

# **The Way Forward**

**Recommendations of the  
Review of the  
Mental Health Act 1996**

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# Transmittal

Hon Jim McGinty MLA  
Minister of Health and Attorney General

Sir,

In early October 2003, a synthesis of the review of the *Mental Health Act 1996* (the WA Act) was published, which foreshadowed a series of proposals for legislative reform for the purpose of subjecting them to public scrutiny and comment. The synthesis itself was already the product of a broad-based enterprise in community consultation lasting some 18 months. The final phase of the review has offered a further opportunity for open participation. A second round of public submissions has been received, numbering over 300, and on 20-23 October 2003, four separate consultative forums on the synthesis of the WA Act were conducted at the Fremantle Arts Centre. The feedback obtained has been effective in motivating important changes to what had been proposed originally.

The review is now in a position to make its final recommendations on the WA Act and these are contained in this report for your consideration. It should be read in conjunction with the earlier synthesis in order to obtain a full appreciation of the rationale for each recommendation. In instances where the recommendations presented here differ significantly from the proposals in the synthesis, the part of this report entitled 'notes' gives corresponding explanations for each change. 'Notes' are also recorded on recommendations that provoked debate during the final phase of the review, even if the decision was eventually to stand by the original proposal. Recommendations that have been essentially unaltered from the original proposals, and which generated little or no debate, do not have an accompanying explanatory note.

I would like to thank the Government for affording me the privilege of working on these important reviews and to find myself heartened by the commitment and extraordinary voluntary efforts of so many people, whose wish is to see Western Australia supported by the best possible mental health laws.

Professor C. D'Arcy J. Holman MBBS MPH(Harv.) PhD FACE FAFPHM FAIM  
Reviewer of the *Mental Health Act 1996* and *Criminal Law (Mentally Impaired Defendants) Act 1996*  
12 December 2003

# Recommendations

## A. General

### New Act

A.1 The means of effecting the legislative changes recommended in this report should be through contemporaneous repeal of the WA Act of 1996 and its replacement by new mental health legislation. The WA Act should continue to stand separate from the *Criminal Law (Mentally Impaired Defendants) Act 1996* (CLMID Act).

## 1. Preliminary

### Repeal of “Senior Mental Health Practitioner” and Criteria for “Mental Health Practitioner”

1.1 The definition of “senior mental health practitioner” in section 3 of the WA Act should be repealed with consequential amendments changing senior mental health practitioner to simply mental health practitioner in:

- subsection 30(3), *Referral of voluntary patient in certain circumstances*;
- section 118, *Seclusion must be authorized*;
- section 119, *Giving of authorization*;
- section 122, *Mechanical body restraint must be authorized*;
- section 123, *Giving of authorization*; and
- subsection 159(2), *Affected person to be given copy of order*.

## **Additional Definitions**

1.2 Definitions of the following terms should be added to section 3 of the WA Act:

“Adolescent”; “assessment”; “audio-visual means”; “carer”; “child”; “competent minor”; “dementia”; “guardian”; “in-patient”; “mental health service”; “notifiable incident”; “treatment”; “urgent medical treatment”; “voluntary patient”; and “youth advocate”. Some definitions will have the meaning given in a specified section of the WA Act.

The definition of “assessment” should require that the individual conducting an assessment is in close personal proximity or personal attendance or used audiovisual means. The definition of “audio-visual means” should clarify that a replayed recording is unacceptable. The definition of “carer” should be consistent with that in proposed carer recognition legislation. The definition of “guardian” should refer to a person who has been appointed under the *Guardianship and Administration Act 1990* to make decisions for a patient under the WA Act. The definition of “in-patient” should include referred persons, persons in authorized hospitals subject to orders under the CLMID Act as well as voluntary and involuntary patients.

## **Meaning of Mental Illness**

1.3 The meaning of mental illness in section 4 of the WA Act should be revised as follows:

- add a new subsection after subsection 4(1), which requires that a determination that a person has a mental illness shall only be made in accordance with internationally accepted standards for the diagnosis of mental illness; and
- amend subsection 4(2) to add exclusions from sufficient grounds for a person who – engages, or refuses or fails to engage (cf holds, which is covered already) in a particular religious or cultural activity; has, or has not, a particular political, economic or social status; is, or is not, a member of a particular cultural, racial or religious group; is involved, or has been involved, in family or professional conflict; has been treated for mental illness or has been detained in a hospital that provides treatment of mental illness.

## **Objects and Principles**

1.4 The objects of the WA Act in section 5 should be replaced with two new sections: one being a new set of objects modelled to an appropriate degree on section 3 of the NT Act; and the other being a set of fundamental principles modelled on sections 9-13 of the NT Act, including, notably, the sections containing principles relating to Aborigines and Torres Strait Islanders (section 11 of the NT Act) and the rights of carers (section 12 of the NT Act). The rights of carers should include a right to information relevant to the ongoing care, treatment and rehabilitation of the person with mental illness, where the disclosure is considered to be in the best interests of the person. In other instances the provisions of the NT Act are inappropriate to WA, as is the case with subsections 3(b), 3(h), 3(k), 3(q), 3(r) and 3(s).

Although not covered in the NT Act, the principles should include: acknowledgment that due to their mental illness and sometimes additional and multiple disabilities and social factors, people with mental illness have a range of needs for health care and disability support and other support services; that access of people with mental illness to health care and support services should be equivalent to the access of the rest of the community; and that information provided to people with mental illness and their carers should be given in a form that they are use to receiving.

## 2. Administrative Provisions

### Functions of the Chief Psychiatrist

2.1 The responsibilities and functions of the Chief Psychiatrist (CP) should be strengthened in setting standards and quality assurance. In section 9 of the WA Act the changes should be:

- rename the section to "*Responsibilities of Chief Psychiatrist for standards of psychiatric treatment and care*";
- amend subsection 9(1) such that the CP has responsibility for the welfare and standards of psychiatric and medical treatment and care of all voluntary patients, involuntary patients and any person in an authorized hospital subject to an order made under the CLMID Act; and
- amend subsection 9(2) and place it ahead of subsection 9(1), such that the CP is required to set standards for psychiatric treatment and care and to monitor and take action on the adherence to standards with respect to all patients using mental health services, including psychiatric hostels;

and with respect to the other functions of the CP in section 10:

- repeal subsection 10(a);
- add a sub-subsection after 10(c)(ii) requiring the CP to promote the provision of balanced information about benefits and adverse side effects of drugs to patients with mental illness and their carers;
- replace subsection 10(d) such that the CP is no longer required to report on matters to the Mental Health Review Board (MHRB), but rather is required to make an annual report to the Minister for Health and the Director General on matters that are the CP's responsibilities; and that the Minister shall table the report before each House of Parliament;
- add a new subsection defining a function as the approval of guidelines to improve treatment and care; and
- add a new section defining a function as the collection, analysis and reporting of statistical information on the maintenance of quality and standards of care provided by mental health services, including returns concerning the use of regulated treatments for mental illness, notifiable incidents and complaints about mental health services;

and with respect to the powers of the CP to give directions in section 12:

- amend subsection 12(1)(a) to extend the power to review decisions of psychiatrists to the treatment of all voluntary patients, involuntary patients and persons in an authorized hospital subject to orders made under the CLMID Act; and

- amend both subsections 12(1) and 12(2) to extend the power of the CP to direct a medical practitioner (as well as a psychiatrist) concerning the treatment of any patient in an authorized hospital.

## **The Chief Psychiatrist's Powers of Direction**

2.2 The definition of “psychiatric health service” in subsection 13(6) of the WA Act should be replaced by a broader definition of ‘mental health service’, partly modelled on subsection 106(1) of the Vic Act. Thus, a mental health service would mean: a hospital, declared place, residential facility such as a licensed hostel, boarding house or non-licensed hostel, admitting or caring for people with mental illness; a community mental health service; a psychiatric outpatient clinic; and any health service that provides specialized psychiatric care or treatment to persons suffering from mental illness.

Powers should be given to the CP to enable him or her to direct any mental health service on the basis of results of an inspection undertaken under subsection 13(1)(a) of the WA Act. This would appropriately appear as a new section inserted after section 13 with provisions as follows:

- a power for the CP by written notice to direct a mental health service: to discontinue, or alter, a practice, procedure or treatment observed or carried out by the service; observe or carry out a practice, procedure or treatment; or provide treatment, or a particular treatment, to a person with mental illness; and
- that a direction under this new section may be given only if the CP is satisfied that the direction is necessary for the welfare, treatment or care of the person with mental illness, and, in the case of a direction concerning treatment, that all rights to informed consent of the person with mental illness have been observed.

Subsection 13(4) of the WA Act should be repealed.

## **Eligibility to be a Mental Health Practitioner**

2.3 Subsection 19(1)(b) of the WA Act should be amended to clarify that a nurse under either division 1 or 2 of the Nurses Act 1992 may be eligible to be a mental health practitioner.

In addition, the reference to “at least 3 years’ experience in the management of persons who have mental illness” at the end of subsection 19(1) should be replaced with the criterion that a mental health service has designated the person as a mental health practitioner using criteria published by the CP.



## 3. Involuntary Patients

### Criteria for becoming an Involuntary Patient

3.1 The following changes should be made to the criteria for involuntary status:

- replace subsection 26(b)(i) with “to protect the person with mental illness from the serious likelihood of immediate or imminent harm, including self-inflicted harm of a kind described in subsection (2);”
- replace subsection 26(b)(ii) with “to protect any other person from a serious likelihood of immediate or imminent harm;”
- add to subsection 26(b) a fourth criterion for involuntary status of “or, in the instance where a person is made an involuntary patient subject to a community treatment order (CTO), to prevent the likelihood of the person suffering from serious mental or physical deterioration”;
- amend subsection 26(c) to make the criterion that “the person has unreasonably refused, or due to the nature of the mental illness, is unable to consent to the treatment”;
- alter the order of the existing subsections of section 26, such that existing subsection 26(b) is last, thus reducing the confusion in the field caused by nesting of criteria connected by ‘or’ within criteria connected by ‘and’; and
- amend the first line of subsection 26(1) to read “A person can be an involuntary patient only if”.

### Referral for Examination

3.2 Changes to sections 29-31 and 33-35 of the WA Act should be made as follows:

- amend subsection 29(1) to enable the medical practitioner or authorized mental health practitioner to refer (as at present) “and if necessary detain for up to six hours” a person for examination by a psychiatrist;
- amend subsection 29(2)(b) to read “at some other place where by arrangement the examination can be carried out by a psychiatrist”;
- add a third subsection to section 29 to clarify that referral of a person who is on a CTO for assessment in an authorized hospital suspends the operation of the CTO for the duration of that referral;
- amend subsection 31(1) so that a referrer is not to refer a person without having “assessed” the person rather than “personally examined” them, and make consequential changes to subsection 33(b) and the title of section 31;

- clarify the wording of subsection 31(2) to read “facts communicated to the referrer are not of themselves sufficient grounds for suspecting that a person should be made an involuntary patient, but may be considered in forming the opinion”;
- add a new section after section 33, requiring that the person is given in written form the facts referred to in subsections 33(a), (b), (c), (d) and (e), but not information referred to in subsection 33(f);
- replace the words “any of the facts which have” with “the information which has” in subsection 33(f);
- amend subsection 34(2)(a) such that “assistance” is replaced by “police action” and change the title of section 34 from “police assistance” to “police action”; and
- add an additional clause to subsection 35(2) that reads “or until a person referred to a place other than an authorized hospital is examined by a psychiatrist” to allow for the situation in which referral is not to an authorized hospital.

## **Referral of Voluntary Patients**

3.3 Section 30 of the WA Act should be changed as follows:

- amend subsection 30(1) to read “..., other than an involuntary patient or a person in an authorized hospital subject to an order made under the CLMID Act, seeks to be discharged from the hospital or may need to be made an involuntary patient” and delete “and a psychiatrist is not available to examine the person”;
- amend subsection 30(3) such that person-in-charge of the ward may detain the patient for up to six hours to be assessed by a medical practitioner or authorized mental health practitioner, who may then decide to detain the patient for up to 24 hours for examination by a psychiatrist; and
- delete subsection 30(6) so as to enable the treating psychiatrist, or any other psychiatrist, to conduct the examination following referral.

## **Examination of Referred Persons**

3.4 Changes to sections 36-39, 41 and 43 of the WA Act should be made as follows:

- add a new subsection to section 36, requiring the person-in-charge of an authorized hospital, or their delegate, to notify as soon as practicable the Council of Official Visitors (COV) of the name of a person received at the hospital;

- amend section 37(1)(c) such that it reads “order that the person be no longer detained”;
- add new subsections to sections 37 and 39 clarifying that a psychiatrist may examine a person by audiovisual means;
- replace section 38 with a new section, which parallels section 36, including in particular equivalent provisions to subsections 36(1)(b), 36(2) and 36(4); and
- amend subsection 41(2) and the title of section 41 such that “police assistance” is replaced by “police action”.

## **Referrals in Rural and Remote Areas**

3.5 Changes to subdivision 4 of the WA Act should be made as follows:

- add a new section giving power to the Minister for Health to declare areas in the State where a referred patient may be detained for as much as an additional 48 hours (beyond the initial 24 hour limit), provided that the extension is ordered by an authorized mental health practitioner or a medical practitioner and the person is examined by a psychiatrist as soon as practicable;
- make consequential amendments to sections 18 and 20, concerning the functions in the Act which may be performed by a medical practitioner or an authorized mental health practitioner; and
- amend section 39 to be consistent with section 37, such that a psychiatrist may order that the person’s detention in the place (other than an authorized hospital) continues for further assessment for up to 72 hours after the person was received at the place; and that the initial and further assessments may be undertaken by the psychiatrist by audiovisual means. The intention is that a patient may be detained in a rural or remote hospital or other facility for up to 72 hours, regardless of when a psychiatrist examines them.

## **Optimal Use of Beds in Authorized Hospitals**

3.6 Changes to sections 46 and 47 of the WA Act should be made as follows:

- amend section 46 to read “... a psychiatrist or the person-in-charge of an authorized hospital, having regard for the guidelines published by the Director General under section 47, may order that the person be transferred to another authorized hospital specified in the order”;
- add a second subsection to section 46 to read “A psychiatrist or person-in-charge of an authorized hospital ordering a transfer may if required

complete a transport order authorizing a police officer to take the person to the alternative authorized hospital”; and

- replace all of section 47 with a new section to read “The Director General shall publish guidelines for the efficient management and best use of beds in authorized hospitals in the State, including best practice by the referrer in nominating an authorized hospital where a bed is likely to be available and the circumstances and procedures by which it is appropriate for a person to be transferred between authorized hospitals”.

## **Period of Detention**

3.7 Changes to sections 48-50 of the WA Act should be made as follows:

- amend subsection 48(2) such that an initial period of detention (presently up to 28 days) is for no more than 21 days after the order is made for a person who is aged 18 years or older, and no more the 14 days for a person under the age of 18 years; and
- amend subsection 49(4) such that a further period of detention as an involuntary patient (presently up to six months) cannot end more than three months after the order for further detention is made.

The latter amendment has an effect on section 50, such that additional periods of further detention are also reduced to a maximum of three months.

The effects of a reduction in maximum initial period of detention should be tested by a trial through administrative action before the amendment is enacted. The conditions evaluated in the trial should be as near as possible to those in the recommendation.

## **Absence Without Leave and Leave of Absence**

3.8 Changes to sections 57-64 of the WA Act should be made as follows:

- amend section 57 by deleting “as an involuntary patient” from the first sentence;
- delete subsection 58(1)(a)(ii) so that the qualified person authorized to apprehend need not be employed at the authorized hospital from which the person is absent;
- delete all of subsection 58(1)(b);
- amend subsection 58(1)(c) to read “a police officer who is authorized by the person-in-charge of the authorized hospital to apprehend and return the person”;
- amend the first line of subsection 58(2) to “A person or a police officer who apprehends a person under subsection (1) is to take the patient to –“;

- delete subsection 58(2)(b);
- amend subsection 60(1) to read “... the psychiatrist may by order cancel the leave given to the patient”;
- amend subsection 60(2) to read “The order is to be served on the patient by or on behalf of the psychiatrist”;
- add a third subsection to subsection 62(2) to read “order that the patient be returned to the authorized hospital using the powers in section 58”; and
- amend subsection 63(1)(b) by deleting the words “written” and “authorized” from the sentence.

### **Detention of Voluntary Patient with Dementia**

3.9 The *Criminal Code 1913* should be amended by inserting a new section immediately after section 337 to read, “A person who exercises duty of care of a person with degenerative brain disease, and as a consequence of their duty of care prevents the person with degenerative brain disease from wandering into an environment where due to their condition they would be at risk of becoming lost or harmed, is not guilty of a misdemeanor under section 337.”

### **Confirmation of Community Treatment Orders**

3.10 Section 69 of the WA Act should be repealed and replaced by a new section that reads, “A CTO made under section 67(1) does not have effect unless, within seven days after it is made, it is confirmed by a medical practitioner or another psychiatrist; except that – if the patient refuses to be examined for the purpose of the making a determination under this section, it shall have the same effect as if a medical practitioner confirmed the CTO.”

### **Supervision of Community Treatment Orders**

3.11 Changes to sections 70-85 of the WA Act should be made as follows:

- replace subsection 70(2)(a) with “if the patient has breached an order in the manner set out in section 80, the supervising psychiatrist has taken the actions in section 81, and the patient has continued to be in breach of the order or failed to observe an order to attend under section 82”;
- amend section 71 such that “police assistance” becomes “police action”;
- add a new subsection to section 74, giving the CP the power to transfer the responsibility for supervising the carrying out of a CTO to another psychiatrist and, in that event, to notify the patient in writing of the transfer;

- add a second new subsection to section 74, enabling the CP to authorize in writing a person to exercise the power of transfer to a different supervising psychiatrist contained in the first new subsection for a specified time period and with respect to a particular mental health service or particular area of the State;
- amend section 75 to enable an authorized mental health practitioner or medical practitioner to undertake the mandatory monthly examination of a patient who is subject to a CTO, where no more than two months has elapsed since an examination by the supervising psychiatrist and where the supervising psychiatrist is unavailable or the supervising psychiatrist delegates the responsibility for the examination using the power in section 77; and to make a report to the supervising psychiatrist, which includes a recommendation as to whether or not the person should continue to be an involuntary patient and which is to be kept in the case record of the patient;
- amend existing section 77 to enable a psychiatrist to request and act on the report of either an authorized mental health practitioner or a medical practitioner to examine a patient who is subject to a CTO;
- amend sections 75 and 77 to make clear that examinations may be undertaken by audiovisual means;
- amend existing section 84 such that “police assistance” is replaced by “police action”; and
- make consequential amendments to sections 18 and 20, concerning the functions in the Act that may be performed by a medical practitioner or an authorized mental health practitioner.

## **4. Interstate Movements**

### **Preparedness for Interstate Agreements**

4.1 Sections 86-87 of the WA Act should be replaced by a stronger legislative basis on which the Minister for Health may enter into agreements with other states and territories for the return of absconding involuntary patients, based on sections 150-158 of the NT Act.

Once the more comprehensive legislation is in place, the Minister for Health should enter into a series of bilateral agreements with each state and territory of Australia to enable the reciprocal arrangements for return of absconding involuntary patients to be implemented.

### **Notifications to Interstate Mental Health Services**

4.2 A new section should be added to part 4 of the WA Act, containing the following provisions with respect to involuntary patients who abscond interstate:

- that a psychiatrist who is aware that an involuntary patient has absconded to another state or territory, and believes that treatment needs to continue, may notify the mental health service of that state or territory by advising the person-in-charge of the identity of the patient, providing a report on their mental illness and recommending that a further mental health assessment be undertaken;
- that if it is unknown to the psychiatrist where the patient has absconded, and the psychiatrist believes that the patient's need for treatment to continue outweighs the patient's right to confidentiality, the psychiatrist may notify the mental health services of all states and territories; and
- that a psychiatrist is not compelled to make any of these notifications.

### **Planned Interstate Transfer**

4.3 In adopting sections 150-158 of the NT Act as a model for replacement of sections 86-87 of the WA Act, attention should be given to ensure that the new provisions adequately support the execution of planned interstate transfers of involuntary patients, either detained in an authorized hospital or subject to a CTO. The provisions should include the following conditions for such a transfer to take place:

- the patient consents to the transfer;

- the mental health service in the other state or territory is willing and able to accept responsibility for the patient;
- the patient is both physically and mentally able to undertake the travel; and
- a psychiatrist in the other state or territory examines the patient to decide as to whether the person needs to be an involuntary patient under that state's law.

### **Notification by a Patient Subject to a CTO Moving Interstate**

4.4 A new section should be added to division 3 of part 3 of the WA Act, requiring a patient subject to a CTO to notify the supervising psychiatrist if he or she intends leaving the state for longer than 14 days at least seven days prior to their date of departure.

### **Service Agreement with the Northern Territory**

4.5 A new division should be added to part 4 of the WA Act, concerned with *Interstate Treatment*, and the title of the whole part should be changed to *Interstate Movements and Treatment*. The *Interstate Treatment* division should empower the Minister for Health to enter into a service agreement with an adjacent territory or state, for:

- the referral, examination and treatment of persons from a declared geographic region of WA in mental health facilities in the other territory or state;
- the cross-border apprehension, restraint and transport of an absconding involuntary patient, within a declared geographic region adjacent to a shared border; and
- the cross-border supervision of a patient subject to a CTO, within a declared geographic region adjacent to a shared border.

The WA Government should commence negotiations with the NT Government with the objective to secure a service agreement for the people of the Kimberley.



# 5. Treatment of Patients

## Structure of Part 5

5.1 Part 5 of the WA Act should be divided into:

*Part 5A – Treatment and Consent* as the amended equivalent to divisions 1, 2, 6 and 7; and

*Part 5B – Regulated and Prohibited Treatment, Seclusion and Restraint* as the amended equivalent to divisions 3, 4, 5, 8 and 9.

Section 92 of the WA Act should also be changed as follows:

- include the definition that “treatment is any therapy, whether a medical, psychological or social, or other therapeutic intervention, whether alone or in combination, that is intended to alleviate or prevent deterioration of a mental illness”;
- remove unnecessary definitions of “informed consent” and “psychosurgery” which merely refer to subsequent divisions; and
- moving the definition of “electroconvulsive therapy” to the equivalent of what is presently division 5 of part 5.

## Principles of Informed Consent

5.2 Sections 95-98 of the WA Act should be expanded by a more comprehensive statement of:

- the requirements for informed consent (with addition of no inducement, communicated on a form designed for that purpose, right to request to have another person present and adequate time to consider);
- the capacity to give informed consent (with addition of the ability to communicate the consent);
- the conditions under which a person may give informed consent (with addition of receipt of advice about alternative treatments, that treatment may be refused, that a second independent opinion may be sought, rights of review, any relevant financial advantage for providers or research relationship); and
- the requirement for the person-in-charge of a treatment facility or agency to ensure that a summary report is made in the person’s case record noting that these sections of the WA Act are complied with.

The changes should follow approximately the relevant provisions in section 7 of the NT Act.

## **Informed Consent by Voluntary Patients**

5.3 A new section should be included in division 2, part 5 of the WA Act, which clarifies that for a voluntary patient to receive psychiatric treatment, they must either give informed consent, have a guardian who gives informed consent on their behalf and who has been authorized for that purpose, or be deemed to be in need of emergency psychiatric treatment.

The *Guardianship and Administration Act 1990* should be amended to empower the Guardianship and Administration Board to appoint guardians for the purpose of the WA Act.

## **Treatment of Mental Illness in Involuntary Patients**

5.4 Section 109 in the WA Act should be replaced by a new section based on the following principles:

- that emergency psychiatric treatment may be given to involuntary patient without informed consent;
- that a person who is in an authorized hospital and subject to an order under the CLMID Act may be given treatment for mental illness without informed consent;
- that, otherwise, treatment of an involuntary patient without informed consent must not be commenced prior to an initial review of involuntary status by the MHRB or similar tribunal, except where the treatment is necessary – (i) to prevent the patient causing imminent harm to himself or herself, a particular person or any other person; (ii) to prevent behaviour of the patient that is likely to cause imminent harm to himself or herself, a particular person or any other person; (iii) to prevent further physical or mental deterioration; or (iv) to relieve symptoms of mental illness.

In addition, a new subsection should require that before authorizing treatment under this section the treating psychiatrist must be satisfied that (i) the treatment is in the best interest of the person; (ii) the anticipated benefits of treatment outweigh any risk of harm or discomfort to the person; (iii) alternative treatments that would be likely to produce equivalent benefits and with less risk of harm are not reasonably available; and (iv) the treatment represents the least intrusive treatment option reasonably available.

There should be a further new subsection requiring that the treating psychiatrist must also take into account (i) the wishes of the person, as far as they can be ascertained; (ii) the wishes of any guardian appointed by the Guardianship and Administration Board for the purpose of the WA Act; and (iii) unless the patient objects, the wishes of any person who is involved in providing ongoing care or support to the person with mental illness.

There should also be a new subsection requiring that all episodes of treatment administered to a person under this section of the WA Act should be recorded in the person's case record.

Sections 111 and 112 of the WA Act should be amended such that a guardian appointed by the Guardianship and Administration Board for the purpose of the WA Act may request the opinion of another psychiatrist and may seek a further remedy if they are dissatisfied.

### **Carers' Involvement in Treatment**

5.4A A new section should be added to division 2 of part 5 of the WA Act, requiring that upon admission to an authorized hospital a patient who is capable of giving consent, must be asked if they have a carer and, if so, if they wish the carer to be consulted regarding decisions about treatment or care.

### **Prohibited Treatments**

5.5 Proposal 5.5 has been withdrawn.

### **Electroconvulsive Therapy**

5.6 A new section should be added to division 5, part 5 of the WA Act that will require persons-in-charge of mental health care services where ECT is performed to provide a monthly statistical report to the CP of the number of patients who completed a course of ECT during the month, the total number of ECT treatments received by each patient, and whether each patient was an involuntary or voluntary patient.

The new section should empower the CP to prescribe a standard form by regulation for the purpose of these monthly statistical reports.

The CP should be required to include a summary of these ECT statistics in his or her annual report.

## **Second Opinions**

5.7 Subsections 104(1)(d) and 111 of the WA Act should be amended to require approval by “an independent psychiatrist”; and to add a new subsection to section 10 to the effect that a function of the CP is to publish guidelines for what constitutes a second opinion from an independent psychiatrist. It would be expected that such guidelines would cover the absence of close professional, pecuniary or social relationships; but also allow for conditions under which the full independence of a second opinion may need to be compromised due to the practicability of obtaining any form of second opinion.

## **ECT not an Emergency Psychiatric Treatment**

5.8 Sections 104(2) and 107(2) of the WA Act should be repealed to reflect current practice that ECT is not given as an emergency psychiatric treatment.

## **Access to Medical Treatment**

5.9 Following the transfer of sections 109, 111 and 112 to division 2 of part 5, division 6 of part 5 of the WA Act should be renamed *Medical treatment*.

A new section should be added to this part, requiring that all persons admitted to an authorized hospital have documented in their case record the results of a complete medical assessment within a reasonable period following reception to that service.

## **Informed Consent to Medical Treatment**

5.10 Section 110 of the WA Act should be replaced with a new section based on the following principles:

- that urgent medical treatment (defined as that which is immediately necessary to save the life of the person, to prevent irreparable harm to the person, to remove a threat of permanent disability to the person or to remove a life-threatening risk to, or to relieve acute pain of, the person) may be given without informed consent, if authorized by a medical practitioner;
- that, otherwise, if the need for medical treatment is not urgent, informed consent should be sought from the person or another person who may consent on their behalf in accordance with subsections 119(2) and 119(3) of the *Guardianship and Administration Act 1990*; and

- that the supervising psychiatrist may act as a person who may consent to medical treatment on behalf of an involuntary patient as if the order of priority of the supervising psychiatrist was that assigned to “a person prescribed in the regulations” at subsection 119(3)(f) of the *Guardianship and Administration Act 1990*.

Reports of urgent medical treatment should be sent to the CP to aid in monitoring and auditing of clinical standards. Statistics on urgent medical treatment should be included in the CP’s annual report.

## **Sterilization and Long-Acting Chemical Contraception**

5.11 A new section should be added to the division of part 5 dealing with “medical treatment”, to ensure that surgical sterilization and long-acting chemical contraception are permissible medical treatments only when informed consent is given in writing by the patient; or by a guardian appointed by the Guardianship and Administration Board, whose consent in the case of surgical sterilization is concordant with consent given by the full Board in compliance with sections 56, 56A and 57 of the *Guardianship and Administration Act 1990*.

In the case of the surgical sterilization of minors with mental illness, further investigation should be made of the need for an order made under the *Family Court Act 1997*.

## **Emergency Psychiatric Treatment**

5.12 The definition of emergency psychiatric treatment in subsection 113(1) of division 7 of part 5 of the WA Act should be amended to make clear that emergency psychiatric treatment is the appropriate necessary intervention required within the circumstances. A provision should be included in subsection 113(1) to give emergency psychiatric treatment to prevent the person from behaving in a way that can be expected to result in serious damage to property. Subsection 113(2) should identify that ECT (as well as psychosurgery) is not permissible as an emergency psychiatric treatment. In subsection 115(b), reports of emergency psychiatric treatment should be sent to the CP rather than the MHRB to aid in monitoring and auditing of clinical standards. Statistics on emergency psychiatric treatment should be included in the CP’s annual report.

## **Seclusion of Patients**

5.13 Division 8 of part 5 of the WA Act concerning seclusion of patients should be amended as follows:

- amend the definition in section 116 so that “seclusion means the deliberate act or omission on the part of another that causes a patient to be alone in a room or area from which free exit is prevented, regardless of the time of day or night”;
- amend section 118 so that the person-in-charge of the ward can authorize and revoke seclusion;
- amend subsection 119(1) to read “... unless no other less restrictive method of control is appropriate and it is necessary to prevent the person from causing injury to him/herself or any other person, or to prevent the person from persistently destroying property”;
- amend subsection 119(4) so that it is clear that each authorization of seclusion is to be recorded on a form prescribed in regulations by the CP and that a copy of this form is filed in the patient’s case record; and
- amend subsection 120(d) so that reports of seclusion are sent to the CP rather than the MHRB. The CP should be required to include a summary of these seclusion statistics in his or her annual report.

## **Mechanical Bodily Restraint**

5.14 Division 9 of part 5 of the WA Act concerning mechanical bodily restraint should be amended as follows:

- amend the definition in section 121 so that “mechanical bodily restraint means the application of a device (including belt, harness, manacle, sheet and strap) on a person’s body to restrict the person’s movement, but does not include (i) the use of a medical or surgical appliance for the proper treatment of physical disease or injury, (ii) the use of attachments to furniture (including a bed with cot sides and a chair with a table fitted on its arms) that are used to reduce a risk of injury caused by falling off or from the furniture; and (iii) the use of mechanical bodily restraint by a police officer considered by that officer to be necessary in the performance of a duty under the Act”;
- amend subsection 123(1) to read “... unless no other less restrictive method of control is appropriate and it is necessary for – ...”;
- incorporate the regulations on mechanical bodily restraint into the WA Act, but retain the ability of the CP to prescribe a standard reporting form by regulation, a copy of which is to be filed in the patient’s case record;

- add to the equivalent of regulation 16(b), “Where a patient is placed into restraint in an emergency, the doctor is required to attend as soon as practicable”;
- incorporate subsections 61(8) and 61(9) of the NT Act into the WA Act, replacing the term “authorized psychiatric practitioner” with “medical practitioner” where used, and ensuring that mechanical bodily restraint cannot be used where it is likely to result in a significant and permanent ill effect to the patient; and
- amend section 124 such that reports of mechanical bodily restraint are made as soon as practicable to the CP rather than the MHRB. The CP should be required to include a summary of these mechanical bodily restraint statistics in his or her annual report.

### **Initial Medication in Rural and Remote Areas**

5.15 A new division should be added to part 5A of the WA Act, which provides as follows:

- a section giving power to the Minister for Health to declare areas in the State where an authorized mental health practitioner, who is a nurse registered in division 1 of the Nurses Act, may administer a medication used in psychiatry under certain conditions;
- a section that defines the conditions as: that the authorized mental health practitioner has personally examined the person; that the practitioner considers that the person has a mental illness; that the practitioner considers that the mental health of the person is deteriorating and suspects, on reasonable grounds, that in the absence of medication, the person will deteriorate such that they should be made an involuntary patient; the practitioner has made a report about the person to a psychiatrist; the psychiatrist authorizes the dispensing of the medication by telephone or electronic transmission; the practitioner documents the psychiatrist’s authorization in the person’s case record; and the person gives informed consent to receiving the medication; and
- a section requiring that when a psychiatrist authorizes the giving of medication in this way, they must examine the person personally or by audiovisual means within 72 hours of the authorization, and review whether or not the use of the medication should continue.

Alternatively or coincidentally, proposed amendments to the *Poisons Act 1964*; may achieve an equivalent outcome by enabling the Minister for Health through regulation to authorize an individual or class of individuals to access and use medicines in the circumstances set out in the regulations.

## **Reasonable Force for Delivery of Treatment**

5.16 A new division should be added to part 5A of the WA Act, which authorizes the use of reasonable force by a mental health practitioner or medical practitioner, where such force is necessary, and where there is no less forceful alternative, for the delivery of an involuntary treatment, which is a legal treatment under the Act and meets the criteria for a treatment given without the patient's consent. Such use of force should be required to be documented in the case record.

## **Appointment of Guardians**

5.17 Proposal 5.17 has been withdrawn.

## **Clinical Trials**

5.18 Further consultation should occur with stakeholders in this review and with clinical researchers concerning the advisability of proceeding with the inclusion of a new section in the WA Act, modeled on section 65 of the NT Act, and requiring that a person must not perform a clinical trial or experimental treatment on a person who is an involuntary patient unless (i) the trial or treatment is approved by an institutional ethics committee; and (ii) either the patient has given informed consent or the research protocol has been approved by the MHRB or similar tribunal.



## **6. Mental Health Review Board [including Schedules 1 & 2]**

### **Right to Legal Representation**

6.1A Clause 3 of schedule 2 of the WA Act should be amended so as to give an involuntary patient a right to legal representation before the MHRB or similar tribunal; and a right to have such counsel made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

### **Timing of Initial and Periodic Reviews**

6.1B Sections 138 and 139 of the WA Act should be amended so as to provide shortened timeframes for review of involuntary status. New timeframes for minors are contained in recommendation Y.7. For adults, there should be a maximum of 35 days before the initial review and three months for subsequent reviews; except that in the case of an involuntary patient who has been subject to a CTO continuously for more than 12 months, the MHRB or tribunal should have a power to elect that a next review may be scheduled within a maximum period of six months.

The practicability of these reforms should be tested by a trial through administrative action before they are enacted. The conditions of evaluation in the trial should be as near as possible to those in this recommendation.

### **Other Matters Concerning Structure and Procedure**

6.1C The synthesis of submissions, consultations and working party and Stakeholder Committee deliberations on the MHRB should be referred to the Department of Health and the Office of the Attorney General for consideration of which, if any, of the issues raised should be addressed as immediate additional amendments to the WA Act and immediate amendments to the State Administrative Tribunal (SAT) legislation as part of the Government's response to this review.

As a matter of priority, the review supports attention to be given to the following:

- membership and composition of tribunal panels in relation to mental health, including the principle that as far is practicable, those available to serve on panels should consist of persons of both sexes and from diverse backgrounds, including indigenous Australian background;

- statements of the functions of the tribunal in mental health and matters to be considered by tribunal panels in making decisions, including the rules of natural justice and the broad range of circumstances affecting the welfare of the patient's case under review;
- clarification of "concurrent sittings", the distinction between the "tribunal" and a "panel", and procedures to resolve a hung panel vote;
- publication of reasons for decisions in a de-identified form;
- access to transcripts of proceedings for a nominal fee;
- the right of carers to a notice of a tribunal hearing with the patient's consent;
- a power of a tribunal panel to request independent second opinions;
- provision of an annual report of the tribunal on mental health matters to the Minister; and
- clarification of the avenue for appeal against a tribunal panel decision.

Definitive advice affecting some of these matters with respect to involuntary patients who are minors is contained in recommendation Y.7.

## **Future Review of the State Administrative Tribunal**

6.2 Before the third anniversary of the commencement of the jurisdiction of the SAT over mental health tribunal matters, an independent review should be undertaken with terms of reference:

- to consider the effectiveness and efficiency of the SAT in performing the functions previously undertaken by the MHRB and in its dealings with mental health matters generally;
- to consider if the transfer of the jurisdiction for mental health matters to the SAT has resulted in any unforeseen detriment to the rights and welfare of people with mental illness; and
- to recommend, following from these considerations, any necessary amendments to the WA Act and the SAT legislation.

## 7. Protection of Patients Rights

### Explanation of Rights

7.1 A new subsection should be added to section 156 of the WA Act, giving more explicit directions as to the nature of the information to be given to persons about their rights, modeled on section 87 of the NT Act. Specifically, the treating psychiatrist, or in the case of a referred person who has not yet seen a psychiatrist, the person-in-charge or their delegate, should be required to ensure that the person and his or her carer or representative are given information detailing:

- the patient's rights and entitlements under the WA Act and how they may be exercised, including the right to receive copies of forms making orders about their care and the circumstances under which they have a right to give informed consent and to request a second opinion;
- the advocacy, legal and interpreter services that are available to the patient; and
- in the case of a carer, the carer's rights under the WA Act.

### Access to Personal Records

7.2 Subsection 160(2) should be amended such that the end of the section reads "... has the right to inspect and be given an accurate reproduction of any relevant documentation no later than two working days before any scheduled review by the MHRB or similar tribunal, for the purpose of preparing for that review".

In addition, two new subsections should replace subsection 161(3) of the WA Act as follows:

- amend existing subsection 161(3) such that the words "suitably qualified person" are replaced by "a medical practitioner or person representing the patient before the MHRB or similar tribunal"; and
- add a new subsection to the effect that it is an offence for a medical practitioner or legal representative to pass on restricted information to the patient: penalty \$1,000.

## **Copies of Orders**

7.3 Additional provisions should be made in section 159 of the WA Act as follows:

- addition of a new subsection before subsection 159(1), which requires a person making a referral in the form specified in section 33 to give a copy of the information covered by subsections 33(a), (b), (c), (d) and (e) [but not (f)] to the person being referred; and
- addition of a further new subsection, which requires that copies of orders are placed in the patient's case record.

## **Offence of Ill-Treatment**

7.4 The maximum penalty for a person with responsibility who ill-treats or willfully neglects a person receiving psychiatric treatment should be increased to imprisonment for 2 years or the corresponding fine, while amending section 162 to state that such an offence does not preclude criminal prosecution or grounds for civil legal action arising from the same ill-treatment or neglect that caused the offence under the WA Act.

## **Definition of 'In-Patient'**

7.5 A change should be made to section 163 of the WA Act, such that the term defined in the section becomes "in-patient" in place of "patient". This should be followed by consequential changes in the remainder of division 2 or part 7 whereby "in-patient" throughout replaces "patient".

## **Possessions, Postal Articles, Telephone and Visitors**

7.6 A number of changes should be made to division 2 of part 7 of the WA Act as follows:

- amend subsection 165(1)(a) to include reference to aids to daily living and medical prostheses, as well as provision of secure facilities for the storage of personal possessions;
- amend subsection 165(2) by adding the words qualifying the "article" to read "article, other than an aid to daily living or medical prosthesis normally used by the patient as a means of assistance or to maintain their dignity";
- add a new subsection before subsection 165(2), stating that "Subsection (1) does not apply to an article, including an aid to daily living or medical prosthesis that under the circumstances might pose a risk of harm to the patient or other persons";

- amend subsection 169(1) to require the psychiatrist to document the order of restriction or denial of entitlement in the patient’s case record, including the reason for the order;
- add a new clause to subsection 170(1) to enable a voluntary patient, as well as involuntary patients and all persons subject to orders made under the CLMID Act, to apply to the MHRB or similar tribunal for a review of an order by a psychiatrist to restrict or deny any entitlements; and
- amend section 171 such that a report by a psychiatrist of any restriction or denial of an entitlement is reported to the COV within 72 hours (who may then assist the patient, if appropriate, in making an appeal), rather than to the MHRB or similar tribunal.

### **Grounds for Refusal to Admit Voluntary Patient**

7.7 A new section should be added to part 7 of the WA Act, entitled *Grounds for Refusal to Admit Voluntary Patient*, modeled in part on section 25 of the NT Act. It should state that on refusing to admit a person or to confirm the admission of a person to an authorized hospital, the psychiatrist must inform the person of the grounds of the decision and that the person has a right to complain to the Office of Health Review.

## **8. Community Support Services**

### **Discharge Planning**

8.1 The title of part 8 of the WA Act should be changed to *Community Support Services and Discharge Planning* so as to give due prominence to the importance of discharge planning. This should be followed by the introduction of a new division, *Discharge Planning*, placed in part 8 and modeled on section 89 of the NT Act, making specific reference to the requirement for liaison with community support services and carers.

## 9. Council of Official Visitors [Including Schedule 3]

### Functions of the COV

9.1 Sections 186 and 188 of the WA Act should be amended to give equal emphasis to the roles of the COV and each visitor both as front-line (non-legal) advocates for the rights of people with mental illness in health care and institutional settings. The role should include referring patients to legal services and non-mental health services; and being observers and reporters of both environmental conditions and standards of assessment, treatment and care in those places.

A clarification should be added to the end of section 188 to state that an official visitor who inspects a private psychiatric hostel and finds that it is not kept in a condition that is safe and otherwise suitable for the care of affected persons shall refer this matter to a person responsible for administering the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*.

There should be a provision that the COV, or any official visitor, may provide reasons to the CP why it believes that the standards of care or environment in a particular service or place warrant investigation. Where the head of the COV has made representations, the CP should be required to advise the head of the COV whether or not an investigation is warranted. If warranted, the CP should be required, subsequently, to advise the head of the COV of what directions, if any, the CP has made as a consequence of the investigation. The Act should enable the head of the COV to include the content of its communications with the CP in the annual report to the Minister as laid before each House of Parliament in accordance with sections 192(3) and 192(4).

## **Affected Persons**

9.2 The meaning of an ‘affected person’ in section 175 of the WA Act should be extended to include –

- a person who is referred for examination by a psychiatrist under section 29 of the WA Act, whether an adult or minor;
- a person, whether an adult or minor, who is admitted as a voluntary patient in an authorized hospital or other hospital or ward, whether public or private, or as an outpatient attending a designated outpatient facility, as approved by the Minister for Health on the recommendation of the Head of the COV;
- a person who is subject to a CTO made under section 67 of the WA Act or extended under section 76;
- a person with mental illness who is subject to an assessment or hospital order made under section 5 of the CLMID Act, regardless of whether they are, at the time, in an authorized hospital;
- a person with mental illness who is subject to a custody order made under the CLMID Act; and
- a person with mental illness who is subject to a structured community order made under the provisions of the CLMID Act.

## **Notification of Right to Request a Visit**

9.3 Section 189 of the WA Act should be amended to require that affected persons and, where applicable, their principal carer, are notified (by means that can be received) by the person-in-charge of a relevant facility of the affected person’s right to request a visit by an official visitor.

## **10. Miscellaneous**

### **Police Action to be Last Resort**

10.0 A new section should be added to the beginning of division 2 of part 10 of the WA Act, stating that where police action is authorized under sections 34, 41, 71 or 84, it is only to be authorized if, in the opinion of the person authorizing police action, there is no less restrictive means of apprehending, escorting or detaining the person who is the subject of the request for police action.

### **Aboriginal Police Liaison Officers**

10.1 An additional section should be included in division 2 or part 10 of the WA Act, enabling the Commissioner of Police to authorize an Aboriginal police liaison officer to exercise the police powers in sections 195-200, where the officer has received training in the use of these powers.

### **Capacity to Vote**

10.2 Sections 201-203 in division 3, part 10 of the WA Act should be repealed, thus giving to involuntary patients a normal right to vote.

### **Inclusion of Patient's Notations in Case Records**

10.3 An additional section should be included in division 4 of part 10 of the WA Act, stating that the person-in-charge of an authorized hospital must ensure that written notations made by a patient receiving treatment or care at the hospital, or by their carer or representative, are included in the patient's case record maintained at the hospital, when requested by the patient or their representative. The new section should require that any such record of patient's notations is clearly labeled as such and does not constitute a part of the hospital's account of the patient's treatment and care.

### **Carers' Rights to Information**

10.4 A new section should be added to division 4 of part 10 of the WA Act, modeled on subsection 91(2) of the NT Act, which permits the disclosure of personal information to a patient's carer, next of kin, representative, employee of a community support service or another person who is closely involved in the care and treatment of the person to whom the information relates, where



the disclosure is relevant to the ongoing care, treatment or rehabilitation of the person, the disclosure is considered to be in the best interests of the person.

## **Notifiable Incidents**

10.5 A new division entitled “*Notifiable Incidents*” should be added to part 10 of the WA Act. The sections within this division should create:

- a definition of a notifiable incident as any of the following incidents that occur in an authorized hospital or to an involuntary patient: death; any medication error in an authorized hospital that has or is likely to have adverse effects; any other misadventure in treatment or care that has or is likely to have adverse effects; assault causing bodily harm on or by a patient; and any other matter declared by the CP to be a notifiable incident;
- a requirement for the person-in-charge of a mental health service to notify the CP of any notifiable incident in a form prescribed by the CP;
- a power for the CP to act on a notification of an incident by: doing nothing; seeking to resolve any issues arising from the incident; or conducting an investigation; and
- providing informative statistics on notifiable incidents and actions arising out of notifiable incidents in the CP’s annual report.

## **Forms**

10.6 A new section should be placed before section 214 in part 10 of the WA Act, giving the CP a power to publish and disseminate forms, and guidelines for their completion, to assist practitioners in exercising any referral, order or notice, or variation or revocation thereof, made using a power in the WA Act, in a manner that meets all of the requirements of the WA Act, and which promotes best practice in psychiatric treatment and care.

## **Review of the Act**

10.7 Section 215 of the WA Act should be amended so as to provide for a further review of the operation and effectiveness of the WA Act as soon as practicable after the expiration of five years from the time when amendments to the Act come into force.

## Y. Minors

### **New Part to the Act on Minors**

Y.1 There should be a new part to the WA Act, entitled *Part 11 – Minors*, dealing with specific provisions to protect children and adolescents receiving treatment and care for mental illness from a mental health service.

### **Definition of a Competent Minor**

Y.2 The new part 11 of the WA Act should define a *competent minor* as a person aged 14 to 17 years, who in the view of a psychiatrist, medical practitioner or authorized mental health practitioner acting in accordance with the provisions of this Act, exhibits maturity in their behaviour sufficient to regard them as functioning at an adult level of decision making. An *adolescent* should be defined as any other person aged 14 to 17 years and a *child* should be defined as any person under the age of 14 years. A new section would clarify that a competent minor may be able to seek voluntary admission to a mental health service and may be able to consent to treatment. A further new section would clarify that a competent minor who refuses voluntary admission to a mental health service or refuses voluntary treatment cannot be forced to accept admission or treatment because it is the wish of a parent or guardian.

### **Rights of Parents or Guardian of a Minor**

Y.3 The new part 11 of the WA Act should contain a section listing the rights of parents or a guardian with respect to a child or adolescent and with respect to a competent minor who receive mental health services as follows:

- for the parents or guardian of a child or adolescent: a right to request services from a mental health provider with or without the child or adolescent's consent; a right to remove the child or adolescent from receiving a mental health service, with or without the child or adolescent's consent and with or without the agreement of the service (provided that the child or adolescent is not an involuntary patient or a ward of the State); a right to give informed consent on behalf of the child or adolescent to treatment or care; a right to detailed information about the child or adolescent's illness and treatment; and a right to be involved in the child or adolescent's treatment and care; and

- for the parents or guardian of a competent minor: a right to request services from a mental health provider; a right to receive information about the competent minor's illness and treatment and to be involved in their treatment or care, provided that the treating practitioner has not made a determination that this is not in the competent minor's best interests.

## **Voluntary Admission of Minors**

Y.4 The new part 11 of the WA Act should deal with the conditions under which minors (children, adolescents or competent minors) may be admitted to psychiatric inpatient care in a hospital (whether an authorized hospital or otherwise) as voluntary patients. The new sections should contain the following elements:

- a competent minor may apply to a mental health service be admitted as a voluntary patient;
- a parent or guardian of a minor (child or adolescent or competent minor) may apply for the person to be admitted to a mental health service as a voluntary patient;
- a medical practitioner must refuse a minor (child, adolescent or competent minor) voluntary admission unless the medical practitioner is satisfied that the person will benefit from the admission;
- a medical practitioner must refuse a competent minor voluntary admission, unless the medical practitioner is satisfied that the competent minor has given informed consent to the admission;
- a medical practitioner who admits a competent minor as a voluntary patient must take all reasonable steps to notify the parents or guardian as soon as practicable after the admission;
- if a parent or guardian applies to the person-in-charge of a hospital for a child or adolescent who is a voluntary patient to be discharged, the person-in-charge must discharge the child or adolescent.

## **Involuntary Admission of Minors**

Y.5 The new part 11 of the WA Act should contain a section to require that before an order for referral or to be an involuntary patient is made in respect of a child or adolescent, the practitioner making the order must consider if the interests of the child would be better served by recourse to the powers given in the *Child Welfare Act 1947*.

It is intended that the process for making a competent minor an involuntary patient would remain the same as for an adult.

## **Segregation of Children and Adults**

Y.6 A section should be included in the new part 11 of the WA Act, requiring that a minor (child, adolescent or competent minor) must not be admitted to an authorized hospital or other psychiatric health service unless the person-in-charge is satisfied that the minor can be cared for and treated in a manner that gives due regard to the minor's age, culture, gender and maturity and, in the case of a child or adolescent, in a facility that is separate from adult patients. If it is necessary for a competent minor to be admitted to an adult facility, it must be ensured that they are separated from severely mentally ill adults and provided with treatment programs suitable for their age and level of development.

## **Review of Involuntary Status of Minors**

Y.7 The WA Act should require a faster-track review process for competent minors, adolescents and (rarely) children, which includes the following elements:

- amend subsection 48(2) of part 3 such that an initial period of detention (presently up to 28 days) is for no more than 14 days for a minor; and
- advise those responsible for the SAT legislation, in relation to part 6, to –
- provide a shortened timeframe for reviews of involuntary status, being a maximum of seven days before the initial review and 28 days for subsequent reviews;
  - require that the composition of the MHRB or similar tribunal should include members with child and adolescent psychiatric expertise;
  - require that a minor's (child's, adolescent's or competent minor's) parents or guardian be requested to be present at a review hearing unless the MHRB or similar tribunal approves an application from the treating psychiatrist requesting, on reasonable grounds, that it is not in the best interests of the minor for the parents or guardian to be present at the hearing; however, a review should not be postponed because no parent or guardian attends;
  - provide that a competent minor may exercise the right to be present at a review hearing and may express their views freely on all matters affecting their involuntary status, but that for a child or adolescent, either the child or adolescent's parent or guardian are present or, in the absence of a responsible parent or guardian, an independent person shall be present to represent the child or adolescent; and

- require that a competent minor or the parents of a child or adolescent have the right to legal representation without payment.

The practicability of these reforms should be tested by a trial through administrative action before they are enacted. The conditions of evaluation in the trial should be as near as possible to those in this recommendation.

## **ECT and Minors**

Y.8 Subsection 104(1) of part 5 of the WA Act should be amended such that children, adolescents and competent minors (regardless of their status or where they are treated) are included in the groups of patients for whom ECT is not to be performed unless it has been recommended by the treating psychiatric and approved by the independent second opinion of another psychiatrist. Furthermore, it should be required that the independent second opinion in the case of a child, adolescent or competent minor is sought from a psychiatrist with specialist training in child and adolescent mental illness.

## **Banned Treatments of Minors**

Y.9 Provisions should be enacted to ban the use of ECT and psychosurgery on a child under the age of 12 years. These bans may be best achieved by the insertion of new sections in part 5 of the WA Act. Specifically:

- insert a new section following section 104 in division 5 of part 5 stating that a person is not to perform ECT on a child under the age of 12 years; and
- insert a new section following section 101 in division 5 of part 5 stating that a person is not to perform psychosurgery on a child under the age of 12 years.

Offences should be created for breaching these sections with heavy penalties.

## **Youth Advocate**

Y.10 A division should be included in the new part 11 of the WA Act entitled *Youth Advocate* and should include the following provisions:

- define a youth advocate as a member of the COV who has been nominated by the head of the COV as a visitor who has received specialized training for that role;
- require that for every minor (child, adolescent or competent minor) admitted to psychiatric inpatient care in a hospital (whether an authorized

hospital or otherwise) there must be either the involvement of their parents or guardian, or a youth advocate, or both;

- require that every competent minor admitted to psychiatric inpatient care is offered a youth advocate; and that every parent or guardian of a child or adolescent is offered a youth advocate;
- provide that the treating psychiatrist may request the involvement of a youth advocate where the psychiatrist considers it to be in the child or adolescent's best interests;
- require that if a minor (child, adolescent or competent minor) is received at an authorized hospital, or admitted to any other form of psychiatric inpatient care, they must be visited by a youth advocate as soon as practicable;
- define the functions of a youth advocate as to: meet with the minor (child, adolescent or competent minor) as soon as is practicable; act as an advocate on their behalf; acquaint themselves with the circumstances of the admission and nature of involvement of their parents or guardian in their care and treatment; where appropriate, to advocate for the rights of the parents or guardian to be involved in the minor's care and treatment, including provision of information and advice; ensure that a minor (child, adolescent or competent minor) is appropriately represented at hearings of the MHRB or similar tribunal; be involved in treatment decisions and discharge planning; be involved in the decision-making process when ECT is proposed as a form of treatment; and make submissions as necessary to clinicians regarding reviews, child welfare issues and a need for a second opinion, where the youth advocate considers a second opinion to be in the minor's best interests; and
- state that a youth advocate is not a legal guardian of a minor.

## **Z. Complaints**

### **New Part to the Act on Complaints**

Z.1 A new part to the WA Act should be created entitled *Part 12 Complaints*, containing provisions to assist members of the public in gaining access to complaint procedures. The first section of the new part should state that any patient, former patient, carer, practitioner, official or other member of the public may make a complaint to a provider of mental health services, including any body involved in the administration of the WA Act, if they are dissatisfied with the services that are provided.

### **Local Complaint Procedures**

Z.2 The new part 12 of the WA Act should include a section that requires the following bodies to have in place a documented set of local complaint procedures for handling of complaints against them and which must be given to any member of the public upon request:

- authorized hospitals;
- community support services allocated funds under part 8 of the WA Act;
- the COV;
- and any other mental health service nominated by the CP as requiring a set of complaint procedures.

In regard to the MHRB or similar tribunal, the issue of appropriate complaint procedures is referred to those responsible for the implementation of the SAT legislation.

### **Complaints not concerning the Administration of the Act**

Z.3A A further section should be placed in the new part 12 of the WA Act, stating that a patient, past patient, carer or official visitor who is dissatisfied with the outcome of a local complaints procedure, or who is dissatisfied with their attempt to resolve a complaint to a medical practitioner or mental health practitioner, may refer their complaint to the Director of the Office of Health Review, provided that the complaint does not concern any alleged failure to recognize the rights given by the WA Act or an involuntary patient or any other matter to do with the administration of the WA Act.

## **Complaints Concerning the Administration of the Act**

Z.3B Section 146 of the WA Act, as replaced by the *State Administrative Tribunal (Conferral of Jurisdiction) Amendment and Repeal Bill 2003*, should be moved to the new part 12 of the WA Act and be changed as follows:

- clarify in subsection 146(1) that a complaint to the MHRB or similar tribunal about any failure to recognize the rights given by the WA Act to an involuntary patient or any other matter to do with the administration of the WA Act may be made by a patient, past patient, carer or official visitor;
- add a new subsection to clarify that this section does not apply to a person seeking a second opinion or further remedy under section 111 or 112 of the WA Act, which should be directed to the CP; and
- add a new subsection to clarify that this section does not apply to a person making complaints against a police officer exercising a police power under the WA Act, which should be directed to the Commissioner of Police.

## **Registration of Complaints with the Chief Psychiatrist**

Z.4 Proposal Z.4 has been withdrawn.

## **Monitoring of Complaints by the Chief Psychiatrist**

Z.5 The new part 12 of the WA Act should provide a power for the CP to require in writing –

- any authorized hospital;
- any community support services allocated funds under part 8 of the WA Act;
- the COV;
- the Office of Health Review; and
- any other mental health service having been nominated by the CP as requiring a set of complaint procedures;

to furnish information at an interval specified in the direction, containing details about the complaints received by that person or body during the interval. The nature of the information to be furnished should be specified by the CP in the direction, and may include information on the number of complaints; the identities of the service providers about which complaints were made; the nature of the complaints; and the outcomes of complaints.



## Notes

- A.1 Participants in the final consultative forums made a convincing argument that not only do the extent of recommended changes warrant a new Act for mental health, but also that the quality of Parliamentary debate, with prospects for further community participation, will be enhanced if the substrate for debate is a whole piece of new legislation.
- 1.2 The need for definitions of “adolescent”, “assessment”, “audio-visual means”, “child”, “competent minor”, “guardian” and “urgent medical treatment” have been added as well as additional clarifications.
- 1.3 The proposed requirement for internationally accepted standards of diagnosis to be approved by the CP has been removed. Although one submission argued that mental illness caused by a treatable physical condition should be excluded from the WA Act, the review considers that patients with a transient organic psychosis (eg, a transient psychosis caused by an endocrine or metabolic disorder) may still require involuntary detention and involuntary treatment in order to protect them and others from harm. Recommendation 5.9 should assist in ensuring that reversible organic causes of mental illness are identified.
- 1.4 Further guidance has been given as to which subsections of section 3 of the NT Act are unsuitable objects for the WA Act. A number of respondents would have liked to have seen reference to the UN Principles and national statement, such as the National Mental Health Statement of Rights and Responsibilities and the National Mental Health Plan, included in the objects of the WA Act. However, the review does not favour such an approach for reasons outlined in the synthesis. The component of the recommendation pertaining to carers is now linked more strongly to recommendation 10.4. Specific attention is now given to people with mental illness who have disabilities.
- 2.1 Some adjustments have been made to this recommendation on the basis of a number of submissions. In particular, the review has accepted an argument that the proposed changes pertaining to a strategic plan for improvement (rather than administration) of mental health services for the State in subsection 10(a) had too much potential for confusion between the roles of the CP and the Office of Mental Health. The review is aware that there still remains potential for confusion between the roles. Whereas the CP is an entity

recognized by the *Health Legislation Administration Act 1984*, the Office of Mental Health has no standing in legislation. It would be possible, however, for the CP to delegate some functions and powers, as appropriate, to the Office of Mental Health using the power to delegate in section 9 of the *Health Legislation Administration Act 1984*.

The review has accepted an argument that not all MIDs held in custody should be the responsibility of the CP, but only those held in authorized hospitals. Other MIDs in custody, especially those with intellectual disability in the absence of mental illness, are more appropriately the responsibility of another authority. The review accepted advice that the annual report of the CP should be caused to be tabled in the Parliament.

Several other extensions of functions of the CP were advocated by the non-government sector, but these calls have been balanced by submissions expressing concern over any further widening of the CP's functions and powers. The review has not accepted an argument that the CP should have no legislated oversight of the treatment and care of voluntary patients on the basis that they have legal autonomy. To the contrary, the review considers voluntary patients with mental illness to be a vulnerable group.

The review does not consider it appropriate for the CP to have oversight of the optimal use of authorized beds, as this would be inconsistent with the separation of the Office of the CP from the Office of Mental Health. A function to review individual decisions to refuse to admit a voluntary patient to an authorized hospital is more appropriately dealt with through the complaints processes and is covered in recommendation 7.7.

- 2.2 The repeal of subsection 13(4) is now included and is considered necessary by the review given that the CP will have a statutory responsibility for the welfare of all voluntary patients as well as involuntary patients. Two submissions expressed concern about the extension of the power of direction of the CP, but many others supported it. At present, the CP has powers of inquiry and inspection but is very limited in the ability to effect changes where needed. A long history of the existence of extensive statutory powers held by the Executive Director of Public Health under the *Health Act 1911* has shown that such powers are very rarely used, but provide a deterrent to inappropriate behaviour and provide a robust basis on which to maintain high standards and to guide reforms. "Declared place" has been included in the scope of the recommendation; whereas an agency providing community support services for people with mental illness has been withdrawn.

- 2.3 The review has accepted arguments put forward to replace all references to time-based criteria for becoming a mental health practitioner for the purpose of the WA Act with criteria based on competence and role delineation.

The review heard many arguments about which classes of psychologist should be eligible to be mental health practitioners. A restriction to clinical psychologist has not been applied in the final recommendations as it would unduly disadvantage populations in rural and remote areas and potentially exclude other classes of psychologists who have relevant expertise.

- 3.1 The recommendation pertaining to the criteria for involuntary status has been considerably simplified because feedback to the review advised that the proposal had been unduly complicated and difficult to interpret. The criterion “to prevent the likelihood of the person suffering from serious mental or physical deterioration” has now been restricted in its application to a person who is made an involuntary patient subject to a CTO. As a consequence, it is no longer considered necessary to strengthen section 65.

The recommendation responds to a significant body of concern that the wording of section 26 should follow UN Principle 16(1) through the inclusion in the criteria of the notions that the likelihood of harm should be both “serious” and “immediate or imminent”. The review does not agree to the deletion of the criterion of damage to property nor the deletion of the self-harm provisions. The fact that the UN Principles give no attention to serious damage to property, serious financial harm, irreparable harm to any personal relationship and serious damage to the person’s reputation is, in the opinion of the review, a deficiency in the UN Principles. Deficiencies of this type form part of the justification for not explicitly adopting the UN Principles in the WA Act.

The part of the recommendation dealing with incapacity for or refusal of giving consent has been modified to be consistent with recommendation 5.4.

- 3.2 A time limit for detention of six hours has been included. It has been clarified that the change from “police assistance” to “police action” in section 34 is more than merely a change in section title. A requirement that police action is to be used as a last resort is covered by new recommendation 10.0.

- 3.3 The recommendation has been adjusted to provide for a two-step process for referral of voluntary inpatients that mirrors closely the process for general referrals for examination by a psychiatrist.

3.4 It became clear from submissions that section 38, concerning examination in a place other than in an authorized hospital, should follow part of the format of section 36, so that a time limit for detention applies.

The review has not acted on a proposal to require the COV to be notified of the identities of patients made subject to CTOs, because the administrative burden of such notifications may not be justified by the benefits. The COV should assign highest priority to patients in the institutional setting.

The recommendation omits the reference in the proposal to a CTO ceasing to have effect in a person made an involuntary patient, because section 73(e) attends to this matter.

3.5 The review has accepted argument that it should be sufficient that a medical practitioner, not necessarily authorized, orders the detention of a patient in a rural or remote area for up to an additional 48 hours. The same argument has been accepted in relation to recommendation 3.11. Submissions to the review indicate that a dichotomy in viewpoint exists between those who believe that rights, such as time limits for detention, should be universally consistent across the State, and those who believe that rights may be justifiably relative to circumstances. The review favours the second approach in relation to referral in rural and remote areas, because it is hardly an achievement in upholding human rights when the consequences of demanding consistency are instances of unnecessary transport of patients to Perth in a chemically induced stupor with intubation. It has been suggested that subsection 21(1)(a)(i) of the WA Act could be used to make sections of specific rural and remote hospitals authorized hospital; but according to subsection 36(1)(b) detention would still be limited to 24 hours.

3.6 In practice, one would expect the Office of Mental Health to prepare the guidelines for the efficient management and best use of beds in authorized hospitals as published by the Director General of Health.

- 3.7 Some mental health service providers and the MHRB expressed concerns that the reduction from a maximum of 28 to 21 days for an initial period of detention will have the perverse effect of increasing the average length of involuntary status, because a number of patients cease to meet the criteria for involuntary status between 21 and 28 days. It should be possible to arrange a trial of the reduction in maximum initial period of detention, through administrative action, to replicate conditions as near as possible to the terms of the recommendation to determine if the concerns are founded. The review has not accepted a proposal to require that a psychiatrist must examine an involuntary patient in an authorized hospital not less than once every 72 hours, as no justification or evidence of a poor frequency of examination was provided.
- 3.8 The review has not recommended a new section after section 63 stating that a person is no longer absent without leave once the involuntary order expires. The reason is that such an approach might provide an incentive for absconding. While it will be argued that the review's position represents custodial thinking, the fact remains that these patients have by necessity been detained on an involuntary basis.
- 3.9 The problem addressed by proposal 3.9 has continued to present a challenge. There has been no disagreement about the need to prevent voluntary patients with dementia from wandering off and coming to harm; nor has there been disagreement that staff who exercise a duty of care by preventing demented patients from wandering should not be expected to commit a misdemeanor. Rather, there have been concerns about the additional administrative burden required to implement the proposal and the oxymoron created by the concept of a 'detained voluntary patient'. There was discussion of the possibility of repeal of section 337 of the *Criminal Code 1913* as a solution, thus relying solely on the general provision in section 333 of the *Criminal Code 1913* relating to deprivation of liberty for the protection of the mentally ill. However, some respondents believed that this course of action left open a gap in the general scheme of protection. In considering these complex issues, the review has arrived at the conclusion that the best way forward is to insert in the *Criminal Code 1913* an additional section, which clarifies that staff who exercise duty of care with respect to persons with degenerative brain disease do not commit a misdemeanor.

3.10 It has been pointed out to the review that outright repeal of section 69 would remove the safeguard of a ‘two-step procedure’ for a person becoming an involuntary patient in the circumstance where, under subsection 67(1), a psychiatrist exercises their general power to make a CTO without a preceding referral. On this basis, it is now recommended that a form of confirmation is retained, but only for CTOs that have been made under subsection 67(1). Recommending that the CTO be deemed to be confirmed if the patient refuses to be re-examined closes a potential loophole. A suggestion that the supervising psychiatrist could review and confirm their own order has been rejected, as the involvement of two separate practitioners is seen to be fundamental to the ‘two-step procedure’.

3.11 The review received two submissions arguing that the proposal to delegate the mandatory monthly examination of an involuntary patient subject to a CTO to an authorized mental health practitioner or medical practitioner would result in a lesser quality of service and a less rigorous process for decision-making concerning involuntary status. The review holds to the opinion that any reduction in quality of service will be small and would be justified by the more efficient use of resources. However, the point has been taken that under the original proposal it might have been possible for a patient made subject to a CTO to continue their involuntary status for some time without direct review by a psychiatrist. The review accepts that such an outcome would represent a curtailment of rights. Thus the recommendation has been modified to ensure that an authorized mental health practitioner or medical practitioner may undertake the mandatory monthly examination only where no more than two months has elapsed since an examination by the supervising psychiatrist. The effect should be that, as a minimum, a psychiatrist examines the person every third month. The review believes that this is a sound compromise between competing principles, given that it is not without due reason that some patients are maintained in the community using CTOs for a considerable length of time as an alternative to a ‘revolving door’ cycle of detention in and release from an authorized hospital. Under these circumstances, it is not the best use of the community’s health care resources for every monthly examination to be necessarily conducted by a psychiatrist.

The recommendation includes an additional provision to ensure that conditions for revocation of a CTO in section 70 are consistent with the intentions of subdivision 3, part 3 of the WA Act, concerning a breach of a CTO.

- 4.2 Concerns were expressed over the loss of confidentiality caused by broadcasting a notification about an absconding involuntary patient to mental health services in other states and territories. The recommendation now requires the psychiatrist to weigh the need for treatment against the right to confidentiality.
- 4.4 An argument was heard that due to section 177 of the *Criminal Code 1913*, which creates the misdemeanor of disobedience to statute law, proposal 4.4 was unnecessary and unduly restrictive. The review considers that the requirement of an involuntary patient who is subject to a CTO to notify the supervising psychiatrist if they intend leaving the State will improve the quality of case management, but has eased the recommendation to omit notification of departure from the State of up to 14 days, to allow for short holidays, attendance to urgent family business and living near the State border.
- 5.1 See note on recommendation 5.5. The term “medical” has not been changed to “pharmacological”, because the former encompasses treatments such as transcranial magnetic stimulation as well as pharmacotherapeutic agents. The review disagrees that the use of the term “medical” here is in danger of confusion with provisions pertaining to medical treatment of conditions other than mental illness, because the definition in recommendation 5.1 explicitly refers to a medical therapy for mental illness.
- 5.3 Some respondents advised that a guardian appointed under the *Guardianship and Administration Act 1990* cannot give consent, on behalf of a represented person, to psychiatric treatment as a voluntary patient. In information supplied to guardians, the Guardianship and Administration Board states that “A guardian cannot request the admission of a represented person to a psychiatric hospital (although the represented person can admit themselves)”. The review could not identify the statutory basis of this position, but its investigations may be incomplete. Subsection 45(2)(d) of the *Guardianship and Administration Act 1990* states that a guardian may “subject to division 3 of this part, consent to any treatment or health care of the represented person”. Division 3 refers to limitations on surgical sterilization. Subsection 45(3) lists actions that a guardian may not take: it refers to consent to sterilization except in accordance with division 3, but makes no reference to psychiatric treatment. Thus the review has not removed the reference to guardians in recommendation 5.3, but rather has included a recommendation for the *Guardianship and Administration Act 1990* to be amended such that the Guardianship and Administration Board may appoint guardians for the purpose of the WA Act.

5.4 The review continued to receive widely disparate advice on the issue of consent to treatment by involuntary patients, and has concluded that there is no jurisdiction in the world that can offer model legislation in this area that addresses all of the competing interests and principles.

UN Principle 11(6) states that a plan of treatment may be given to a patient without their consent if (a) the person is an involuntary patient; (b) an independent authority is satisfied that the patient lacks the capacity to consent or unreasonably withholds consent; and (c) the independent authority is satisfied that the treatment is in the best interest of the patient's health needs. UN Principle 7 allows, as an alternative, for a guardian to give consent; and UN Principle 8 allows for emergency psychiatric treatment without consent. It is clear, therefore, that the WA Act is presently inconsistent with the UN Principles, a fact given great prominence in submissions received from consumer groups and non-government organizations. The review was urged to consider sections 55-57 of the NT Act concerning tribunal reviews of treatment and section 18 of the *Victorian Mental Health (Amendment) Act 2003* concerning the insertion of new section '19A. *Treatment plans*' into the Vic Act.

Against the proposal, the review received multiple submissions from service providers, the MHRB and the Office of the CP, who all believed that the proposal was unworkable. They argued that any delays in treatment would be harmful to patients, placing patients and staff at a significant safety risk and prolonging the duration of involuntary detention. They also argued that the State's meager workforce of public sector psychiatrists and the MHRB or similar tribunal would become overwhelmed by any system that required urgent reviews of involuntary treatment. At Graylands Hospital, it was estimated that even a mandatory second opinion prior to commencing involuntary treatment would require two additional full-time psychiatrists to be employed at the hospital merely to perform such a statutory duty. Increased lengths of stay in Graylands, which has an occupancy of 97%, would precipitate an acute crisis in bed provision. It was also pointed out that treatment plans need to be varied in response to the patient's condition; thus rendering impracticable a system requiring approval of treatment plans. Other relevant arguments are that a principal purpose of being made an involuntary patient under the WA Act is so as to administer involuntary treatment; and that the MHRB or similar tribunal is not overall an appropriately skilled body to make treatment decisions.



One submission argued that a patient should be deemed to have unreasonably withheld consent only in circumstances where that unreasonableness can be put down to the effect of the mental illness. This could mean, for example, that a person with a long-standing and well-documented philosophical or religious objection to the use of medications or ECT, which has been consistent regardless of their mental state, would be able to withhold consent to such treatments as an involuntary patient. The review considers such an approach to be detrimental, as it would inevitably result in untreated patients having to be detained involuntarily for long periods of time in order to protect them and the community. However, the review considers that it should be possible for an involuntary patient to decline a medical treatment for conditions other than mental illness where their refusal is not the result of their mental illness (see 5.10).

The review has insufficient evidence to recommend statutory treatment plans. Taking into account that under WA law, becoming an involuntary patient occurs for the purpose of receiving treatment without informed consent, it is considered that the initial review by the MHRB or similar tribunal of involuntary status is, by its nature, a review by an independent authority of a decision to treat a person as an involuntary patient, in keeping with UN Principle 11(6)(b). Drawing on the experience with sections 55 and 56 of NT Act, the review is recommending an approach that allows treatment to proceed pending an initial review, provided that certain conditions are met. The review, in considering the totality of all issues that have come to light does not support either the use of mandated second opinions for treatment, nor the use of guardians to give consent for involuntary patients, nor a tribunal review process for treatment that is separate from the existing process for involuntary status. The recommendation in its final form states that the views of patients, guardians and carers should be taken into account. Moreover, it is recommended that a guardian should be able to request a second opinion.

5.4A This new recommendation has been added because the review has accepted arguments put forward by carer representative organizations that involvement of a carer in treatment decisions, where the patient wants this, will often be of benefit.

5.5 An unintended and unforeseen consequence of proposal 5.5, which would have given the CP a power to deem a therapy to be a prohibited treatment by regulation, was a negative reaction mostly from alternative therapists. Following the publication of a newspaper notice by the Church of Scientology's Citizens Committee on Human Rights, the review received 179 submissions on this topic from alternative therapists practicing naturopathy, kinesiology, reflexology, reiki, therapeutic massage, vitamin and herbal therapy, acupuncture, chiropractic, as well as five submissions from other counselors, psychologists and psychotherapists, and one submission from a medical practitioner.

Proposal 5.1 had defined treatment as "any therapy, whether, psychological or social, or other therapeutic intervention, whether alone or in combination, that is intended to alleviate or prevent deterioration of a mental illness". The concerns of respondents centred mostly around a fear that a future CP, and especially one with a highly medicalized viewpoint on treatment, might use the proposed power in 5.5, in combination with the proposed definition in 5.1, to prohibit one or more alternative therapies as treatments for mental illness, thereby impacting on freedom of choice and the commercial viability of the alternative therapy sector.

Proposal 5.5 had arisen from the Treatment of Patients Working Party and had been endorsed without debate by the Stakeholder Committee. In section 99, the WA Act already prohibits deep sleep therapy and insulin coma or sub-coma therapy, and it was the attraction of an efficient mechanism for the prohibition of any similarly dangerous treatment in the future that motivated the proposal. There had been no specific consideration of alternative therapies.

It would be possible to offer an alternative recommendation, such as a power of the Minister for Health, on the advice of the Director General, to prohibit a treatment on the grounds of a risk of causing life-threatening harm. However, proposal 5.5 was seen by the review as a relatively minor proposal in the scheme of the synthesis; and the review is concerned that the controversy surrounding proposal 5.5 might continue as a distraction from progress on more important recommendations. The regulation of the alternative therapy sector is not a matter for this review and there are other, less direct mechanisms that could be used in an emergency to ban a treatment that was found to cause grave danger to the public. On balance, the review considers that the prudent course of action is to withdraw proposal 5.5. The review does not consider that the proposed definition of treatment in 5.1 needs to be withdrawn, as the point of controversy was the effect of proposal 5.5 *in the presence* of the definition of 5.1, and not proposal 5.1 *per se*.

- 5.6 The review has not accepted a submission arguing that administration of ECT on a non-consensual basis should require the approval of an independent body in addition to the agreement of two psychiatrists.
- 5.7 The review has accepted criticisms that in some instances the necessary increase in the statistical monitoring by the CP has been over-zealously pursued in the proposals and that some re-balancing of the recommended extent of statistical monitoring is necessary. To this end, the proposal for the CP to collect statistics on second opinions has been removed from this recommendation. The review holds to the position that “independence” of second opinions is a matter where idealism must be tempered by the practical difficulties of getting any form of second opinion. Unlike the existing WA Act, the recommendation requires that a second opinion be “independent”. However, what exactly constitutes “independence” is best stated in guidelines rather than prescribed in the Act; otherwise the reform may prove unworkable.
- 5.10 This recommendation has been considerably simplified by taking advantage of the framework provided by section 119 of the *Guardianship and Administration Act 1990*. This will ensure that with respect to treatment of non-psychiatric medical conditions, involuntary patients are managed no differently from other members of the community who may be incapable of consenting to medical treatment. Advantage is taken of the hierarchical structure of persons who may consent to medical treatment on behalf of another person in subsection 119(3) of the *Guardianship and Administration Act 1990* to identify the supervising psychiatrist as performing the role as a very last resort.
- 5.11 The proposal was non-controversial, but failed to acknowledge the requirement in division 3 of the *Guardianship and Administration Act 1990* for concordant consent of the full Guardianship and Administration Board, before a guardian may give consent to surgical sterilization of a represented person. The review has become aware very late in the production of its recommendations that there may need to be some further consideration of how this new section of the WA Act applies to minors, because it may require a direct order of the Family Court of WA.

5.13 The proposal had referred to the patient’s belief that they are alone and free exit is prevented. While the intention was to account for the circumstance in which a deception of being secluded might be practiced, the problem is then that seclusion does not legally occur in the absence of such belief, thus making seclusion of a demented person possible without statutory safeguards. On balance, the review considers that removal of reference to belief is preferable.

The principle of the least restrictive option has been strengthened in the recommendation; but also, persistent destruction of property has been added as a justification for seclusion.

The review has accepted that it could inflame the situation to give a copy of an authorization of seclusion to a patient on the spot, and that a preferable approach would be to require that a copy is filed in the patient’s case record where it may be accessed later through the appropriate procedures.

The recommendation clarifies the intention that the CP should report statistics on seclusion annually.

5.14 The same applies as in recommendation 5.13, concerning the placement of a copy of the authorization form in the patient’s case record. The reference to the NT Act provisions now recommends “medical practitioner” rather than ‘psychiatrist’, as it will be necessary for this function to be performed by a medical practitioner in rural and remote areas.

While the necessity to clarify that use of handcuffs by police officers is not “mechanical bodily restraint” has been questioned, the Police themselves have sought this greater clarity in the Act and the review concurs.

The principle of the least restrictive option has been strengthened in the recommendation.

The recommendation clarifies the intention that the CP should report statistics on mechanical bodily restraint annually.

5.15 An option has been added to this recommendation, concerning the possibility of using proposed amendments to the *Poisons Act 1964* to achieve an equivalent outcome.

- 5.16 A requirement has been added for use of force in the delivery of treatment to be documented in the case record. A small number of submissions expressed concern about the use of reasonable force by mental health practitioners in the delivery of treatment. However, if involuntary treatment is to occur, sometimes a patient must be restrained while the treatment is administered. The review stands by the recommendation, acknowledging that it provides an important clarification for mental health practitioners by legitimizing an existing practice, when it is necessary. Two submissions from patient advocacy organizations indicated that they found the recommendation acceptable.
- 5.17 The review has accepted that guidelines for the appointment of guardians are a matter for the Guardianship and Administration Board and not the CP. Thus the proposal has been withdrawn.
- 5.18 The review received a proposal *de novo* for inclusion of a new section in the WA Act concerning a procedure for authorization of clinical trials using involuntary patients as study participants. While the review sees merit in this proposal, it is reluctant to make a definitive recommendation in an area that has not previously been subject to consultation and critical appraisal. Therefore, the recommendation is for this matter to be given further consideration before a position is adopted.
- 6.1A, 6.1B and 6.1C Some respondents to the synthesis of the WA Act expressed disappointment that the proposals stopped short of making a series of specific recommendations, due to the interposition of the *State Administrative Tribunal (Conferral of Jurisdiction) Amendment and Repeal Bill 2003* during the course of the review. The matter has been reconsidered with the conclusion that in respect of matters concerning structural and procedural detail, such as tribunal panel composition, function, notice of reviews, publication of reasons of decisions, access to transcripts, requesting second opinions, annual reports and appeals, it is impossible for this review to make definitive recommendations. This is because the approach taken to these matters will need to take into account the general structural and procedural models adopted by the SAT, and the latter are outside the terms of reference of this review. Nevertheless, the original proposal at 6.1 has been strengthened to become recommendation 6.1C, which contains more general direction as to the areas of structure and procedure that warrant attention by those responsible for the SAT legislation and its implementation.

There are, however, two matters for which the review has found sufficient justification in recent submissions and previous considerations to draw them out as specific recommendations. These concern a right of involuntary patients appearing before the tribunal to affordable legal representation and shortening of the timeframes of initial and periodic reviews. The rationale for a maximum of 35 days before an initial review is to ensure that all patients are reviewed within two weeks of them having a (revised) initial period of detention of 21 days under section 48 converted to an order for continuing detention. Allowing the MHRB or similar tribunal to elect for a longer timeframe for patients continuously on a CTO for more than 12 months may avoid unnecessary reviews of patients who require long-term involuntary management in the community. While shorter timeframes are desirable from the perspective of patient rights, the review shares some of the concerns that shorter timeframes may be impracticable or yield the perverse outcome of longer involuntary stays, because of the way that review timings interact with the course of mental illness and its treatment. Accordingly, the review is recommending that the practicability and effects of the shorter timeframes are evaluated in an administrative trial before they are adopted in legislation.

- 7.1 A reference to carers' rights has been added to the recommendation given that a number of carers' rights are created by the envisaged reforms. The proposal contained an error in omitting that a person not yet seen by a psychiatrist should be advised of their rights by the person-in-charge or their delegate.
- 7.2 A number of respondents expressed concerns that reliance solely on freedom of information legislation to gain access to patients' records does not cater to all justifiable circumstances. Section 92 of the NT Act and section 24 of the Vic Act were suggested as models. The Office of the CP, while generally supporting the proposal, also argued for retention of a special provision for access to a case record by a patient or a representative when a review is scheduled at the MHRB or similar tribunal. There appears to be sufficient grounds, therefore, to question the wisdom of repealing sections 160 and 161, and on this basis the proposal has been withdrawn and replaced by a recommendation to limit the use of section 160 to preparations for any scheduled review of involuntary status. The issue of timely access to the records has also been addressed, as has the loophole of a "suitably qualified person" being able to pass on restricted information to the patient. Moreover, given the new explicit purpose of section 160, the "suitably qualified person" in section 161 has been redefined as a medical practitioner (who may counsel the patient before a hearing) or the patient's legal representative.

- 7.3 This recommendation has been altered to be consistent with recommendations 5.13 and 5.14.
- 7.6 While it is highly desirable that aids to daily living and medical prostheses remain in the patient's possession, the review has accepted that in some circumstances even these articles may pose a risk of harm to self and others. A time limit of 72 hours has been added to the requirement for a psychiatrist to report any restriction of rights to the COV.
- 7.7 This recommendation is new and arose out of one of the consultative forums on the synthesis of the WA Act. The synthesis had not addressed the issue of patients' rights when denied voluntary admission to an authorized hospital. The review considers that the appropriate avenue for complaint is the Office of Health Review.
- The review received a proposal *de novo* for inclusion of provisions in the WA Act to ensure that an involuntary patients may make contact with his or her legal practitioner, minister of religion or a Christian science practitioner. This may warrant further consideration, but at this time the review does not see a need for a specific provision of this type that goes beyond that in section 168 of the WA Act, albeit subject to section 169.
- 8.1 The proposal to include provisions in the WA Act to require discharge planning, as required by the NT Act, was not universally supported, but did receive very strong support from community organizations and those representative of carers. In view of the increasing rate of post-discharge suicide within the first 14 days after separation from an authorized hospital in WA, the review stands by this recommendation as it is considered to be a life-saver.
- 9.1 The wording of the recommendation has been adjusted so as not to preclude an individual official visitor raising a matter with the Office of the CP. However, formal requirements for a fully documented response are limited to instances where the head of the COV raises a matter with the CP. Referral of patient to legal services has been included as a function. Also, a clarification has been added concerning the need for official visitors to refer poor environmental conditions in private psychiatric hostels to a person who has direct statutory responsibility for the inspection and licensing of such hostels.

- 9.2 It has been clarified that only people with mental illness who are subject to orders made under the CLMID Act are affected persons.
- 9.3 Of the two options presented in the synthesis, a requirement to be notified of the right to request a visit was preferred by respondents over the notion of a mandated visit. The COV itself did not support mandated visits.
- 10.0 This is a new recommendation added in response to representations received from consumers and the police service, who believe that there are too many instances of unnecessary use of police escorts. Alternatives to the use of police, such as a special transport unit, are not matters that require legislative reform. Alternatives would be difficult to provide in rural and remote areas.
- 10.1 Doubts were expressed that this legislation could enable the Commissioner of Police to do as requested. An alternative would be to add the words, “and/or an Aboriginal police liaison officer” to those sections of the WA Act that refer to police action, but the review believes that there is greater merit in the recommended approach as it would enable the strategy to be targeted to areas of particular need for the involvement of Aboriginal police liaison officers.
- 10.3 Those who believed that the case record should be solely a record of medical issues made by health professionals did not accept the proposal. In recognition of this view the recommendation now requires that a patient’s comments are clearly labeled as such and do not form part of the hospital’s account of the patient’s treatment and care.
- 10.5 The review has accepted that the proposal to create an offence for failure to notify an incident to the CP was too punitive. The specified part of the list of notifiable incidents has been contracted in the interests of practicability.
- 10.6 The review stands by its decision not to recommend the prescription of details of the “forms” in the WA Act, but rather to give them legal status through their approval by the CP.



10.7 The review received a submission arguing that the WA Act should be reviewed at 10 years after the commencement of the 1996 Act, due to changing treatments and practices, regardless of if and when amendments arising from this review are enacted. However, the review considers that it would be inappropriate to conduct a review shortly after a new Act comes into force, because time will be required to observe its performance before any further changes are recommended.

Y.2 The definition of a “competent minor” (previously referred to as a “mature minor”) has continued to present a challenge to the review, with many respondents expressing discomfort with an automatic assignment of some aspects of adult autonomy to a person aged 14-17 years by virtue of their age alone. The new wording of the recommendation addresses this issue, through the addition of a behavioural criterion. This will inevitably be criticized for introducing a subjective element to the basis for the assessment of “competent minor” status; but the review considers that this cause of uncertainty is preferable to inappropriate application of the law to adolescents with mental illness who are incapable of adult-like decision-making. There are consequential changes to recommendation Y.5 and Y.6.

In addition, the recommendation includes explicit reference to the capacity of a competent minor to refuse voluntary admission or treatment despite the wishes of a parent or guardian.

Y.4 The review has accepted the views of several respondents who argued that a parent or guardian always has a right to be notified that a minor has been admitted to hospital, even in the situation where a competent minor is estranged from the parents or guardian. Improvements in the definition of a “competent minor” as outlined above have resulted in a more rational framework for recommendations Y.4 and Y.5, such that the voluntary and involuntary admission processes for a competent minor more closely follow those applicable in the case of adults.

- Y.7 A change has been made to the recommendation, to give competent minors the right to free representation before the MHRB or similar tribunal in their own right. The MHRB has expressed the reservation that the simultaneous application of reforms that decrease the period in which a review of involuntary status of minors must occur and require a greater number of people to be present will be unworkable due to problems in scheduling reviews. The recommendation now clarifies that a review should proceed even if a parent or guardian fails to attend. A trial of the recommendation imposing conditions by administrative action, as near as possible to the terms of the recommendation, should be undertaken before the reforms are enacted.
- Y.8 The need for the second opinion to be independent has been clarified. This recommendation continues to represent a compromise amidst diverse viewpoints held in the community.
- Z.2 The recommendation has been modified such that the CP need not approve local complaints procedures. This makes the recommendation more acceptable to a range of stakeholders including the COV.
- Z.3A and Z.3B Based on representations made in submissions and further consideration the review has substantially modified proposal Z.3. There are now two separate recommendations, concerning second-tier management of complaints, which make a distinction between complaints that are about the rights of involuntary patients and administration of the WA Act (Z.3B), and those about other matters (Z.3A). The MHRB or similar tribunal is identified as the appropriate body to deal with the former and the Office of Health Review with the latter. The existing role of official visitors as patient advocates with respect to complaints has been given explicit acknowledgment.
- Z.4 The proposal that complaints may be registered with the CP has been withdrawn on the basis that there is already sufficient attention to strengthening of complaints mechanisms and monitoring, notably recommendation Z.5, such as to render this proposal unwarranted.
- Z.5 Concerns were expressed about the scope and manageability of the original proposal; for example, it could have unintentionally included complaints discussed with legal representatives. The scope of the recommendation has been restricted to selected mental health services.

## List of Abbreviations

CLMID Act	Criminal Law (Mentally Impaired Defendant) Act 1996 in Western Australia
COV	Council of Official Visitors
CP	Chief Psychiatrist
CTO	Community treatment order
MHRB	Mental Health Review Board
MID	Mentally impaired defendant
NT Act	Northern Territory Mental Health and Related Services Act 2002
SAT	State Administrative Tribunal
UN Principles	United National Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care published in 1991
Vic Act	Victorian Mental Health Act 1886
WA	Western Australia
WA Act	Western Australian Mental Health Act 1996