553 0600.

**Submissions Close:**  
**4:00pm, Monday, 31 January 2022**

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## Chapter 1

# Introduction to the review process



“

This is your opportunity to have your voice heard... so many people may have the same story and your story is really important, from consumer, carer and clinician perspectives.

”



# Introduction

## The Statutory Review Process

Section 587 of the *Mental Health Act 2014* (the Act) requires that the Minister for Mental Health (Minister) ‘*must review the operation and effectiveness of the Act as soon as practicable*’, five years from the commencement of the Act, which came into effect on 30 November 2015.

In addition, section 587 requires that the Minister ‘*must, as soon as practicable, prepare a report about the outcome of the review; and cause a copy of the report to be laid before each House of Parliament*’.

## Terms of Reference

The Minister approved the Terms of Reference in early 2021 when the Review formally commenced. The Terms of Reference are broad and allow for feedback on the range of matters covered by the Act.

The terms state that the Review will:

1. Review the operation and effectiveness of the Act, ensuring that there are multiple perspectives including from carers<sup>1</sup>, consumers<sup>2</sup> and clinicians.
2. This review will include consideration of the following:
  - a. Recommendations and outcomes of the post-implementation review completed in 2017<sup>3</sup>;
  - b. the set of proposed amendments to the Act;
  - c. the set of proposed deferred amendments to the Act (Deferred Amendments) identified in 2019<sup>4</sup>;

- d. the register containing issues raised by stakeholders, studies, or review reports since 2015<sup>5</sup>;
- e. translational issues<sup>6</sup> relating to the Act previously reported to the Office of the Chief Psychiatrist since 2015;
- f. issues specifically encountered by clinicians in applying the provisions of the Act; and
- g. any other relevant matters or issues raised by stakeholders during the process of consultation for the review.

## Guiding Principles

The Guiding Principles for this Review are based on principles developed by the Department of Communities in their review of the *Children and Community Services Act 2004*. The Minister approved the Guiding Principles in early 2021.

The Guiding Principles are as follows:

1. Legislation should be developed or amended only when there is no other appropriate way of responding to an issue after taking all relevant circumstances into account, for example using policies, procedures, guidelines and/or education.
2. Legislative changes should seek to advance the human rights of persons with mental illness, their families and carers.
3. Due consideration be given to submissions from all stakeholders recognising their efforts, areas of expertise and lived experience.
4. Recommendations for significant legislative change should be evidence-based, with due consideration given to possible flow-on effects including unintended consequences.

<sup>1</sup> The perspective of families will also be recognised.

<sup>2</sup> Individual people treated under the Act are referred to as ‘voluntary inpatient’ or ‘involuntary patients’ (sometimes ‘involuntary inpatients’ or ‘involuntary community patients’). The term ‘consumers’ is generally used in this document to describe these individuals. However, it is acknowledged that some people may not identify as consumers.

<sup>3</sup> See Chapter 2.

<sup>4</sup> See Chapter 4.

<sup>5</sup> See Chapter 4.

<sup>6</sup> Clinicians contact the Office of the Chief Psychiatrist for assistance in understanding and applying the various provisions of the Act within a clinical setting, whilst upholding the objects of the Act and its principles.

5. Regard should be given to the principles of substantive equality in recognition of the differing impact legislation may have on certain groups in the community<sup>7</sup>.
6. Overly prescriptive provisions which set out processes or requirements in detail can be counterproductive and should generally be avoided and addressed through policy and practice guidance where possible.
7. Legislative changes should not seek to direct the specifics of clinical practice, nor create an interface which may lessen therapeutic engagement, nor create an excessive administrative burden which may significantly reduce the practical time in direct face to face clinical care.

### Timeframe

The intended timeframe for the Review is estimated to be 15 months from the release of the Discussion Paper, to the final report being provided to the Minister for tabling in Parliament.

While every effort will be made to achieve this timeframe, it is acknowledged there may be events which delay the conduct of this Review (i.e. implications associated with COVID-19) and that delays are preferable to compromising the quality and integrity of the final report due to time constraints.

### Steering Group

A Steering Group has been established to oversee and guide the Review process and contribute to the final report and recommendations.

The Steering Group membership is:

- Ms Debora Colvin, Independent Chair
- Dr Sarah Pollock, Chief Advocate, Mental Health Advocacy Service
- Dr Nathan Gibson, Chief Psychiatrist, Office of the Chief Psychiatrist
- Ms Karen Whitney, President, Mental Health Tribunal
- Dr Mark McAndrew, Psychiatrist, Head of Clinical Service
- Vicki O'Donnell, Chairperson, Aboriginal Health Council of Western Australia
- Dr Audrey Koay, Executive Director Patient Safety and Clinical Quality Directorate, Department of Health
- Dr Joanne Kirker (Carer representative);
- Mrs Carli Sheers (Consumer representative);
- Dr Sophie Davison, Chief Medical Officer, Mental Health, Mental Health Commission
- Ms Kim Lazenby, Head of System Development, Mental Health Commission.

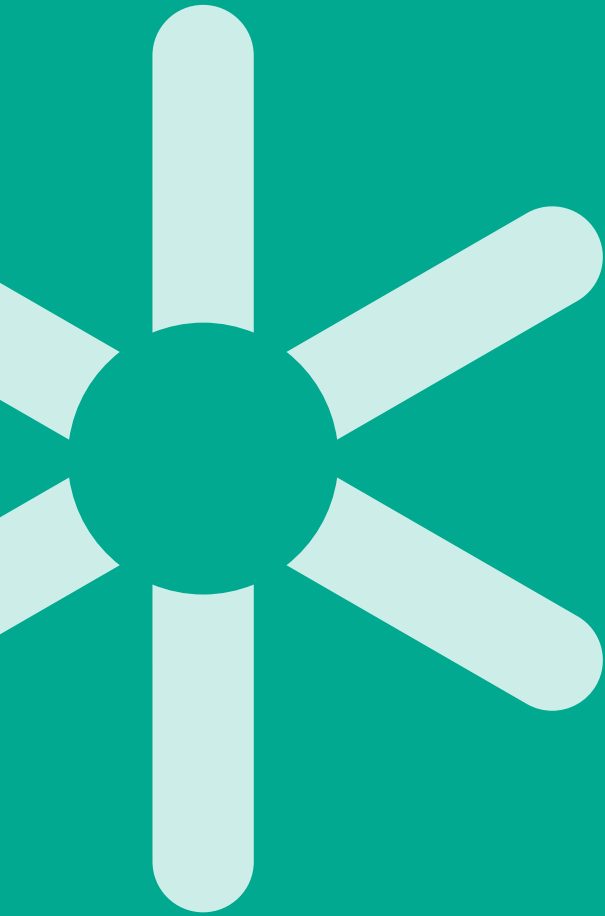
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<sup>7</sup> The Steering Group recognises that in addition to substantive equality, the importance of equity will be considered as a guiding principle throughout the review process.

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## Chapter 2

# The Mental Health Act (2014)



“

I feel very lucky to be a living example of recovery and am passionate about making sure my peers have the same opportunity to recover

”

# The Mental Health Act (2014)

## Background to the Act and its Operation

### Development and Implementation of the Current Act (2003 – 2015)

Following an extensive consultation process and statutory review undertaken by Professor D'Arcy Holman (Holman Review), the Act repealed and replaced the *Mental Health Act 1996* (the 1996 Act) on 30 November 2015.

The Act embodies the Holman Review recommendation to advance the rights of persons with mental illness, their families and carers. After the Holman Review was completed, there were further rounds of significant consultation in relation to the draft Mental Health Bills; the first bill was drafted in 2007 with a redraft in 2011, and then a green bill in 2012.

As the agency responsible for administration and monitoring of the Act, the Commission developed and led the implementation planning process in collaboration with other relevant stakeholders and with input and oversight from a Mental Health Bill Implementation Reference Group. A series of working groups were established to inform and develop required processes and documentation to support implementation, that involved consumer and carer representatives, government agencies, clinicians and other mental health service staff.

A 12-month implementation period prior to the commencement of the Act, from November 2014 to November 2015, enabled the preparation of the Regulations, training of relevant stakeholders and implementation of other transitional arrangements. All individual projects and strategies were endorsed by the Mental Health Bill Implementation Reference Group.

### Post-Implementation Review (2017)

Two years after the Act came into operation, the MHC carried out a post-implementation review. The purpose of the post-implementation review was to review the regulatory impact of the Act and whether the Objects of the Act are being achieved. The stakeholders described below were considered to be key stakeholders in the post-implementation review given their specific role and defined responsibilities under the Act:

- Mental Health Commission;
- Department of Health and Health Service Providers;
- Chief Psychiatrist;
- Mental Health Tribunal;
- Mental Health Advocacy Service; and
- Health and Disability Services Complaints Office.

The Commission also included consumers, families and carers as key stakeholders, in relation to their experience of the provision of mental health services under the Act.

The post-implementation review report was prepared across five broad focus areas:

- Rights for consumers;
- Rights for personal support persons;
- Recourse (for consumers);
- Other advancements; and
- Unintended consequences.

These focus areas highlight the key areas of change from the previous Act that are relevant to achieve the Objects of the Act.

One of the main concerns that came through the post-implementation review was a concern that the spirit of the Act was not being complied with. A common theme reported by some stakeholders, although not directly related to the Objects of the Act, was a perception that the Act had placed additional administrative workloads on clinicians. The concern was that this may impact on clinicians' ability to give effect to the spirit of the Act.

There was also a concern that the online training modules and other documentation was focussed on compliance, rather than on the spirit of the Act.

The post-implementation review resulted in a number of recommendations that aimed to enhance the effectiveness of the Act in meeting the Objects, identify opportunities for improvement, and also assist in preparing for the Review of the Act. Only three of the post-implementation review recommendations suggested that possible legislative amendments were required. These three issues are discussed in more detail later in this paper. The remaining recommendations of the post-implementation review were focused on operational, administrative and educational initiatives. The Commission continues to work with key stakeholders to progress these post-implementation review recommendations. A copy of the post-implementation review can be found on the Commissions website at the link set out in the footnote below<sup>8</sup>.

In addition to the issues identified through the post-implementation review process, there have been a number of other issues that have previously been brought to the attention of the Commission. These will be considered as part of this Review. These issues, which include the three issues arising out of the post-implementation review) are referred to as the '**previously identified issues**' and are set out in Chapter 3 for discussion and comment.

### Previously Proposed Amendments (2019)

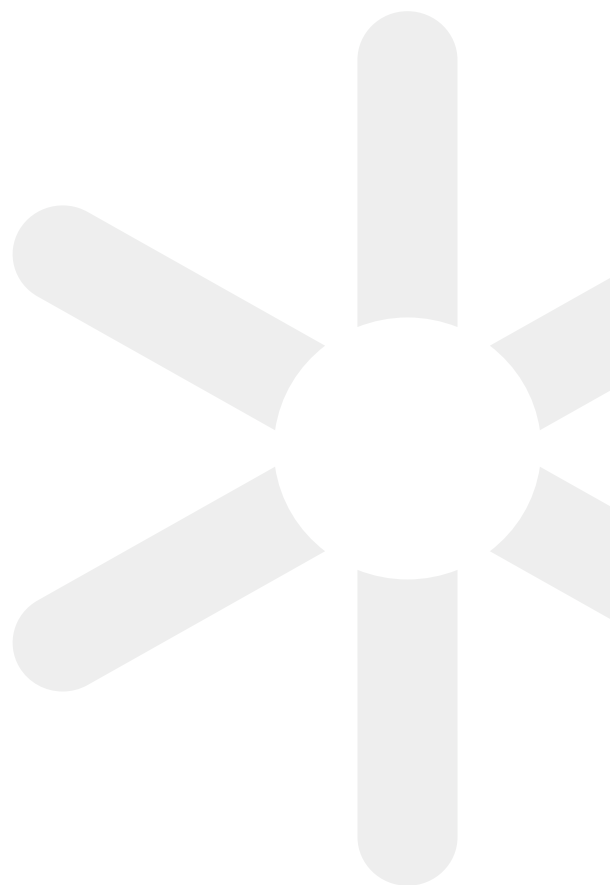
Since the Act commenced on 30 November 2015, the Commission has received a range of requests for possible amendments. During 2019, the Commission carried out limited consultations on the various suggested amendments<sup>9</sup>. By the conclusion of 2019, over

60 proposed amendments had been considered as part of the limited consultation. Those stakeholders consulted agreed in-principle that 45 out of the 60 amendments should progress. These 45 proposed amendments would either correct an omission in the Act, clarify various matters of the Act, or improve administrative processes. These 45 proposals are referred to as the '**previously proposed amendments**' and are set out in Chapter 4 for discussion and comment.

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<sup>8</sup> <https://www.mhc.wa.gov.au/media/2540/post-implementation-review-of-mental-health-act-2014-final.pdf>

<sup>9</sup> The MHC consulted stakeholders with statutory responsibilities under the Act. This included the Chief Psychiatrist, the Mental Health Advocacy Service, the Mental Health Tribunal and the Health and Disability Services Complaints Office. The MHC also consulted with the Department of Health's Mental Health Unit, the Western Australia Police Force and the Mentally Impaired Accused Review Board. At the time, it was intended that consultation on the 45 amendments would occur with consumers and carers once the amendment bill had been drafted.



## The Act and its Various Parts

The Act is divided into 29 parts and each part deals with a specific topic or area. A brief summary of each part is detailed below which you may like to refer to when preparing your feedback.

### Useful questions to consider addressing in your submission:

- What is working well with the Act... Why do you think this is... How did this impact you?
- What is not working well with the Act... Why do you think this is... How did this impact you?
- If something is not working well, do you think a change to the Act will improve it?
  - » If yes, what change to the Act do you think is required?
    - Can you identify any problems with changing the Act in this way?
    - What experience, knowledge or information supports the changes to the Act that you suggest?
  - » If a change to the Act is not needed, how could change be achieved? policies, procedures, guidelines and/or education?
- Are your responses based on your perspective/experience as a consumer, family member or carer, clinician or another stakeholder?
- Any other feedback on the Act?

If you would like to access more detailed reference information, an electronic version of the Act is available on the Government of Western Australia, Department of Justice legislation website, [www.bit.ly/MHACT2014](http://www.bit.ly/MHACT2014)

Additional supporting information about the Act is available at: [www.mhc.wa.gov.au/mhactresources](http://www.mhc.wa.gov.au/mhactresources)

## Part 1

### Preliminary Matters

Part 1 contains three provisions that set out the short title of the Act; its commencement dates; and that the Act binds the State, and to the extent permitted, the Crown. These are the provisions that establish the Act.

## Part 2

### Terms and Concepts

Part 2 sets out terms and concepts, as well as definitions. For example:

- Division 2 defines when a person has a mental illness;
- Division 3 sets out matters relevant to a person's best interests;
- Division 4 sets out matters relevant to a person's wishes; and
- Division 5 (section 9) defines what communication includes and how communication should be made.

## Part 3

### Objects

Part 3 sets out a list of Objects, to which a person or body performing a function under the Act must have regard. The Objects underpin how the Act should be interpreted and applied.

The Objects of the Act are:

- h. to ensure people who have a mental illness are provided the best possible treatment and care
  - i. with the least possible restriction of their freedom; and
  - ii. with the least possible interference with their rights; and
  - iii. with respect for their dignity;
- i. to recognise the role of carers and families in the treatment, care and support of people who have a mental illness;

- j. to recognise and facilitate the involvement of people who have a mental illness, their nominated persons, and their carers and families in the consideration of the options that are available for their treatment and care;
- k. to help minimise the effect of mental illness on family life;
- l. to ensure the protection of people who have or may have a mental illness;
- m. to ensure the protection of the community.

## Part 4

### Charter of Mental Health Care Principles

The Charter of Mental Health Care Principles is a set of principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness (both voluntary and involuntary patients). The Charter aims to influence the interconnected factors that assist with a person's recovery from mental illness.

In summary, the 15 principles state that mental health services must treat people experiencing mental illness with dignity and respect; and that includes respecting their right to make decisions about their own lives. Mental health services and private psychiatric hostels must always consider these principles when they provide treatment, care and support to a person.

The Act requires that anyone performing a function under the Act must have regard to the Charter of Mental Health Care Principles (applies to both voluntary and involuntary patients). These are set out in Schedule 1 of the Act.

Further information can be found at Charter of Mental Health Principles ([www.mhas.wa.gov.au](http://www.mhas.wa.gov.au))

## Part 5

### Decision Making Capacity and Informed Consent

Part 5 provides information on how decision making capacity and informed consent is referred to in the Act. For the purposes of the Act, capacity is the extent to which a person is able to make reasonable judgments about their admission to hospital, treatment, personal welfare and discharge. Capacity is one of the criteria

for making someone an involuntary patient, and the Act presumes:

- Adults (aged 18 years and over) have capacity to make treatment decisions for themselves, unless they demonstrate that they do not have capacity.
- Children (aged under 18 years) do not have the capacity to make treatment decisions, unless they demonstrate that they have the capacity.

## Part 6

### Involuntary Patients

Part 6 provides a framework for the process of how a person may be referred for an examination by a psychiatrist and sets out the requirements for conducting an assessment and examination under the Act. This includes:

- Setting out the requirements around detaining and transporting the person if that is required and sets out the strict criteria that must exist before an inpatient treatment order or community treatment order can be made.
- Setting out the special provisions which require that if the person is of Aboriginal or Torres Strait Islander descent, a practitioner who conducts their assessment or examination must, as much as possible, collaborate with an Aboriginal or Torres Strait Islander mental health worker, and significant members of the person's community (such as Elders and traditional healers).<sup>10</sup>

Part 6 also requires that if the person does not speak English as a first language, or has a hearing impairment, they are entitled to an interpreter.

<sup>10</sup> In response to a post-implementation review recommendation, in 2020 the Mental Health Advocacy Service carried out an Inquiry into Services for Aboriginal and Torres Strait Islander people and Compliance with the Mental Health Act 2014 (Mental Health Advocacy Service Report). In summary, the Mental Health Advocacy Service Report made 15 recommendations which the then Minister for Mental Health, asked the MHC to progress: The recommendations require operational and system changes to ensure that these provisions are complied with. There were no recommendations for legislative amendments to those provisions at that time. The report is available at [MHAS-Final-Report-on-the-Inquiry-into-Strait-Islander-People-and-Compliance-with-the-Mental-Health-Act-2014-July-2020.PDF](#)

## Part 7

### Detention for Examination or Treatment

Part 7 provides further details about the requirements before a person can be detained in order to carry out an assessment or examination under the Act. This includes time limits for detention.

The framework which allows for a person, who is either detained or subject to an involuntary treatment order under the Act, to be returned to the hospital or place that the person has left is also included in this Part. This is called an apprehension and return order.

## Part 8

### Community Treatment Orders

Part 8 sets out the processes around community treatment orders. It also outlines how long a community treatment order is in effect and the requirements for the order to be reviewed at regular intervals, as well as the requirements and process that will apply if a person on a community treatment order breaches the conditions of the order.

## Part 9

### Notifiable Events

Part 9 sets out the requirement that carers, close family members and other personal support persons of an individual who is under the Act, are to be notified of certain events. This Part imposes a duty on staff to inform these people of certain events including matters relating to the person's physical location and treatment status under the Act.

## Part 10

### Transport Orders

Part 10 sets out the requirements and framework for making and carrying out transport orders. In some limited circumstances, transport orders may be made to take a person to a hospital or other place for assessment, examination or treatment. For example, where there is no other safe way of transport, the practitioner may make a transport order to authorise a transport officer or police officer to transport the person. There are extensive procedural requirements around the making and carrying out of transport orders.

## Part 11

### Apprehension, Search and Seizure Powers

Part 11 provides a police officer with the power to apprehend a person and arrange for them to be assessed by a practitioner. A police officer can only exercise these powers when they reasonably suspect the person has a mental illness and needs to be apprehended to protect their own health or safety, or the health and safety of others. This part also sets out search and seizure powers and prescribes strict requirements around how these are to be carried out.

## Part 12

### Exercise of Certain Powers

Part 12 sets out the principles for detention under the Act. This includes that detention must be for as brief a period as practicable; with the minimum degree of force; and the detained person must be accorded the least restriction on freedom, with privacy, and with dignity and respect. This Part also sets out the prescribed provisions for the exercise of ancillary powers of reasonable assistance, force and directions.

## Part 13

### Provision of Treatment Generally

Part 13 prescribes the general matters on treatment for patients, including voluntary and involuntary patients and mentally impaired accused persons, and includes patient rights such as:

- Further opinions;
- Treatment, support and discharge planning;
- Requiring clinicians to collaborate with an Aboriginal and Torres Strait Islander mental health worker and significant members of the person's community (such as Elders and traditional healers) in relation to treatment of Aboriginal and Torres Strait Islander persons to the extent it is practicable and appropriate to do so; and
- Requiring clinicians to comply with the Chief Psychiatrist's standards and guidelines.



## Part 14

### Regulation of Certain Kinds of Treatment and Other Interventions

Part 14 details the regulation of types of treatment including electroconvulsive therapy, emergency psychiatric treatment, psychosurgery, deep sleep and insulin coma therapy, and strict regulation of other interventions including seclusion and bodily restraint.

## Part 15

### Health Care of People in Hospitals

Part 15 relates to ensuring that the physical condition of people treated under the Act are also addressed. This Part establishes a requirement that a person admitted into hospital must be examined by a medical practitioner within 12 hours of admission, unless the person is a voluntary inpatient and does not consent to the examination.

## Part 16

### Protection of Patients' Rights

Part 16 deals with the rights of inpatients; and with the role of a nominated person. For example, among other rights, an inpatient must have their rights explained to them, have access to medical records, have freedom of lawful communication, and contains a duty not to ill-treat or wilfully neglect patients for which there are penalties. This Part also provides that the nominated person for a patient is entitled to receive information and be involved in treatment decisions.

## Part 17

### Recognition of Rights of Carers and Families

Part 17 provides the rights and roles of carers and families in patients' treatment and care and sets out the processes for promoting their participation.

## Part 18

### Children who have a Mental Illness

Part 18 sets out some specific requirements regarding the treatment of children with mental illness (aged under 18 years). For example, it is a requirement that the best interests of the child is the primary consideration. In deciding what is in the child's best interests, the child's wishes, the child's parent or guardian views and the child's nominated person's views must be considered.

## Part 19

### Complaints about Mental Health Services

Part 19 describes the complaints processes available to a person. For example, if a person wishes to complain about how they have been treated, they may make a complaint through the internal process of the mental health service; or to the Health and Disability Services Complaints Office (HaDSCO).

More information is available at [www.hadSCO.wa.gov.au](http://www.hadSCO.wa.gov.au).

## Part 20

### Mental Health Advocacy Services

Part 20 creates the framework which establishes the Mental Health Advocacy Service and provides for the advocates who have specific statutory functions in relation to certain categories of persons who come under the Act. This includes those who are subject to an involuntary treatment order and some categories of voluntary patients.

More information is available at [www.mhas.wa.gov.au](http://www.mhas.wa.gov.au).

## Part 21

### Mental Health Tribunal

Part 21 establishes the Mental Health Tribunal (Tribunal) which is an independent decision-making body. The Tribunal's primary role is to review every new involuntary treatment order made by psychiatrists in Western Australia within 35 days (10 days for children). The Tribunal reviews each order again regularly (every three months for adults and every 28 days for children). The purpose of the Tribunal's review is to determine whether the patient still needs the involuntary treatment order.

The Tribunal also decides a range of other questions under the Act on application by a relevant person. For example, psychiatrists may apply to the Tribunal for approval to perform electroconvulsive therapy or psychosurgery. Patients and other interested persons may apply for review of involuntary treatment orders outside the system of scheduled reviews. They may also ask the Tribunal to review restrictions imposed on freedom of communication or other decisions affecting patient's rights.

More information is available at [www.mht.wa.gov.au](http://www.mht.wa.gov.au).

## Part 22

### Review by State Administrative Tribunal

Part 22 provides for a process where a person who is dissatisfied with a decision of the Tribunal can apply to the State Administrative Tribunal for a review of the Tribunal's decision. There is no fee for the application to the State Administrative Tribunal, and a person may appear in person, or be represented by another person, such as a lawyer.

## Part 23

### Administration

Part 23 provides for the role description and duties of the Chief Psychiatrist:

- Has overall responsibility for the treatment and care of people experiencing mental illness who come within the scope of the Act;
- Publishes standards and guidelines for the treatment and care to be provided by mental health services;
- Deals with reports from services about serious matters such as possible staff misconduct, and any serious risks to the welfare of patients while they are in hospital;
- May visit an authorised hospital at any time; and
- May visit any other mental health service if it is suspected that proper standards of treatment and care are not being maintained.

More information is available at [www.chiefpsychiatrist.wa.gov.au](http://www.chiefpsychiatrist.wa.gov.au).

## Part 24

### Interstate Arrangements

Part 24 provides a framework which would allow Western Australia to enter into agreement with other states and territories in order to allow for the mutual recognition of mental health orders across state and territory boundaries.

## Part 25

### Ministerial Inquiries

Part 25 allows for the Minister to appoint a person to conduct an inquiry into, and report on, any matter relating to the treatment, care or other services provided to a person who has or may have a mental illness; or the administration or enforcement of the Act.

## Part 26

### Information

Part 26 provides for voluntary disclosure of information by public authorities and mental health services. This Part also provides for the confidentiality of patient information unless it is authorised.

## Part 27

### Miscellaneous Matters

Part 27 provides for various things including penalty provision for obstructing or hindering a person performing functions under the Act, protection from liability when performing a function and protection from liability when detaining a person with mental illness.

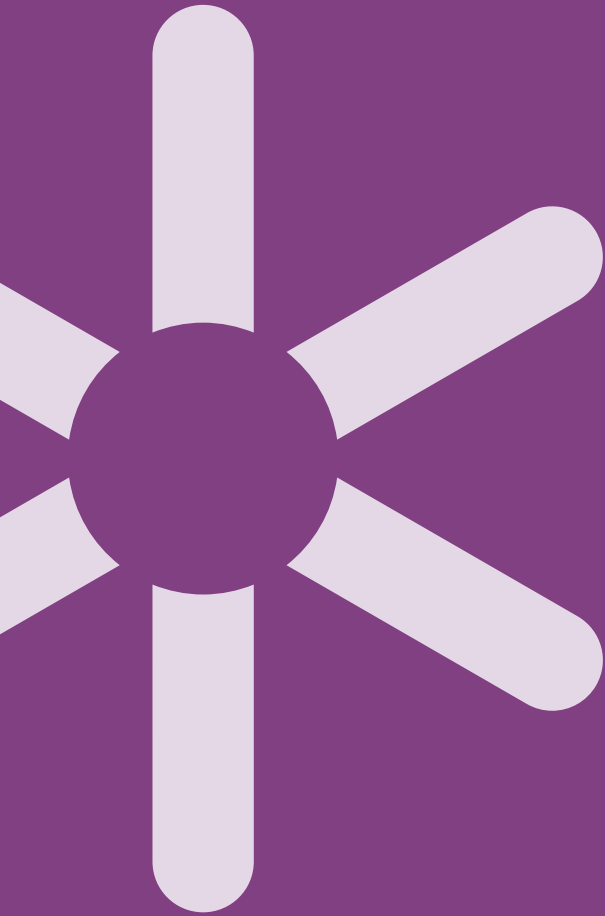
## Parts 28 To 29

Parts 28 and 29 deals with repeals and transitional matters. These are provisions that relate to ensuring that the 1996 Act was repealed and that various things done under the old act could transition (and still have effect) when the Act commenced.

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## Chapter 3

### Previously Identified Issues



“

The changes we make here are to make the Act more useful for all involved... to get the best engagement for all stakeholders – consumers, carers and clinicians, so that the experience is as least traumatic as possible, and as most therapeutic as possible, all within that framework of rights

”

# Previously Identified Issues

Since 2015, when the Act first came into operation, various issues have been brought to the Commissions' attention. These issues have either been identified via the post implementation review process, or by a variety of different stakeholders including: private individuals, other government agencies, health service providers, non-government agencies, and the statutory bodies established under the Act.

In this chapter, the issues raised have been grouped into themes with information provided on the relevant section of the Act and the background to the issue (including any suggestions for resolving the issue). A small number of issues do not have a suggestion for amendment.

**Comment on any or all of the issues is welcomed.**

## If you are providing feedback on a Previously Identified Issues in this part:

Please indicate in your response (where possible):

- The issue number identified in the Discussion Paper (eg 3.1);
- Your view on the issue;
- If you think an amendment would assist, what would you suggest? Why have you suggested this?
- If you don't think an amendment would assist, what would you suggest? Could this issue be addressed through policies, procedures, guidelines and/or education?

## Theme 1

### Consumers

There have been eleven issues raised that come within this category, including the use of restraints in non-authorised hospitals, apprehension and return orders and referral and detention timeframes.

**Note:** In addition to the issues set out below, please remember that you can make any other comments about provisions relating to **consumers** in the Act.

#### 1.1 Identifying Aboriginal and Torres Strait Islander status on the Approved forms

##### Section of the Act:

Currently not a requirement under the Act.

##### Background

The Act does not currently require recording whether a person identifies as Aboriginal or Torres Strait Islander. This has been raised as an issue because the Act sets out additional protections for persons who identify as Aboriginal or Torres Strait Islander (see parts 6 and 13 in relation to the involvement of Aboriginal mental health workers and Elders). The Mental Health Advocacy Service has identified that the provisions are not being complied with and overall Aboriginal or Torres Strait Islander people are not consistently being offered their rights (see footnote 6). This information would encourage and assist mental health services to comply with the Act and assist Mental Health Advocacy Service to provide better follow up to people who identify as Aboriginal or Torres Strait Islander and ensure that their rights are being observed.

This issue relates to the recommendations made through the post-implementation review which were subsequently considered by the Mental Health Data Management Group (Data Management Group) at the Department of Health. The Data Management Group noted that, as a result of the review of the State-wide Standardised

Clinical Documentation, the clinical assessment forms have been updated to include the following information:

- If the patient identifies as Aboriginal or Torres Strait Islander;
- if the patient was offered the involvement of a significant member of the person's community;

if they accepted that offer, or not.

These revised clinical forms are currently used in paper-based formats. These will be integrated electronically into the Psychiatric Services Online Information System.

The Data Management Group identified that there is already information recorded in the mental health online system which allows for the following information to be gathered and reported:

- The number of service contacts delivered by Aboriginal Mental Health/Aboriginal Liaison workers.
- The number and proportion of Aboriginal clients who have contact with community mental health services.
- The number of delivered Aboriginal Cultural Input, Traditional Medicine and Traditional Healer Service Event items by public community mental health services.

An amendment to the Act has been suggested which would require that information on whether a person identified as Aboriginal or Torres Strait Islander be recorded on the Act's Approved forms. There is another view that this issue may already be addressed through operational changes to clinical forms and that this requirement would result in duplication and unnecessary additional administrative tasks for clinical staff.

## 1.2 Inability to transfer a patient when on a Form 3C – Continuation Orders

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**Section of the Act:** Part 6, sections 55 and 56.

### Background

The Act provides for a person to be assessed and referred for an examination by a psychiatrist. In certain circumstances, a person can be detained to allow for the examination to take place, and in addition to this, a continuation order may be necessary to extend the period of detention. Continuation orders allow for a further examination to be made as to whether to treat a person as an involuntary patient. Continuation orders are not always necessary but are allowed under the Act.

The Act does not currently make provision for the transfer of a person on a continuation order to another authorised hospital. A concern has been raised that a person, while on a continuation order at one authorised hospital, cannot be transferred to another authorised hospital.

It has been suggested that the Act should be amended to allow for a person to be transferred between authorised hospitals while on a continuation order. It has also been highlighted that this was not a widespread issue across mental health services.

There is also a view once a person is at an authorised hospital, the examination by a psychiatrist should be completed at that authorised hospital and the person should not be moved around while their status under the Act is still to be determined.

## 1.3 Apprehension and Return Orders

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**Section of the Act:** Part 7, section 99.

### Background

Under the Act, an apprehension and return order is made where a person is absent without leave from a hospital or other place and there is no other safe means to return the person other than to make an apprehension and return order. The person in charge of the hospital (or other place), or a medical practitioner, are currently the only categories of persons authorised to make this type of order.

The Act requires that the person be returned to 'the hospital or other place specified' in the apprehension and return. This wording constrains police, who cannot take the person to any location other than the specified hospital or other place named in the ARO. Concerns have been raised that such a constraint may jeopardise the health of the person apprehended in regional areas who must be returned to a metropolitan mental health service, as set out in the apprehension and return order. For example, this means that, where a long journey is required to return the person to the specified place, the person would not have their mental or physical state reviewed regarding their fitness for transport back to the hospital or other place.

An amendment has been suggested which would allow the police or transport officer to take the person to the nearest hospital for assessment and if necessary, for treatment. However, there are questions around how

any change would operate in practice. For example, what will happen if the place the police want to take the person does not have staff or services that can meet the needs of the person? If changes are made, who should be responsible for ensuring that there is a suitable practitioner and services for the person if they are taken to the new location.

## 1.4 Restriction on freedom of communication

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**Section of the Act:** Part 16, section 262.

### Background

The Act requires services to inform the Mental Health Advocacy Service when an order is made restricting a patient's freedom of communication. However, it does not require a copy of the form documenting the reasons for the restriction to be provided to the Mental Health Advocacy Service. Providing the form would give the Mental Health Advocacy Service the nature of, and reasons for, the restriction.

It has been suggested that the Act should be amended to require that a copy of the form be provided to the Mental Health Advocacy Service. A legislative requirement will create a duty on the psychiatrist or the mental health service to provide the Mental Health Advocacy Service with a copy of the order. Another view is that this issue may have been resolved operationally as the Mental Health Advocacy Service can (by current agreement) access the form through the mental health online system

## 1.5 Voluntary inpatient rights (including older adult inpatients)

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**Sections of the Act:** Part 16, Division 2, Subdivision 2 – Rights of inpatients generally and section 348.

### Background

A concern was raised that older adults are primarily admitted as 'voluntary' patients to locked wards. For example, a person on a guardianship order under the Guardianship and Administration Act 1990 (GAA) may be admitted as a voluntary patient by consent of their guardian who may be a family member but be

accommodated in a facility that has locked doors and as a result their freedom of movement is restricted, and they are in effect being detained. There is a concern that the GAA does not afford enough protection to the older adult, in contrast to the Act. For example, there is no independent review of the psychiatrist's decision by the Tribunal. This may also be an issue for other voluntary patients, not just older persons, if they are on a ward that is locked.

There is also concern that in some cases older adults are being held on locked wards with the approval of next of kin without a guardianship order. On the basis of 'least restriction' the person is held on the ward in this manner to the extent that they are 'compliant', but they may not know or fully understand their rights and do not have access to Mental Health Advocacy Service<sup>11</sup> advocates or review by the Tribunal.

It has been suggested that the Act be amended to provide that:

- It be expressly stated that voluntary inpatients have the right to freedom of movement and all that this entails (for example, to have the right to leave); and
- Older adults who are voluntary inpatients in locked wards should be 'identified persons' under the Act so they can also be assisted by the Mental Health Advocacy Service.

A related issue included at Amendment 17: Voluntary Patients in locked inpatient mental health services and it includes the proposed amendment:

- Amend Act to expressly state that regardless of whether a voluntary inpatient is placed in a locked or unlocked ward, a voluntary patient has the right to leave the ward and/or hospital at any time without permission. The proposed amendment could be based on similar wording in the Mental Health Act 2009 (SA).

**Note:** It would be useful to consider how any amendments would interact with the rights and obligations of a guardian appointed under the GAA.

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<sup>11</sup> The definition of a private psychiatric hostel is set out in the Private Hospital and Health Services Act 1927 (PHHSA), which is administered by the Department of Health. Any amendment to the PHHSA sits within the portfolio responsibility of the Department of Health.

## 1.6 Restraints in non-authorised hospital wards

**Section of the Act:** Part 14, sections 227 and 228.

### Background

This issue stems from discussions during the 2019 consultations with key stakeholders around the use of restraint during naso-gastric feeding of children with eating disorders. These children are treated primarily in non-authorised hospital wards as voluntary patients.

The provisions in the Act relating to the use of restraints only apply to authorised hospital wards and therefore cannot be applied to patients (adults or children, voluntary and involuntary) who may be restrained on wards in non-authorised hospital wards.

The stakeholders consulted in 2019 noted that there was also a broader issue around the use of restraint more generally of children and adults in non-authorised hospitals. Similarly, restraints in emergency departments are not covered by the provisions in the Act.

This issue does not have a suggested amendment. Your comments are welcome.

## 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*. That act defines a **private psychiatric hostel** as:

- a. *private premises in which 3 or more persons who —*
- b. *are socially dependent because of mental illness;*  
*and*
- c. *are not members of the family of the proprietor of the premises, reside and are treated or cared for.*

### Background

An issue was raised that, as step up/step down services do not come within the category of a private psychiatric hostel, consumers staying in them are not included as 'identified persons for the purposes of having access to the Mental Health Advocacy Service. A concern was expressed that consumers staying in step up/step down services may be just as vulnerable as residents in private psychiatric hostels and therefore should have the same automatic right to advocacy services.

Other types of supported accommodation, however, may also not meet the definition of private psychiatric hostel. For example, the Commission funds a number of services where two people are supported for 24 hours a day 7 days a week due to their complex condition and vulnerability (so are socially dependent and reside at the premises) but because they are less than 3 people in the one premises, they do not meet the definition. This means they do not have access to the Mental Health Advocacy Service advocates nor do they come within the definition of a mental health service and therefore within the jurisdiction of the Chief Psychiatrist.

Other new supported accommodation services are being developed aside from the step up / step down services which also may not meet this definition. Examples include government run (as distinct from private) transitional care supported accommodation services which would not come within the definition because they are not 'private' but the residents are likely to have complex needs and vulnerabilities.

Other views note that step up/step down services are quite different to private psychiatric hostels. For example:

- Step up/step down services are considered short term, transitional accommodation, with the maximum length of stay being 30 days and the average stay 7 – 14 days;
- Consumers are not residents and are required to have their own community accommodation (though this is expected to change in at least one step up / step down that is planned for youth);
- Consumers are required to be socially independent (noting that there are issues around what this means).

It has been suggested that the Act be amended to separately define hostels in some other way to allow for consumers staying in step up/ step down services and other supported accommodation which may or may not meet the definition in the Private Hospital and Health Services Act 1927 to be able to access the Mental Health Advocacy Service in the same way as residents of private psychiatric hostels do (that is, upon request of the person).

## 1.8 Definition of ‘mental health service’

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**Section of the Act:** Section 4.

### Background

A ‘mental health service’ is defined in the Act to include: a hospital that provided treatment or care to people who may have a mental illness; a community mental health service; or any service that is prescribed by the regulations (no services have yet been prescribed). Private psychiatric hostels are specifically excluded in the definition except in relation to the Mental Health Advocacy Service and Chief Psychiatrist, but that definition is said to be outdated and not reflect contemporary services.

Under the Act the Chief Psychiatrist is responsible for the treatment and care of various categories of people including: all involuntary patients and all voluntary patients provided with treatment or care by a mental health service.

Treatment is defined in the Act as meaning the provision of a psychiatric, medical, psychological or psychosocial intervention. Care is not defined in the Act.

In recent years new types of services have been developed to meet the needs of the Western Australian community. While it is possible to have a specific service prescribed by the regulations as a mental health service, a broader issue has been raised to whether new services should be captured by the definition of ‘mental health service’ for the purposes of the Chief Psychiatrist’s oversight.

This issue does not have a suggested amendment. Your comments are welcome.

## 1.9 Referral and detention timeframes - back to back use of Forms 1A and 3

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**Section of the Act:** Part 6, various including sections 28, 44 and 45.

### Background

Concerns were raised that there had been occasions where ‘back-to-back’ forms requiring a mandatory examination by a psychiatrist (form 1A) and detaining people (form 3s) had been completed (i.e. where a referral and detention orders are made and when they expire another set of orders are made). This has resulted in that person’s lengthy detention for over 3 days in the metropolitan region, primarily in emergency departments. It is said that the time limits set by Parliament are therefore being rendered ineffective, and in some cases, based on the wording of the Act, the Act may also be being breached where a new detention order is made.

The Act sets out the framework and timeframes as follows:

- Section 44 - A referral for an examination by a psychiatrist remains in force for 72 hours from the time when the referral is made unless the referral is extended under section 45.
- Section 45 – Allows for one extension where the person is outside the metropolitan area.
- Section 28 states that a person cannot be detained for a continuous period of more than 72 hours where the referral is made in a metropolitan area or 144 hours if the place where the referral is made is outside a metropolitan area. Section 28(11) also states that the person cannot continue to be detained if the referral expires before the person is taken to an authorised hospital or other place.

Other concerns were expressed that a person who needs referral and detention may be put at risk if there was a prohibition on making subsequent referral and detention forms in cases where a person was considered to meet the criteria under the Act and required examination by a psychiatrist. This issue is said to be exacerbated by the lack of available hospital beds and people having to wait days for hospital admission.

This issue does not have a suggested amendment. Your comments are welcome.



## 1.10 Further Opinions

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**Section of the Act:** Sections 182,183 and 184

### Background

The Act recognises that right to obtain a further opinion is an important one and safeguards this right by providing that a person, (or their nominated person, carer, or close family member), may request a further opinion if they are dissatisfied with the treatment that is being provided to them. People on community treatment orders may also request a further opinion on whether it is appropriate for the supervising psychiatrist to continue the community treatment order.

The Act currently requires that the patient's psychiatrist or, in some instances, the Chief Psychiatrist obtain the further opinion 'as soon as practicable' after receiving the request. Further opinions must be given in writing and kept on file. A copy must also be provided to the patient (and to the requesting person if it was requested by a person other than the patient, subject to the patient's consent). If the further opinion has been obtained by the Chief Psychiatrist, a copy must also be given to the patient's psychiatrist. A patient's psychiatrist 'must have regard' to any further opinion that is obtained, including regard for any recommendations made about the provision of treatment to the patient.

If a person is dissatisfied with the further opinion, the Act allows for the matter to be referred to the Chief Psychiatrist. However, the Act also provides for the patient's psychiatrist, or the Chief Psychiatrist, to refuse a request for an additional further opinion if the patient's psychiatrist or the Chief Psychiatrist believes that obtaining an additional further opinion is not warranted.

There have been concerns raised that there are often lengthy delays in obtaining a further opinion and that often the further opinion does not have the appearance of being truly independent of the mental health service where the person was being treated because the psychiatrist providing the further opinion is from the same mental health service.

A Mental Health Advocacy Service report in 2017<sup>12</sup> (and various subsequent Mental Health Advocacy Service annual reports) noted that neither the Act nor

the Department of Health's Operational Directive on further opinions were being complied with and that it was difficult to get someone from outside the hospital, where the person was being detained, to prepare the further opinion.

In early 2018, the Department of Health completed an internal Further Opinions Impact Study (Study).

The aim of this internal Study was to better understand and evaluate the operational impacts (on health services) of further opinions requested in accordance with the Act. However, the Department of Health's ability to conduct meaningful analysis and produce insights was constrained by data quality issues which were due to inconsistent recording of data by health services. In the end, data sourced from the Mental Health Advocacy Service, together with data obtained through a survey of psychiatrists conducted by the Department of Health, and partial activity data, was used to produce a limited assessment of the impact of requests for further opinions and some of the specific objectives of the impact study were not achieved.

This issue does not have a suggested amendment. Your comments are welcome.

## 1.11 Treatment, support and discharge plans

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**Section of the Act:** Sections 185,186, 187 and 188.

### Background

The Act provides that a person on an involuntary order has a right to be involved in the preparation and review of a treatment, support and discharge plan. Treatment, support and discharge plans must be prepared 'as soon as practicable' after a person is placed on an involuntary order and be reviewed and revised as necessary. The Act also provides that a patient or other interested person can apply to the Mental Health Tribunal (Tribunal) to issue a service provider with a compliance notice for non-compliance with a 'prescribed requirement' of the Act. A prescribed requirement includes ensuring that a patient's treatment, support and discharge plan is prepared, viewed or revised.

During 2017, the Mental Health Advocacy Service conducted an inquiry into treatment, support and

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<sup>12</sup> <https://mhas.wa.gov.au/assets/documents/Final-Further-Opinions-Report-and-Survey-by-MHAS-July-2016-to-June-2017.PDF>

discharge plans which was published in 2018<sup>13</sup>. The inquiry concluded that the requirement for treatment, support and discharge plans were not being fully complied with by mental health services. The inquiry noted that a contributing reason for this included that clinicians were unaware of the requirements of the Act. Subsequent Mental Health Advocacy Service annual reports have continued to note poor compliance with respect to treatment, support and discharge plans. In the Tribunal's 2019-20 Annual Report, it was noted that there were no compliance notices issued by the Tribunal. However, the Tribunal did issue 18 recommendations to psychiatrists to review a patient's treatment, support and discharge plan<sup>14</sup> to ensure that it fully complied with the Act and the Chief Psychiatrist's guidelines<sup>15</sup>.

This issue does not have a suggested amendment. Your comments are welcome.

## Theme 2

### Personal Support Persons

“Carers, family members and support people are a crucial part of the team, and their perspective is just as important”

Under the Part 2, section 7 of the Act a personal support person includes the guardian or enduring guardian of an adult, the parent or guardian of a child, a close family member, a carer, or a nominated person. This issue relates to rights for personal support persons, and specifically to a psychiatrist's decision not to notify a personal support person.

**Note:** In addition to the issues set out below, please remember that you can make any other comments you like about provisions relating to **personal support persons** in the Act.

### 2.1 Decision not to notify personal support person

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**Section of the Act:** Part 9, section 140.

#### Background

A concern was raised that a decision not to notify a personal support person could have a major impact on a patient and further that they need to be informed, as soon as possible, about their rights.

Section 140(1) of the Act requires that the person responsible for notification of a notifiable event, which are set out in Schedule 2 of the Act, must ensure that, as soon as practicable after the event occurs, that any carer, close family member, or other personal support person of the person is notified.

Sections 142 (1) and (2) of the Act provide that notification is not required if the medical practitioner or authorised mental health practitioner or psychiatrist determines that notification is not in the best interests of the person. In such cases, the person responsible for notification must, as soon as practicable, file a record of the decision and the reasons for it, and provide a copy to the Chief Mental Health Advocate.

It has been suggested that the Act be amended to require notification to the Chief Mental Health Advocate within 24 hours, rather than 'as soon as practicable'. Another view is that imposing a specific timeframe will increase the administrative workload on clinicians.

## Theme 3

### Children

Part 18 of the Act states that when performing a function under the Act, the best interests of the child must be a primary consideration, and regard must also be given to the child's wishes and the views of the child's parent or guardian. This is in accordance with the objects of the Act. In addition, section 303 refers to the importance of protecting the safety of a child while they are a patient in hospital specifically where they are admitted to a service which also admits adults.

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<sup>13</sup> <https://mhas.wa.gov.au/assets/documents/Treatment-Support-and-Discharge-Plans-TSD-PLANS-Inquiry-final-report-March-2018.PDF>

<sup>14</sup> <https://mhas.wa.gov.au/assets/documents/Treatment-Support-and-Discharge-Plans-TSD-PLANS-Inquiry-final-report-March-2018.PDF>

<sup>15</sup> <https://www.mht.wa.gov.au/wp-content/uploads/2020/09/FINAL-MHT-Annual-Report-2019-20-V4.1.pdf>

Various issues that have been raised with the MHC that relate to the rights of children under the Act<sup>16</sup>. These include issues such as access to advocacy, reporting obligations in relation to the use of off-label treatment for children and the reporting requirements for children admitted as inpatients to adult mental health services.

**Note:** In addition to the issues and questions set out below, please remember that you can make any other comments you like about provisions relating to **children** in the Act.

### 3.1 Mandatory notification to Mental Health Advocacy Service when child admitted as an inpatient to an adult ward

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**Section of the Act:** Part 20, section 357.

#### Background

As part of the post-implementation review recommendations, number 40 stated that the Commission would consider an amendment to the Act requiring the Mental Health Advocacy Service be notified of any child placed on an adult ward.

Through the post-implementation review, a concern was raised that not all children admitted as inpatients receive an automatic visit from an advocate from the Mental Health Advocacy Service. Section 357 of the Act currently requires the Mental Health Advocacy Service to visit or contact all children who have been placed on an involuntary order within 24 hours of that order being made. Services are required to notify the Mental Health Advocacy Service of involuntary children.

Children who are admitted as voluntary inpatients may request contact by the Mental Health Advocacy Service pursuant to a Ministerial Direction under the Act who are then required to visit or make contact within a reasonable time after the request has been made (however notification of the Mental Health Advocacy Service is not mandatory).

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<sup>16</sup> It was proposed, during the 2019 consultations, that the categories of persons the subject of the Ministerial Direction, and some other categories, should be formally incorporated into the Act as an amendment. These categories of persons may access the Mental Health Advocacy Service upon request. This forms part of the Proposed Amendments discussed in chapter 4.

It has been suggested that the Act be amended to require mandatory notification to the Mental Health Advocacy Service when a child is admitted as an inpatient to an adult mental health ward, irrespective of whether the child is admitted as a voluntary or involuntary inpatient.

### 3.2 Restraint of children in non-authorised hospitals

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**Section of the Act:** Not covered in the Act. The suggested amendment is to Part 14, section 227.

#### Background

A concern was raised about the lack of regulation around the use of restraint during naso-gastric feeding of children who have eating disorders and who are admitted to a general hospital. Most children receiving inpatient treatment for eating disorders are not treated in authorised hospitals but to a general hospital medical ward and most are admitted as voluntary patients.

The Act regulates certain treatments and interventions, including the use of restraint, where that use occurs in an authorised hospital. Section 228 of the Act sets out principles that apply when using restraints. The use of restraint must be carried out in accordance with various requirements in the Act, including requirements around monitoring, recording and reporting. These provisions apply to both adults and children in authorised hospital wards and apply whether those adults and children are voluntary or involuntary patients. They do not apply in non-authorised hospital wards such as general hospitals.

It had been suggested that the Act be amended so that the provisions for restraining a person under section 227 also apply to children receiving treatment for eating disorders in non-authorised hospital wards. However, initial discussions of this proposal raised the related issues of management of eating disorders in both children and adults, as well as the use of restraints more generally for children and adults who are inpatients in a non-authorised hospital. Background information on this issue is available at the footnote below<sup>17</sup>.

This issue does not have a suggested amendment. Your comments are welcome.

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<sup>17</sup> [http://www.nmahsmh.health.wa.gov.au/services/statewide\\_WAEDOCS.cfm](http://www.nmahsmh.health.wa.gov.au/services/statewide_WAEDOCS.cfm)

### 3.3 Segregation of children from adult inpatients

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**Section of the Act:** Part 18, section 303.

#### Background

Section 303 is a protection under the Act which requires certain things to occur when a child is admitted to an inpatient mental health service that also admits adults. When considering and applying section 303, the person in charge of the inpatient mental health service must first be satisfied that:

- the mental health service can provide the child with treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual beliefs; and
- the treatment, care and support can be provided to the child in a part of the mental health service that is separate from any part of the mental health service in which adults are provided with treatment and care if, having regard to the child's age and maturity, it would be appropriate to do so.

If a decision is made to admit the child as an inpatient, a written report must be provided to the child's parents which confirms the reasons why the person in charge is satisfied that admission can be done in accordance with the requirements set out in section 303. A copy of the report must be filed, and another copy given to the Chief Psychiatrist.

Youth inpatient mental health units cater specifically for children and young people aged 16 – 24 years. These units have been developed in recent years to better meet the needs of the Western Australian community. As a result, youth inpatient mental health units have some patients who are children (up to 18 years of age), and others who are adults (between 18 – 24 years of age).

In 2019, the Commission and the Chief Psychiatrist looked into the operation of section 303 in relation to these youth inpatient mental health units. This process clarified that section 303 applies to any child admitted to any inpatient mental health service where adults are also admitted. This includes services such as the youth inpatient mental health units. As a result, the Commission and Chief Psychiatrist worked with health service providers to ensure understanding of the reporting responsibilities under section 303 but it was noted

that the scope and application of section 303 required clarification and that this would be undertaken through the Review.

The Commission is seeking to consult stakeholders on what amendment, if any, is needed to accommodate initiatives such as youth inpatient mental health units in the Act. For example, the Queensland Mental Health Act 2016 (Qld) expressly excludes child and adolescent units from certain notification requirements similar to that of section 303<sup>18</sup>.

One suggestion has been to amend the Act so that youth inpatient mental health units are excluded from being required to comply with section 303 reporting requirements.

### 3.4 Off-label treatment for children

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**Section of the Act:** Part 18, section 304.

#### Background

A medication is described as being used for an 'off-label' purpose, if the Therapeutic Goods Administration has not been asked to evaluate the use of the drug for the proposed purpose. This does not mean that the use has been rejected by the Therapeutic Goods Administration. For example, medication approval and registration are often not specifically sought for children, and as a result, children often receive medication that has only been formally approved by the Therapeutic Goods Administration for adults. There are no general requirements to report off-label prescribing in any patient population. These requirements are mandatory for industry (such as manufacturers) and encouraged for prescribers.

The Act currently requires that when an off-label treatment is provided to a child who is an 'involuntary patient'. A record must be retained, and a copy provided to the Chief Psychiatrist. The Act also requires the Chief Psychiatrist to report this information in the annual report.

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<sup>18</sup> *Mental Health Act 2016* (Qld), section 231 sets out an obligation to notify the public guardian if a minor is admitted to a high security unit; or an inpatient unit of an authorised mental health service, **other than a child and adolescent inpatient unit**. (Our emphasis). A 'child and adolescent unit' means an inpatient unit of an authorised mental health service that provides treatment and care only to minors or young adults. Example – an inpatient unit of an authorised mental health service that admits only minors, or patients between 16 and 21 years.

The Chief Psychiatrist's annual report for 2019-20 noted that: *for the reporting period, there were 13 notifications about children who were involuntary patients and received off-label treatments, which is less than the number of notifications received in the previous financial year. Most notifications were from mental health services in the metropolitan area. The average (mean) age of involuntary children provided with an off-label treatment was 16 years*<sup>19</sup>.

At the time the Act was introduced, the rationale for section 304 was that it would ensure that off-label treatment was not provided to children in circumstances where it is not warranted and also to promote transparency<sup>20</sup>.

It is noted that health professionals have a responsibility to prescribe the most effective and safe treatment for their patients. As such, off label does not imply an improper, illegal, contraindicated or investigational use. The off-label use of medicines for children and adolescents is a common and important issue for prescribing practice across child and adolescent psychiatry, paediatrics and primary care. There is a need to ensure that clinicians when prescribing off label are doing so in a safe and considered way with consideration of the various clinical guidelines that are available.

There is a view that section 304 does not meet the goal of improving the safety and quality of prescribing of psychotropics to all children and adolescents receiving treatment in Western Australia since section 304 only refers to off-label treatment provided to children who are involuntary patients. It is also the Chief Psychiatrist's view that oversight of off-label treatment provided to children is best achieved through the safety and quality mechanisms of the West Australian Therapeutics Advisory Group and existing standards and guidelines.

It is suggested that section 304 of the Act be revoked.

## Theme 4

# Regulation of Certain Kinds of Treatment

Section 192 of the Act describes electroconvulsive therapy as a treatment involving the application of an electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent.

There are two issues that have previously been raised with the Commission that relate to the use of electroconvulsive therapy under the Act: reporting serious adverse events as part of electroconvulsive therapy statistics reporting requirements in the Act, and applications to the Tribunal regarding electroconvulsive therapy.

**Note:** In addition to the issues set out below, please remember that you can make any other comments you like about the provisions relating to **electroconvulsive therapy in the Act**.

## 4.1 Reporting of electroconvulsive therapy statistics

**Section of the Act:** Section 201.

### Background

It has previously been noted that aspects of the reporting requirement under section 201 of the Act creates duplication, as death or serious negative outcomes associated with electroconvulsive therapy are already reported as a notifiable incident to the Chief Psychiatrist, pursuant to section 526 of the Act, in an approved form<sup>21</sup>.

It has been suggested that this duplication in the Act be removed by amending section 201.

<sup>19</sup> <https://www.chiefpsychiatrist.wa.gov.au/chief-psychiatrists-annual-report-2019-2020/>, page 53.

<sup>20</sup> Explanatory Memorandum to the Act (paraphrased).

<sup>21</sup> Form 13, available from the Chief Psychiatrist's office. At the time of writing, Form 13 captures the definition of **serious adverse event** as set out in section 201, and further provides explanatory details.

## 4.2 Application to the Tribunal to use electroconvulsive therapy

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**Section of the Act:** Part 21, Division 6.

### Background

In certain circumstances, including where the patient is a child aged between 14 and 18 years and where the patient is an adult who is an involuntary patient (or under the Criminal Law (Mentally Impaired Accused) Act 1996), a psychiatrist may apply to the Tribunal for approval to perform electroconvulsive therapy. Under section 410, the written application must include a treatment plan, including where the electroconvulsive therapy will be provided and the minimum period that it is proposed to elapse between any two treatments (amongst other things).

A suggestion has been made that in addition to the above, the Tribunal should also be required to consider, at the time of the electroconvulsive therapy application, whether the involuntary patient is still in need of an involuntary order (Tribunal may already consider this issue if they choose to. The amendment would require them to consider it).

A further proposal has also been made that the requirements set out under section 410 be removed altogether on the basis that these are clinical considerations that should be left for clinicians to determine. An alternative view is that such matters should have the additional oversight of the Tribunal.

## Theme 5

### Mental Health Advocacy Service

The Mental Health Advocacy Service provides advocacy services and rights protection to identified persons. The main category of identified persons are those who are detained or subject to an involuntary treatment order under the Act. The Mental Health Advocacy Service is obliged to make contact or visit these persons people within certain timeframes set out in the Act. The focus is to ensure that these people are aware of their rights under the Act.

Various issues that have previously been raised with the Commission that relate to the Mental Health Advocacy Service. There are three issues in this chapter: the first two relate to administrative issues such as how the Mental Health Advocacy Service appoints advocates, and how the Chief Mental Health Advocate delegates powers to senior advocates. The third issue relates to clarifying the term 'financial interest' as it relates to the Mental Health Advocacy Service.

Other categories of 'identified persons' are those who are residents of private psychiatric hostels, and certain categories of children who are voluntary patients. Again, the focus for the Mental Health Advocacy Service is to ensure that these people are aware of their rights under the Act. The Mental Health Advocacy Service does not take the place of other mental health services which provide a range of care and support to people.

**Note:** In addition to the issues set out below, please remember that you can make any other comments you like about the provisions relating to the **Mental Health Advocacy Service**.

## 5.1 Engagement of advocates

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**Section of the Act:** Section 350.

### Background

Currently, the Act provides that mental health advocates are to be engaged by the Chief Mental Health Advocate under a contract for service, as independent contractors and not as employees. This means, for example, that advocates cannot be paid for leave and must supply their own 'tools'.

In order to assist the Mental Health Advocacy Service with its operations, it has been suggested that the Act be amended:

- to enable advocates to be engaged directly by the Chief Mental Health Advocate on a contractual basis allowing for full-time, part-time and casual contracts; or
- to state that mental health advocates must be appointed by the Chief Mental Health Advocate and leave the Act silent on the contractual terms.

## 5.2 Chief Mental Health Advocate delegate

**Section of the Act:** Section 350.

### Background

Currently, the Act does not allow for senior mental health advocates to be appointed. In practice, the Chief Mental Health Advocate currently delegates certain advocates with specific functions of the Chief Mental Health Advocate as determined by the Chief Mental Health Advocate. These advocates are then designated as senior mental health advocates. The senior advocate role differs from that of an advocate as they carry out less field work and essentially acts as a deputy Chief Mental Health Advocate.

It has been suggested that the Act be amended to include a provision for the Chief Mental Health Advocate to 'appoint one or more mental health advocates as a Senior Mental Health Advocate who is delegated functions of the Chief Mental Health Advocate as determined by the Chief Mental Health Advocate'.

## 5.3 The term 'financial interest'

**Section of the Act:** Section 373.

### Background

Section 373 of the Act provides that a mental health advocate may not provide their functions as an advocate to a person receiving care or treatment by a body or organisation the advocate has a financial interest in. This disqualification extends if a person closely associated with the advocate has a financial interest in the body or organisation.

The term 'financial interest' is not defined in the Act. It has been suggested that this lack of definition creates uncertainty for the Mental Health Advocacy Service. For example, if the term 'financial interest' is construed very broadly, then an advocate would be unable to provide a service to a person who is an inpatient in a mental health ward of a hospital where the advocate's partner is working in another part of that hospital unrelated to the mental health ward.

However, section 373 already provides for certain types of financial interest to be excluded by prescribing them in the regulations, (although none are currently prescribed). The possible solution to this issue may be for the Commission to progress amendments to the regulations exempting certain 'financial interests'.

## Theme 6

# Mental Health Tribunal

The Mental Health Tribunal (Tribunal) is an independent decision-making body that reviews each involuntary treatment order made by psychiatrists. The purpose of the Tribunal's review is to determine whether the patient needs the involuntary treatment order.

**Note:** In addition to the issue set out below, please remember that you can make any other comments you like about the **Tribunal** provisions in the Act (or any other aspect of the Act).

## 6.1 Written reports for hearings

**Section of the Act:** Will require additional provision in Part 21 – Mental Health Tribunal.

### Background

It has been suggested that a requirement be added to the Act to allow the Tribunal to require the treating psychiatrist of an involuntary patient to prepare and submit a written report prior to a Tribunal hearing.

There is another point of view which highlights that psychiatrists (or a clinical person) already usually attend hearings, noting that the Tribunal reported in its annual report for 2019-20 that psychiatrists attended 64% of hearings, and psychiatric registrars attended at 34% of hearings (either with a psychiatrist or alone).<sup>22</sup> There is a concern that requiring the writing of an additional report will impose additional administrative workload on clinicians.

<sup>22</sup> <https://www.mht.wa.gov.au/wp-content/uploads/2020/09/FINAL-MHT-Annual-Report-2019-20-V4.1.pdf>

## Interstate Arrangements

Part 24 of the Act provides for interstate arrangements and agreements with other jurisdictions. Currently, in order for these arrangements to occur the Act requires that ‘corresponding laws’ be prescribed in the regulations and that there be intergovernmental agreements between the jurisdictions involved before such arrangements can be in place.

Due to each state and territory having their own mental health legislation the solution to this issue is complex. The most cohesive response would be a national one. There is currently work being done nationally to resolve this issue.

### 7.1 Mutual recognition of mental health orders and interstate arrangements

**Section of the Act:** Part 24.

#### Background

As part of the post-implementation review recommendations, number 45 noted that the Commission would progress necessary amendments to allow for interstate arrangements. This aligned with Action 26 of the Fifth National Mental health and Suicide Prevention Plan which commits all Australian governments to improve consistency across their mental health legislation.

To progress post-implementation review recommendation 45, the Commission commissioned a report on interstate arrangements in under the Act and in other jurisdictions (both in Australia and overseas), noting that the Act requires that ‘corresponding laws and orders’ be prescribed in the regulations and that there be intergovernmental agreements between the jurisdictions involved, before such arrangements can place.

The Report identified that arrangements between states/territories in Australia are particularly complex because each jurisdiction has its own mental health legislation, with each using different terminology and criteria. There are also significant differences between the jurisdictions

as to their processes for the interstate movement of consumers on civil mental health orders. In addition, several jurisdictions, including WA, currently do not have operational interstate arrangement, while other jurisdictions did have some arrangements in place, but these were not comprehensive or consistent across jurisdictions. The Report also noted that Queensland and South Australia had reviewed their legislative provisions in this area and removed the requirement for intergovernmental agreements. The Report concluded that interstate arrangements between the states and territories would continue to be fragmented, even for those states and territories, unless a national approach was undertaken to resolve this issue.

Nationally, there has been broad agreement between the states and territories that a national legislative scheme is the preferred approach to mutual recognition of mental health orders.

A National Mutual Recognition Project (NMRP) is now currently progressing this work. The NMRP team is planning to deliver the model legislation to the Health National Council Reform Committee<sup>23</sup> by the end of 2021. It will then be up to individual states and territories to ensure that the model legislation around mutual recognition of mental health orders passes through their own legislative processes.

A related issue included in Chapter 4, Amendment 36: Interstate arrangements for mental health orders includes the proposed amendments:

1. Amend the definition of ‘corresponding law’ to include a descriptive definition. Currently the definition requires corresponding laws to be declared by the Regulations. This may cause delays when corresponding laws change and can therefore delay interstate movements.
2. Provide a descriptive definition of ‘corresponding orders’ from other jurisdictions.

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<sup>23</sup> Formerly the COAG Health Council.



## Theme 8

# Audio-visual Communication

Audio-visual (AV) communication can be used by a mental health practitioner to conduct an assessment under the Act.

**Note:** In addition to the issue and questions set out below, please remember that you can make any other comments you like about the use of **AV communications** under the Act.

## 8.1 Use of audio-visual communications under the Act

**Section of the Act:** Sections 48 and 79.

### Background

In 2020, and in order to deal with the public health challenges arising from the COVID-19 pandemic, the Mental Health Infection Control Directions (Directions) were issued pursuant to the *Public Health Act 2016*<sup>24</sup>. The Directions require practitioners (including psychiatrists) to use infection control measures when assessing or examining a person for the purposes of the Act. (An assessment may lead to a formal referral for examination by a psychiatrist, and possibly a detention order to allow that examination; while an examination may lead to a person being placed on an involuntary order). Options for Infection control include the wearing of personal protective equipment, physical distancing, physical barriers or audio-visual communication. The practitioner is to determine which infection control measure is appropriate in the circumstances. One of the infection control measures available is audio-visual communication. The Directions also require that where a practitioner is required to self-isolate for any reason, they must use AV communication as the infection control measure when carrying out an assessment or examination. To resolve the conflict between the Directions and the Act (which requires assessments and examinations to be conducted in person, except in non-metropolitan areas), modifications to the Act were made through the *COVID-19 Response and Economic*

*Recovery Omnibus Act 2020*. These modifications to the Act are limited in duration and will cease when the Directions or replacement Directions cease to have effect.

During consultations on these modifications, stakeholders raised the issue that there are a range of other circumstances where AV communication may be necessary when conducting an assessment or examination under the Act. This may include, but is not limited to, situations where there is a shortage of psychiatrists or practitioners in a particular metropolitan area. Requiring face to face assessments and examinations where there is shortage may negatively impact on the timeliness of treatment and care for people.

Other states have statutory provisions which allow for clinicians to use AV communication in some circumstances. For example, the Queensland legislation provides that an assessment or examination may be done using AV if the person doing the assessment or examination considers it clinically appropriate.<sup>25</sup>

It has been suggested that the Act be amended to allow for AV communications to be used for assessment and examination under the Act where it is not practicable to assess or examine the person face to face, and where the use of AV communication would be clinically appropriate. The decision to use AV communication would be at the discretion of the person carrying out the assessment or examination. This should include considerations for including a personal support person (notably one that is culturally appropriate) during the assessment or examination.

<sup>24</sup> The Directions were updated in August 2020, see <https://www.wa.gov.au/sites/default/files/2020-09/D19-CHO%20Mental%20Health%20Infection%20Control%20Directions%20%28No.2%29-V4-Final-310820-%28SIGNED%29.pdf>

<sup>25</sup> *Mental Health Act 2016* (Qld) s 795.

## Theme 9

# Select Committee Into Alternate Approaches To Reducing Illicit Drug Use And Its Effects On The Community

A recommendation made by the WA Parliament Select Committee into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community, Help, Not Handcuffs: Evidence-based approaches to reducing harm from illicit drug use (Select Committee).

## 9.1 Select Committee - Recommendation 41

**Section of the Act:** Consideration of how the Act applies in particular situations.

### Background

The Select Committee made the following finding and recommendation:

Finding 93: Psychiatrists are interpreting the Act differently, and there is a lack of clarity around how these provisions should apply to people experiencing drug-induced psychosis.

Recommendation 41: The Commission clarify through the statutory review of the Act how and when the Act can be used to detain people experiencing drug-induced psychosis who may not also be mentally ill.<sup>26</sup>

The recommendation requires additional research and work to be done on this issue, noting that evidence given to the Select Committee noted that the Act can already be applied to a person with drug-induced psychosis during those periods when the criteria under the Act was met. However, the competing demands of 'least restrictive alternative' under the Act, also mean that a person cannot be detained or be under an involuntary order once they no longer met that criteria.<sup>27</sup>

This issue does not have a suggested amendment. Your comments are welcome.

<sup>26</sup> [https://www.parliament.wa.gov.au/Parliament/commit.nsf/\(Report+Lookup+by+Com+ID\)/76DC63572B331E7F482584BE00219B5F/file/id.alt.191111.rpf.final.xx%20web.pdf](https://www.parliament.wa.gov.au/Parliament/commit.nsf/(Report+Lookup+by+Com+ID)/76DC63572B331E7F482584BE00219B5F/file/id.alt.191111.rpf.final.xx%20web.pdf)

<sup>27</sup> Above, at pages 162 – 164 which sets out the evidence on which Finding 93, and Recommendation 41 were made.

## Theme 10

# Clinical Governance Review

This theme sets out a recommendation that was made to the panel conducting the Review of the *Clinical Governance of Public Mental Health Services in Western Australia* (Clinical Governance Review)<sup>28</sup>.

## 10.1 Mental health governance - legislate for Lived Experience partnerships

**Section of the Act:** Requires new provisions.

### Background

In the Clinical Governance Review the panel noted submissions made to it regarding the clinical governance and clinical leadership for mental health services:

*Further suggestions to strengthen the genuine representation of people with lived experience were made in the joint submission by WAAMH [Western Australian Association for Mental Health] and CoMWHWA [Consumers of Mental Health WA]. This suggested a model of state-wide mental health governance through either new legislation or via amendment of the Mental Health Act 2014 (WA). Key goals of this legislation would be provision of functions similar to the Disability Services Act 1993 (WA). Considerations could include a Ministerial Advisory Council for People with Lived Experience reporting to the Minister for Mental Health, but with a quota to provide for majority lived experience representation (similar to the Disability Services Act 1993) and a new Mental Health Commission Board with a quota to provide for majority representation by people with lived experience.<sup>29</sup>*

<sup>28</sup> Clinical Governance Review dated October 2019, published 4 March 2020: <https://ww2.health.wa.gov.au/Reports-and-publications/Review-of-the-clinical-governance-of-Public-Mental-Health-Services> For information on the provisions of the *Disability Services Act 1993*, see: [https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc\\_42879.pdf/\\$FILE/Disability%20Services%20Act%201993%20-%20%5B04-e0-02%5D.pdf?OpenElement](https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42879.pdf/$FILE/Disability%20Services%20Act%201993%20-%20%5B04-e0-02%5D.pdf?OpenElement) See Part 3 for the provisions relating to the establishment of the Ministerial Advisory Council on Disability.

<sup>29</sup> Ibid, p25.

The Clinical Governance Review did not adopt this submission, but it did make other recommendations which has led to new governance arrangements being introduced for mental health, alcohol and other drug services in Western Australia.

The Mental Health Executive Committee (MHEC), which relates to the public mental health system, and the Community Mental Health, Alcohol and Other Drug Council (CMC), which relates to the community mental health sector, have been established to bring the sector together and strengthen links between community services representatives and Commission policy, planning and commissioning. Both the MHEC and CMC have lived experience representation.

As part of the new governance structure, the position of Chief Medical Officer, Mental Health (CMOMH) has also been created to assist in strengthening the Commission's leadership role across the sector. The CMOMH also plays a key role in the MHEC and CMC. More information about the new governance arrangements which were made as a result of the Clinical Governance Review can be found on the Commission website. A link is provided in the footnote below.<sup>30</sup>

Given that these governance arrangements are still in their early stages, this issue does not have a suggested amendment.

## Theme 11

### Culture and Spirit of the Act

A person or body performing a function under the Act must have regard to the 15 principles set out in the Charter of Mental Health Care Principles, which state that mental health services must treat people experiencing mental illness with dignity and respect; and that includes respecting their right to make decisions about their own lives. The principles are intended to facilitate recovery from mental illness and for some people, they encapsulate the culture and spirit of the Act. Mental health services and private psychiatric hostels must always consider these principles when they provide treatment, care and support to a person.

#### Specific questions regarding the Culture and Spirit of the Act:

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?
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?
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?
4. What is being done well to ensure that the Objects of the Act and the Charter are being met?
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?
6. What are the barriers to implementing any suggested changes?

<sup>30</sup> <https://www.mhc.wa.gov.au/about-us/sector-governance/>

## 11.1 Post-implementation review recommendation

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**Section of the Act:** Whole of the Act.

### Background

The final recommendation stated that: *'the Mental Health Commission is to ensure the 'spirit' of the Act, in achieving cultural change as experienced by consumers, families and carers in the provision of mental health services, is assessed and captured more effectively in the statutory review of the Act.'*<sup>31</sup>

The use of the word spirit refers to the general intent or real meaning of the Act. The Holman Review recommended that the Act address the advancement of the human rights of consumers, their families and carers and the Act encapsulates that intent, or spirit through the Objects and the Charter of Mental Health Care Principles.<sup>32</sup>

Stakeholders' feedback to the post-implementation review suggested that there is a tension between the clinicians' compliance with the Act and the spirit of the Act. Specifically, responses to the post-implementation review raised that:

- The administrative obligations on clinicians may impact on their ability to work in the spirit of the Act; and
- Online training programs and Approved Forms appear to be for compliance, rather than for effecting cultural change and working with the spirit of the Act.

Some stakeholders reported to the post-implementation review that the Act has placed an additional administrative workload for clinicians, and as a result had reduced the time available to provide direct clinical care. The additional administrative workload results from more forms, whether for specific purposes (such as for seclusion and restraint) or for other reasons (such as notifications to personal support persons).

Compared to the 1996 Act, the Act contains increased safeguards for consumers and their personal support persons, this includes a level of monitoring which involves notifications and completion of forms.

Safeguards are essential and are intended to embody the spirit of the Act, by ensuring consideration of human rights and facilitating collaboration and involvement in treatment and care.

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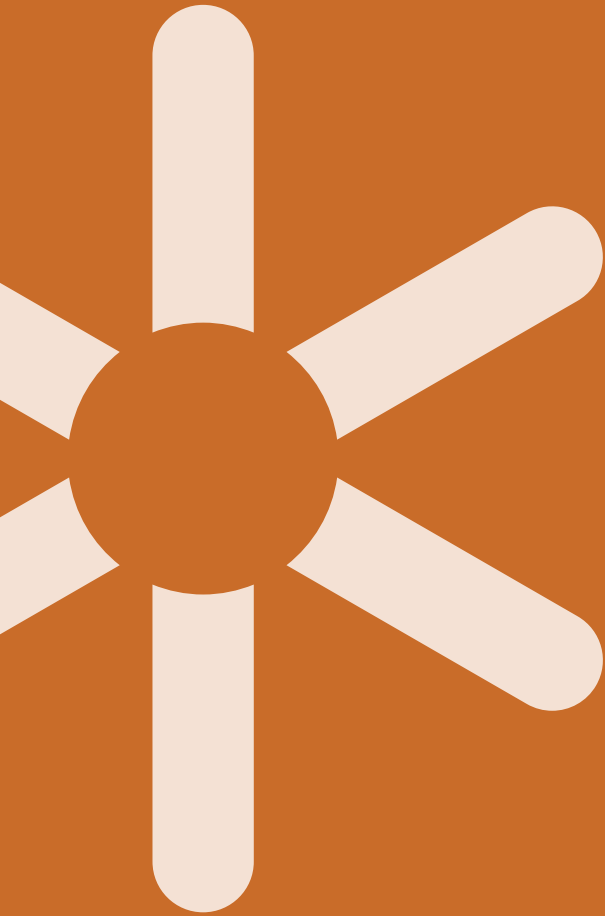
<sup>31</sup> <https://www.mhc.wa.gov.au/media/2540/post-implementation-review-of-mental-health-act-2014-final.pdf> Recommendation number 48.

<sup>32</sup> Schedule 1 of the Act. Sections 11 and 12 require a person, body and mental health service to have regard to the Charter when performing a function or providing treatment, care and support to patients.

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## Chapter 4

# Previously Proposed Amendments



“

We all want better care, better rights, greater capacity for engagement for better outcomes. Our challenge is to create something that at its best, brings people together

”

# Previously Proposed Amendments

In 2019, the Commission conducted limited consultation on a range of proposed amendments received since 2015. The Commission consulted those stakeholders with statutory responsibilities under the Act. This included the Chief Psychiatrist, the Mental Health Advocacy Service, the Mental Health Tribunal and the Health and Disability Services Complaints Office. The Department of Health's Mental Health Unit, the Western Australia Police Force and the Mentally Impaired Accused Review Board were also consulted.

Over 60 proposals were consulted on and at the conclusion of these consultations, there were 45 proposed amendments which had the in-principle agreement of the stakeholders involved in the consultation.

The 45 Proposed Amendments will either correct an omission in the Act, clarify certain matters, improve administrative processes, or improve rights protections under the Act.

For example, there are:

- 10 amendments which seek to clarify matters or fix omissions in the Act.
- Four amendments which will either facilitate the rights protections of persons under the Act or the operation of the Mental Health Advocacy Service.
- 12 amendments which either facilitate the operation of the Tribunal or provide for statutory clarification of the administrative roles in the Tribunal.

At the conclusion of the 2019 consultations, the Commission intended to progress the Proposed Amendments. This did not go ahead due to the effect of COVID-19. The Proposed Amendments are therefore being progressed as part of this Review.

**Comment on any of the Previously Proposed Amendments is welcomed**

## If you are responding to the Previously Proposed Amendments in this part:

Please indicate in your response (where possible):

- The amendment number;
- Your view on the issue;
- If you think the suggested amendment should be made, why or why not?

## Part 2

# Terms and Concepts

## Amendment 1:

### Definition of Psychiatrist

**Section of the Act:** Definitions Section 4

#### Background

The Chief Psychiatrist must be satisfied that a person is sufficiently qualified to practise as a psychiatrist under the Act. Currently, a 'psychiatrist' is a medical practitioner who is a Fellow of the RANZCP or has been prescribed by the Regulations. The process of regularly amending the table in Regulations to add psychiatrists is inefficient, creates red tape and can delay psychiatrists being able to perform functions under the Act (while they wait for the Regulations to be amended). This could potentially affect the provision of timely treatment and care. It is proposed to allow the Chief Psychiatrist, by order published in the WA Government Gazette, to designate a medical practitioner as a psychiatrist for the purposes of the Act, consistent with the Chief Psychiatrist's existing powers

#### Proposed Amendment

Provide that the Chief Psychiatrist, by order published in the WA Government Gazette, may designate a medical practitioner as a psychiatrist or revoke an order designating a person as a psychiatrist, subject

to consulting with the Medical Board of Australia established under the Health Practitioner Regulation National Law (Western Australia) and the RANZCP. The Chief Psychiatrist will be required to maintain a register of designated psychiatrists, like the current requirement to maintain a register of authorised mental health practitioners.

### **Amendment 2:**

#### **Definition of Child and Adolescent Psychiatrist for Tribunal hearings**

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**Section of the Act:** Definitions Section 4

##### **Background**

There are no specific requirements in the Act regarding the clinical qualifications for a Child and Adolescent Psychiatrist. However, where the Tribunal is reviewing a child patient, the Act requires the constitution of the Tribunal to include a child and adolescent psychiatrist. If there is no child and adolescent psychiatrist available, then the Tribunal must have regard to the views of a medical or mental health practitioner who has qualifications, training or experience relevant to children with a mental illness or is authorised by the Chief Psychiatrist for this purpose. To date, no practitioner has been so authorised. Without a definition in the Act, it has been problematic determining which psychiatrists may meet the necessary criteria.

##### **Proposed Amendment**

Provide for a definition of a Child and Adolescent Psychiatrist to include either:

- Completion of RANZCP's Certificate of Advanced Training in Child and Adolescent Psychiatry: OR
- Accredited Membership of RANZCP's Faculty of Child and Adolescent Psychiatry based on:
  - » completion of RANZCP's Certificate of Advanced Training in Child and Adolescent Psychiatry;
  - » completion of an approved training program in child and adolescent psychiatry and currently working in child and adolescent psychiatry or related field (e.g. perinatal or youth mental health).

### **Amendment 3:**

#### **Use of reasonable force with respect to a person on: a referral for examination by a psychiatrist, a transport order, or an apprehension and return order**

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**Section of the Act:** Section 28

##### **Background**

The Act currently authorises the use of reasonable force in certain limited circumstances, which includes when a person, on a referral for examination by a psychiatrist, is being transported to a place of examination or apprehended and under a transport order or apprehension and return order.

However, this does not extend to the situation where a person has been referred and detained but is waiting for a transport order to be acted on. This is a gap in the Act which creates uncertainty for clinicians and other staff, including concerns about increased risk to the person and staff.

An amendment to the Act is required to correct the omission.

##### **Proposed Amendment**

Amend the Act to allow that an authorised person may use reasonable force, in the circumstances described, and in accordance with the existing provisions in the Act which regulate the use of reasonable force. The Regulations also be amended to prescribe 'a staff member of a mental health service' or 'a health professional at the place'.

### **Amendment 4:**

#### **Revoking a Referral Made in Relation to a Person Who is Already on a Community Treatment Order**

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**Section of the Act:** Sections 30 and 31

##### **Background**

An involuntary patient on a Community Treatment Order who is referred for examination by a psychiatrist, if reviewed prior to that examination, can have the referral order revoked. However, as the patient was on a Community Treatment Order, the effect of this revocation prior to examination under the Act is that the suspended Community Treatment Order ceases applying to that person. As this is not the intended outcome,

an amendment is required to clarify that revoking a referral for such a person ceases the suspension of the Community Treatment Order and brings it back into force.

#### **Proposed Amendment**

Provide that where a Community Treatment Order was suspended because of a referral for examination and the referral is revoked prior to that examination, the Community Treatment Order is no longer suspended and resumes.

#### **Amendment 5:**

**Provide for continuation of detention at a general hospital to allow for further examination by a psychiatrist**

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**Section of the Act:** Division 3

#### **Background**

Health service providers consider that the legislated 24-hour maximum time period allowed for an examination to be conducted after a person is received at a general hospital is insufficient as more time may be required to allow for thorough assessment and examination and may stop a person being placed on an involuntary treatment order prematurely. Health service providers seek to extend the period for examination by a psychiatrist in a general hospital to mirror the provisions that allow continuation of detention for this purpose when a person is being examined at an authorised hospital.

#### **Proposed Amendment**

Provide that the psychiatrist completing an examination in a general hospital can make an order authorising the person's continued detention to enable further examination, subject to the same times limits that currently apply under the Act when a person is at an authorised hospital.

#### **Amendment 6:**

**Inability to revoke an Order authorising reception and detention in an authorised hospital for further examination**

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**Section of the Act:** Division 3

#### **Background**

There does not appear to be a mechanism in the Act for a psychiatrist to revoke an existing order authorising reception and detention in an authorised hospital for

further examination. The order remains valid for 72 hours. The Chief Psychiatrist recommends that if a person is subsequently examined by any psychiatrist within the 72-hour period, prior to being received at an authorised hospital, and it is determined that they no longer require the order, there should be the capacity to revoke the order, in keeping with the Objects of the Act.

#### **Proposed Amendment**

Provide that an order authorising reception and detention in an authorised hospital for further examination can be revoked when the person is examined by a psychiatrist prior to being received at the authorised hospital, who determines that the order is no longer required.

#### **Amendment 7:**

**Leave of Absence**

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**Section of the Act:** Division 6

#### **Background**

The Act currently provides for several variations of patient leave, but no definitions. The Act places onerous obligations on psychiatrists to fulfil a range of administrative requirements (consultation, recording, and notification if a patient does not return on time, etc.) for all types of leave. Currently this includes escorted leave for five (5) minutes to smoke a cigarette, through to long term unescorted leave.

#### **Proposed Amendment**

Limit the meaning of 'leave' to overnight leave. The other various kinds of day leave can be governed by the patient's treatment, support and discharge plan, prepared in collaboration with the patient and personal support persons, following ongoing risk assessment and use of clinical judgement.

### **Part 9**

## **Notifiable Events**

#### **Amendment 8:**

**Notifying personal support person**

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**Section of the Act:** Various provisions

#### **Background**

The Act currently requires health service providers to notify a patient's personal support person of various notifiable events. Certain events which should have been included as notifiable events have been omitted, likely as an oversight.



### Proposed Amendment

Insert additional notifiable events to ensure that a person must always notify a personal support person of orders regarding the continuation of detention, further examination at an authorised hospital, examination without referral and a Community Treatment Order is no longer in force.

## Part 10

### Transport Orders

#### Amendment 9: Transport Orders

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**Section of the Act:** New provisions

#### Background

Health service providers can extend a transport order or revoke it if it is no longer needed. However, there are constraints where changes in other circumstances require an amendment to the existing transport order. Such circumstances include a change to the risk level (affecting who should be responsible for the transport) or a change to the place of examination (affecting destination). Currently, transport orders cannot be varied in these ways. This can create unnecessary red tape and impact on time frames for transportation.

#### Proposed Amendment

Enable a transport order to be amended to allow for changes in circumstances such as:

- a change in assessed risk level which requires a change in who provides the transport, or
- where a change in destination is required.

## Part 11

### Apprehension, Search And Seizure Powers

#### Amendment 10: Apprehension by police for assessment

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**Section of the Act:** Part 11 Division 1

#### Background

The Act currently allows, in certain limited circumstances, for a police officer to apprehend a person and take them

to a place where they can be assessed. The Act is silent as how handover, or reception of the person at hospital, should occur. This includes a lack of clarity around the ability of hospital staff to detain the person if necessary, and the obligations of police officers while the person is waiting to be assessed.

An amendment is required to authorise detention at the time of reception until such time as a person may be detained in accordance with the existing processes under the Act.

#### Proposed Amendment

Amend the Act to:

- define 'reception';
- enable hospital staff to detain a person apprehended and brought in by police until completion of an assessment by a clinician; and
- allow for a mandatory maximum time frame for detention of X hours (to be determined) between being detained and being assessed.

**Note:** there may be operational issues for police depending on when 'reception' of the person occurs. Timeframe for detention requires further consultation.

#### Amendment 11: Gender of person conducting search

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**Section of the Act:** Section 163 and new provisions

#### Background

A person conducting a search must, if practicable, be a person of the same gender as the person to be searched. The Sex Discrimination Act 1984 (Cth) aims to prevent discrimination on grounds of sexual orientation, gender identity and intersex status, and has been subject to recent amendments. The search provision in the Act may contravene this recent amending legislation.

Consistent with the Criminal Investigation Act 2006, WA Police recommends that the requirement to ask a person who they would prefer to conduct a search should be restricted to when the person conducting the search is uncertain of the person's gender. In addition to laws, the WA Police has an internal policy that complements this approach.

#### Proposed Amendment

Provide that if a person's gender is unclear, the person responsible for conducting the search must ask a person

whether a male or female should conduct the search and, where practicable, act in accordance with that response. In the absence of an answer, the person must be treated as if they are of the gender that they appear to be. This proposal is based on a corresponding provision in the Criminal Investigation Act 2006.

**Note:** most workable solution is to follow existing provisions in other legislation. Having different laws and processes risks causing confusion.

## Part 12

### Exercise of Certain Powers

#### Amendment 12: Transport officers' use of mechanical restraints

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**Section of the Act:** Section 172

#### Background

The Act enables transport officers to use reasonable force when performing their functions. St John Ambulance and other transport officers are concerned about the limits of their powers to use mechanical restraints, resulting in their reluctance at times to carry out certain patient transports. This can mean greater demand for police transport services.

The power to use reasonable force may authorise use of mechanical restraints, however concern remains, particularly for officers other than police, that the relevant provision is not expressly stated. Expressly state that the power to use reasonable force by relevant persons when apprehending, transporting and detaining a person may include power to use mechanical restraints subject to requirements that force is proportionate to the risk and individual circumstances, similar to principles in the Act around use of detention.

#### Proposed Amendment

Expressly state that the power to use reasonable force by relevant persons when apprehending, transporting and detaining a person may include power to use mechanical restraints subject to requirements that force is proportionate to the risk and individual circumstances, similar to principles in the Act around use of detention.

## Part 14

### Regulation of Certain Kinds of Treatment and Other Interventions

#### Amendment 13: Emergency psychiatric treatment

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**Section of the Act:** Sections 203, 204

#### Background

The Act currently authorises a medical practitioner to provide emergency psychiatric treatment. In practice, EPT is frequently provided by a nurse with a medical practitioner's authorisation.

#### Proposed Amendment

Amend the Act to formally provide for a nurse to provide EPT and complete the relevant documentation, upon such authorisation being given by a medical practitioner.

#### Amendment 14: Definition of seclusion

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**Section of the Act:** Section 212

#### Background

The definition of seclusion refers to the person being alone. There is a lack of clarity in the Act as to whether a person is in seclusion if there is a doctor or nurse in the seclusion room or area, given that the person is not technically alone, but it is not within the person's control to leave. However, practically, the person must be observed, examined on a regular basis and provided with food and other requirements.

#### Proposed Amendment

Insert in the definition of seclusion, words to the effect of 'a patient's seclusion is not taken to have been interrupted or terminated merely by reason of a scheduled observation or examination or the giving of necessary treatment or care'.

### Amendment 15:

#### Informing treating psychiatrist of seclusion or bodily restraint

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**Section of the Act:** Section 217

##### Background

Services must notify, within specified time frames, a patient's treating psychiatrist of the use of seclusion or restraint. However, the treating psychiatrist is not always on duty or on call. It is operationally more practical to require services to notify an 'on duty psychiatrist' rather than the patient's treating psychiatrist, supported by obligations to inform the treating psychiatrist in due course.

##### Proposed Amendment

Amend the Act to allow that when the treating psychiatrist is unavailable, services to notify an 'on duty psychiatrist', supported by an obligation to inform the treating psychiatrist in due course.

## Part 16

### Protection of Patients' Rights

#### Amendment 16:

##### Complaints to the Chief Psychiatrist

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**Section of the Act:** Section 257

##### Background

Currently, under the Act a person who is refused voluntary admission to an authorised hospital may make a complaint to the person in charge of the hospital, HaDSCO or the Chief Psychiatrist. This is the only express occasion in the Act where complaints may be made to the Chief Psychiatrist. However, the Chief Psychiatrist is not a complaints body, whereas the services and HaDSCO are the appropriate organisations to receive such complaints.

##### Proposed Amendment

Amend section 257 to remove the option of making a complaint to the Chief Psychiatrist by a person refused voluntary admission to an authorised hospital. Retain the ability for a complaint to be made to either the person in charge of the authorised hospital or HaDSCO.

### Amendment 17:

#### Voluntary Patients in locked inpatient mental health services

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**Section of the Act:** New provision

##### Background

The Act provides for facilitating patients' rights, including the right to the least possible restriction of a person's freedom while receiving treatment and care. The Mental Health Advocacy Service has raised concerns about the freedom of movement for voluntary patients in 'open wards' that have locked doors, though some wards have put up signs informing voluntary patients of their rights in this regard. Mental Health Advocacy Service requests that a specific right to freedom of movement of such voluntary patients be stated in the Act and they be entitled to leave the ward unless treating professionals seek to review their status.

##### Proposed Amendment

Amend Act to expressly state that regardless of whether a voluntary inpatient is placed in a locked or unlocked ward, a voluntary patient has the right to leave the ward and/or hospital at any time without permission. The proposed amendment could be based on similar wording in the Mental Health Act 2009 (SA).

## Part 19

### Complaints About Mental Health Services

#### Amendment 18:

##### Removal of exemption from complaints review by HaDSCO for mental health services wholly funded by the Commonwealth

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**Section of the Act:** Section 305

##### Background

HaDSCO deals with complaints about mental health services. However, HaDSCO's jurisdiction under the Act does not extend to complaints about mental health services which are wholly funded by the Commonwealth. This is because the definition of a 'mental health service' in the MH Act excludes such services from the complaints process. However, there is no express limitation of this kind on HaDSCO's jurisdiction under

the Health and Disability Services (Complaints) Act 1995 (HaDSC Act). To date there has been a reasonably sound argument that HaDSCO has jurisdiction under the HaDSC Act for the management of complaints about mental health services where such services are wholly funded by the Commonwealth.

### **Proposed Amendment**

Amend the Act to remove the exclusion of Commonwealth funded mental health services from the complaints process to provide certainty and enable such complaints to be managed under the Act.

## **Part 20**

# **Mental Health Advocacy Services**

### **Amendment 19:**

#### **Mental Health Advocacy Service – Access to voluntary patients**

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**Section of the Act:** Section 348

#### **Background**

The Act enables the Mental Health Advocacy Service to provide advocacy services to certain limited classes of voluntary patients. The Mental Health Advocacy Service has previously requested that the classes of voluntary patients who can access advocacy services be expanded and obtained a Ministerial Direction which gave effect to this request (dated 1 January 2017). The Mental Health Advocacy Service requests that those voluntary patients the subject of a Ministerial Direction be included in the Act. (The Ministerial Direction could then be revoked). The Mental Health Advocacy Service also seeks further expansion of the classes of voluntary patients who can access the Mental Health Advocacy Service beyond those already referred to in the Act or listed in the Ministerial Direction.

All additional categories of voluntary patients would only be seen by the Mental Health Advocacy Service upon request from the voluntary patient. This means that there will be no requirement on health service providers to notify the Mental Health Advocacy Service other than when a request is received from a patient. Where a request is received, the Mental Health Advocacy Service would be required to contact the person within a set time frame after receiving the request, being 7 days for adults and 24 hours for children. These timeframes conform to

existing timeframes in this part of the Act.

### **Proposed Amendment**

Per the Ministerial Direction, prescribe the following classes of patients as identified persons:

- a. children who are voluntary inpatients in an authorised hospital;
- b. children who are voluntary inpatients in a public hospital;
- c. children who have been assisted by the Mental Health Advocacy Service in the last 6 months, while either a voluntary patient or an involuntary inpatient, and who are being treated, or are proposed to be treated, by a community mental health service; and
- d. a person, who while an identified person, was being assisted by the Mental Health Advocacy Service in relation to a complaint or issue that remains unresolved, and where some further action can reasonably be taken to resolve the complaint or issue.

Prescribe the following additional classes of voluntary inpatients as identified persons:

- e. long term voluntary inpatients in authorised hospitals (6 months for adults, and 3 months for children);
- f. persons on a Community Treatment Order admitted to an authorised hospital as a voluntary inpatient;
- g. voluntary inpatients in an authorised hospital who are, or in the past 24 hours have been, subject to an order restricting their freedom of communication; and
- h. voluntary inpatients in an authorised hospital who have been subject to seclusion or bodily restraint.

### **Amendment 20:**

#### **Timing of notifications to the Mental Health Advocacy Service**

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**Section of the Act:** Section 357

#### **Background**

The Mental Health Advocacy Service is required to contact every involuntary patient within seven (7) days of an involuntary treatment order being made, or within 24 hours for children. It is difficult for the Mental Health Advocacy Service to comply if health service providers do not provide timely notifications. In practice, an operational agreement has been reached with health

service providers to achieve the above time frames. The Mental Health Advocacy Service says this has been working to date but also seeks legislative prescribing.

#### **Proposed Amendment**

Require services to notify the Mental Health Advocacy Service within 48 hours of an involuntary treatment order being made or within X hours (to be determined) for children. Also requires amendment to section 145.

**Note:** consultation required regarding the time frame for notification about children.

#### **Amendment 21:**

#### **Involuntary Child / MIA Child in Authorised Hospital -Request for Contact by the Mental Health Advocacy Service**

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**Section of the Act:** Section 357

#### **Background**

The Act requires children to be contacted by the Mental Health Advocacy Service within 24 hours in all situations, except in two (2) situations (which may be the result of an oversight when the Act was introduced).

These relate to a child under an involuntary treatment order who requests contact and a mentally impaired accused child detained in an authorised hospital who requests contact. This would be consistent with all provisions relating to the Mental Health Advocacy Service's requirements to contact children. The Mental Health Advocacy Service currently has a protocol to contact all children within 24 hours in any event so no practical implications from making this amendment.

#### **Proposed Amendment**

Provide that an identified person who is a child, either under an involuntary treatment order or is a mentally impaired accused, who requests contact by the Mental Health Advocacy Service must be visited or otherwise contacted by a mental health advocate within 24 hours of the request or notification being received by the Mental Health Advocacy Service.

#### **Amendment 22:**

#### **Powers of Mental Health Advocates – Inquiry Power Regarding Discharge or Withdrawal of Care**

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**Section of the Act:** Section 359

#### **Background**

Advocates often deal with consumer complaints about a person's discharge from a service that involves the eviction from a hostel. Although arguably covered by the Act, the Act does not specifically refer to the powers of mental health advocates to make inquiries about discharge or withdrawal of care that results in eviction.

#### **Proposed Amendment**

Expressly provide that a Mental Health Advocate can make inquiries regarding the discharge of or withdrawal of care to a person by a mental health service or other place.

### **Part 21**

## **Mental Health Tribunal**

#### **Amendment 23:**

#### **Application to Mental Health Tribunal for provision of electroconvulsive therapy**

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**Section of the Act:** Various

#### **Background**

Currently, under the Act, a psychiatrist may apply to the Tribunal for approval to provide electroconvulsive therapy. Clinical stakeholders state that the details in the Act requiring approval by the Tribunal are too prescriptive and may lead to delays in the provision of treatment, thus increasing the potential for negative outcomes for patients. The Tribunal should not determine clinical issues, but rather provide oversight of the provision of electroconvulsive therapy.

It is noted that, in comparison with other Australian jurisdictions and New Zealand, the Western Australian Act is more prescriptive in its requirements for approval of electroconvulsive therapy by a Tribunal.

Currently, the application to provide electroconvulsive therapy must include a treatment plan, including where the electroconvulsive therapy will be provided and the minimum period that it is proposed to elapse between

any two (2) treatments (amongst other things). Practical issues arise where the location may need to change or the minimum period between electroconvulsive therapy sessions is not fully complied with. For example, where a treatment plan refers to 'no less than two (2) days apart', but electroconvulsive therapy is provided 46 hours later. In any event, the Chief Psychiatrist's clinical standards regarding the provision of electroconvulsive therapy will continue to apply and provide necessary safeguards.

The Mental Health Advocacy Service sought an additional requirement that any application for electroconvulsive therapy be supported by a patient's treatment, support and discharge plan. This is supported by the Tribunal and Chief Psychiatrist.

#### **Proposed Amendment**

Amend the Act to remove the following electroconvulsive therapy specifications from Tribunal approval requirements:

- The mental health service where electroconvulsive therapy will be provided; and
- The minimum period proposed to elapse between any two (2) treatments.
- Retain the following electroconvulsive therapy specifications in Tribunal approval requirements:
- The maximum number of electroconvulsive therapy treatments to be performed; and
- The maximum period over which electroconvulsive therapy is to be performed.

Further amend the Act to require the Tribunal to have regard to the patient's treatment, support and discharge plan when considering an application for electroconvulsive therapy.

Further amend the Act to remove the requirement for the Tribunal to be satisfied that the electroconvulsive therapy will be performed at a mental health service approved for that purpose by the Chief Psychiatrist. Instead, add a requirement to the electroconvulsive therapy provisions in the Act that electroconvulsive therapy can only be performed at a mental health service approved for that purpose by the Chief Psychiatrist. Non-compliance with this requirement may then be included as an offence, along with non-compliance with other electroconvulsive therapy provisions in that Part of the Act.

### **Amendment 24:**

#### **Calculating the timing of periodic reviews by the Tribunal**

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**Section of the Act:** Section 387

#### **Background**

The Tribunal has raised concerns that, by strategic use of certain provisions, the Tribunal can be required to conduct monthly reviews rather than three (3) monthly periodic reviews, as per the definition of 'periodic review period'. This is contrary to the intention of the Act to facilitate balancing patient rights with administrative requirements. The Tribunal proposes an amendment to ensure that where the Tribunal conducts a review upon application by the person, or other person, it is included as a 'last review' in the calculation of the periodic review period.

#### **Proposed Amendment**

Provide that where the Tribunal conducts a review upon application by a person, or other person, it is included as a 'last review' in the calculation of the periodic review period.

### **Amendment 25:**

#### **Provide Tribunal Members with explicit power to administer an oath or affirmation**

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**Section of the Act:** New provision

#### **Background**

It is arguable that the Act does not provide Tribunal members with statutory power to take an oath or affirmation. However, the Tribunal seeks express power to take an oath or affirmation.

#### **Proposed Amendment**

Expressly provide that Tribunal members may administer an oath or take an affirmation.

## Amendment 26:

### Provide for a transcript of oral reasons delivered during a Tribunal hearing to suffice as compliance with a request for reasons

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**Section of the Act:** New provision

#### Background

The Act provides for a party to request the Tribunal provide reasons for the Tribunal's decision. A transcript is a written or printed version of material originally presented in another medium. Tribunal members usually give the parties oral reasons for the decision at the conclusion of the hearing, complemented by the informal practice of providing reasons for decision in the transcript. This facilitates the applicant's understanding of the Tribunal's decision by getting clarity at the time of the hearing.

Allowing the transcript of the decision to suffice as reasons for decision means that Tribunal members are not required to write a formal decision, saving time and associated costs and ensuring speedier dispensing of the Tribunal's decision or reasons.

#### Proposed Amendment

Provide that, if a party requests reasons for decision by the Tribunal, a written transcript of the part of proceedings that contain the reasons for decision given orally may suffice. This would be subject to the requirement in the Act that any reasons must be in a language, form of communication and terms that the person is likely to understand.

## Amendment 27:

### Enable the Tribunal to correct any clerical mistakes, accidental errors, omissions, miscalculations or defects of form, contained in its decisions or reasons

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**Section of the Act:** New provision

#### Background

In judicial and quasi-judicial matters, 'technical' or administrative mistakes, errors, omissions, miscalculations or defects of form can occur with judgments, reasons, orders or on certificates. Once a statutory right has been exercised a Tribunal member becomes *functus officio*. The effect of this is that having decided on the particular issues submitted, the Tribunal lacks power to re-examine the decision and

thus correct any of the above. It is impractical and cost inefficient to require formal appeals to amend any such matters. Usually such occurrences are amended by laws providing that the judicial or quasi-judicial body, on the application of any party or of its own motion, may, at any time, correct the mistake, accidental error, omission, miscalculation or defect of form. This is colloquially called the 'slip rule'.

#### Proposed Amendment

Amend the Act to provide that the Tribunal may, at any time, correct a clerical mistake, accidental error, omission, miscalculation or defect of form in its reasons or decisions.

## Amendment 28:

### Clarify when a decision of the Tribunal takes effect

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**Section of the Act:** New provision

#### Background

The Tribunal is aware that mental health services can be uncertain as to when a Tribunal decision takes effect, particularly regarding decisions changing a patient's status from involuntary to voluntary, when a patient is free to leave detention immediately. However, staff may be reluctant to permit them to leave until receipt of the Tribunal's written notice of decision, which may not occur on the day of the hearing. A practical amendment providing that the Tribunal's decision takes immediate effect, subject to any stated exceptions, would minimise confusion, save resources and ensure, where appropriate, patients can access their rights expeditiously, including that they are not detained unlawfully.

#### Proposed Amendment

Clarify that a decision of the Tribunal has immediate effect, subject to any terms otherwise stated in the order, and the enforceability of the decision is not dependent on a written notice of decision mailed or otherwise communicated to the parties.

## President's Powers to Direct, Administer and Manage the Business of the Tribunal

The President is appointed by the Governor on recommendation of the Minister. The Act sets out limited responsibilities of the President. These include making Tribunal rules providing for anything required or permitted by the Act or that assist the efficient, economic and expeditious operation of the Tribunal, including organising and managing its business. The President is required to provide a report to the Minister for tabling. Otherwise, there is no specific legislative description of the President's position or formal statement of responsibilities. These proposed new provisions, below, are consistent with facilitating the decision-making function of the Tribunal.

### Amendment 29: Provide the President is responsible to the Minister for administering Tribunal business

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#### Proposed Amendment

Provide that the Tribunal President is responsible to the Minister for administration of the Tribunal and for organising the business of the Tribunal.

### Amendment 30: Expressly enable the President to advise the Minister

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#### Proposed Amendment

Provide that the President can advise the Minister on actions the President considers would lead to:

- a. more convenient, economic, and efficient disposal of the business of the Tribunal; or
- b. avoidance of delay in the conduct of proceedings; or
- c. the Act and related laws including regulations being more effective.

### Amendment 31: Revocation of section 492 providing for meetings of the Tribunal

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#### Proposed Amendment

Delete section 492 of the Act to remove the requirement regarding meetings of members.

### Amendment 32:

Enable the President to create a code of conduct for members of the Tribunal

#### Proposed Amendment

Provide for the President of the Tribunal being able to make and maintain a code of conduct for members that must be complied with.

### Amendment 33:

Enable the President to regulate the education, training and professional development of Tribunal members

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#### Proposed Amendment

Provide the President is responsible for directing, and the Minister for ensuring appropriate provision is made for the education, training, and professional development of Tribunal members regarding performance of their functions.

### Amendment 34:

Regulation of Members regarding conflicts of interest and engaging in other employment

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#### Proposed Amendment

Enable the President to regulate members engaging in other employment and/or other activities that create a conflict or potential conflict of interest, or otherwise affect the ability of members to carry out their responsibilities professionally.

## Part 23

## Administration

### Amendment 35: Chief Psychiatrist's access to information regarding former patients

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**Section of Act:** Division 2

#### Background

The Act currently limits the Chief Psychiatrist in the ability to access information regarding former patients, including those who have died or been discharged. If the Chief Psychiatrist is unable to access information, it could impact on the Chief Psychiatrist's capacity to investigate their experience or properly enforce standards for mental health services.



### Proposed Amendment

Amend the Act to allow the Chief Psychiatrist to obtain information regarding former patients, including deceased patients, in order to facilitate investigation of their experience and enforce standards for mental health services based on that information.

## Part 24

# Interstate Arrangements

### Amendment 36:

#### Interstate arrangements for mental health orders

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**Section of Act:** Part 24 generally

#### Background

In 2018, the Commission commissioned a research project looking at interstate arrangements for mental health orders in order to identify best practice and inform the development of such arrangements under the Act. The research noted that arrangements between States/Territories in Australia are particularly complex because each jurisdiction has its own mental health legislation using different terminology and criteria. There are also significant differences amongst jurisdictions as to frameworks for interstate movements of consumers. In addition, some jurisdictions, including Western Australia, do not currently have operational interstate arrangement provisions or they require an Intergovernmental (or Ministerial) agreements to be in place before any mutual recognition of interstate orders. formal interstate movements can take place. This has resulted in a patchy ineffective system nationwide. A best practice approach would require all states and territories to have mirror provisions allowing for mutual recognition of mental health orders.

There is currently work underway at a national level which is developing national draft model laws on mutual recognition. While awaiting the draft model laws (which can potentially progress as part of a future amendment bill to the Act), the Commission intends to remove the current statutory barriers to the recognition of interstate orders in the Act.

#### Proposed Amendments

1. Amend the definition of 'corresponding law' to include a descriptive definition. Currently the definition

requires corresponding laws to be declared by the Regulations. This may cause delays when corresponding laws change.

2. Similarly, provide a descriptive definition of 'corresponding orders' from other jurisdictions.
3. Remove the requirement for an intergovernmental agreement as this creates an unnecessary and additional barrier.

## Part 27

# Miscellaneous Matters

### Amendment 37:

#### Approved form of medical records

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**Section of Act:** Section 582

#### Background

The Act requires medical records to be in a form approved by the Chief Psychiatrist. This requirement does not serve any useful purpose and is unworkable. Further, there is an Australian Standard (AS 2828) regarding both papers based and digital health medical records requirements.

#### Proposed Amendment

Delete the requirement that medical records be in an approved form.

### Amendment 38:

#### Terms of Involuntary treatment orders

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**Section of the Act:** Parts 6 & 7 various provisions

#### Background

Services completing involuntary treatment order forms do not always include the patient's contact details. This makes it difficult for Tribunal and the Mental Health Advocacy Service to contact the patient, particularly when the person is on a Community Treatment Order. The Mental Health Advocacy Service requests the inclusion of addresses, phone numbers and possibly emails on involuntary treatment orders.

#### Proposed Amendment

Amend the Act to require services to include the patient's current address and telephone number (if any) on the involuntary treatment order. Consideration will also be given to the inclusion of email addresses, where available and if appropriate.

### **Amendment 39:**

#### **General Hospital to General Hospital Transfer**

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**Section of the Act:** Parts 6 & 7 various provisions

#### **Background**

The Act provides for transfer of involuntary inpatients from a general hospital to an authorised hospital, and between authorised hospitals. However, there is no provision allowing for an involuntary inpatient to be transferred between general hospitals.

#### **Proposed Amendment**

Provide for transfer of an involuntary patient from one general hospital to another general hospital to be included in the transfer provisions.

### **Notifications to external bodies / entities**

There is information that the Chief Psychiatrist, Tribunal, the Mental Health Advocacy Service or Mentally Impaired Accused Review Board may require to enable them to properly perform their functions. However, relevant services are not authorised to provide such information. This is likely due to an oversight but does create a gap in the Act which requires rectification. A number of amendments are required to enable the notification of certain decisions and provision of information, noting that this aligns with the objects of the Act.

### **Amendment 40:**

#### **Notifying certain decisions regarding CTOs**

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#### **Proposed Amendment**

Add a requirement to notify the Tribunal, the Mental Health Advocacy Service, Mentally Impaired Accused Review Board and Chief Psychiatrist where a Community Treatment Order has been made without referral and is since confirmed or is no longer in force.

### **Amendment 41:**

#### **Notifying Admission and Detention of mentally impaired accused**

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#### **Proposed Amendment**

Add a requirement to notify the Mental Health Advocacy Service within a certain timeframe regarding the admission into and detention of a mentally impaired accused person in an authorised hospital.

### **Amendment 42:**

#### **Providing a copy of Making or Revocation of Inpatient Treatment Orders in a general hospital**

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#### **Proposed Amendment**

General hospital to provide a copy of the order to the Chief Psychiatrist.

### **Amendment 43:**

#### **Providing a copy of Transfer Orders to the Mental Health Advocacy Service, Tribunal, Mentally Impaired Accused Review Board and Chief Psychiatrist**

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#### **Proposed Amendment**

Add a provision requiring a copy of Transfer Orders between hospitals to be provided to the Tribunal, the Mental Health Advocacy Service, Mentally Impaired Accused Review Board and Chief Psychiatrist.

### **Amendment 44:**

#### **Authorise recording, disclosure or use of information for Tribunal and Mentally Impaired Accused Review Board**

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#### **Proposed Amendment**

Amend the Act to authorise the recording of, disclosure to or use of information by the Tribunal and Mentally Impaired Accused Review Board.

### **Amendment 45:**

#### **Providing a copy of Continuation Orders to the Mental Health Advocacy Service, Tribunal, Mentally Impaired Accused Review Board and Chief Psychiatrist**

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#### **Proposed Amendment**

Add a provision requiring a copy of Continuation Orders to be provided to the Tribunal, Mental Health Advocacy Service, Mentally Impaired Accused Review Board and Chief Psychiatrist.





Government of **Western Australia**  
Mental Health Commission

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