

ATTACHMENT 1

THE WAY FORWARD FOR MENTAL HEALTH

LEGISLATION IN WESTERN AUSTRALIA

REPORT ON THE REVIEW OF THE MENTAL

HEALTH ACT 1996

The Government's Response to the Review's Recommendations

CONTENTS

1.0 Background	3
2.0 Review.....	3
3.0 Terms of Reference for the Review of the Mental Health Act 1996.....	4
4.0 Synthesis of the Review	4
5.0 Recommendations that are accepted and advance the human rights of persons with mental illness.....	5
6.0 Recommendations that are accepted and clarify the Act	9
7.0 Recommendations not accepted	10
8.0 Resource Implications of the Review	12
9.0 Conclusion.....	13
APPENDIX	14

THE WAY FORWARD FOR MENTAL HEALTH LEGISLATION IN WESTERN AUSTRALIA

REPORT ON THE REVIEW OF THE MENTAL HEALTH ACT 1996

1.0 Background

- 1.1 The *Mental Health Act 1996* (the 'Act') came into effect on 13 November 1997 with bipartisan support and was recognised as a major advance from the *Mental Health Act 1962* particularly in relation to patient's rights and treatment for people with mental illness. For example, patient's rights were strengthened with the introduction of the Mental Health Review Board, the replacing of the Board of Visitors with the Council of Official Visitors and having a specific part of the legislation dealing with those rights. In relation to treatments, deep sleep therapy, insulin coma and sub-coma therapy were prohibited, while Electroconvulsive Therapy was regulated. Care in the community was advanced with the introduction of Community Treatment Orders, which allowed involuntary treatment in the community.
- 1.2 Section 215 of the Act acknowledged the ongoing nature of legislative reform in mental health by requiring the Minister for Health to carry out a review of the operation and effectiveness of the Act as soon as practicable after the expiration of five years from its commencement.

2.0 Review

- 2.1 On 14 November 2001, the then Minister for Health, the Hon Bob Kucera, appointed Professor D'Arcy Holman to undertake the statutory review on behalf of the Minister. In publicly announcing the Review, Minister Kucera stated that his government wanted to see '*improved treatment and care for people with a mental illness or disorder and the protection of the rights of the mentally ill, their carers and families.*'
- 2.2 Subsequently, a decision was made to incorporate the *Criminal Law (Mentally Impaired Defendants) Act 1996* into the same review process.
- 2.3 Resources to undertake the reviews were approved by the Minister for Health on 12 June 2002, and terms of reference were approved by the Minister in consultation with the Attorney General on 22 July 2002.

3.0 Terms of Reference for the Review of the Mental Health Act 1996

To review the operation and effectiveness of the *Mental Health Act 1996* and in the course of that review consider and have regard to:

- a) the effectiveness of the operations of the Mental Health Review Board and the Council of Official Visitors;
- b) the need for the continuation of the functions of the Mental Health Review Board and the Council of Official Visitors; and
- (c) such other matters as appear to be relevant to the operation and effectiveness of the Mental Health Review Act 1996.

4.0 Synthesis of the Review

- 4.1 Following an extensive review process which included the receipt of submissions and the convening of a number of working groups a synthesis of the review of the Act, entitled '*The Way Forward*' was published in October 2003. This synthesis allowed further public review of the proposals put forward. The final phase of the review offered a further opportunity for open participation. A second round of public submissions was received, numbering over 300, and on 20-23 October 2003, four separate consultative forums on the synthesis of the WA Act were conducted. The feedback obtained has been effective in assisting important changes to what had been initially proposed.
- 4.2 The review has made its final report and recommendations on the Act and these were presented to the Minister for Health on 12 December 2003.
- 4.3 The majority of these recommendations have been accepted. They advance the rights of persons with mental illness while further supporting the responsibilities of mental health clinicians and the police in balancing quality of care for persons with mental illness and the important issues of community safety.
- 4.4 After consideration and further advice the recommendations are presented in three categories:
 - i) Recommendations which are accepted and advance the human rights of persons with mental illness;
 - ii) Recommendations which are accepted, that clarify the Act and its functions; and
 - iii) Recommendations that are not accepted.

Each recommendation and the Government response is listed in the Appendix.

- 4.5 Recommendations made in regard to the Mental Health Review Board (the 'Board') are limited due to the introduction of the *State Administrative Tribunal (Conferral of Jurisdiction) Amendment and Repeal Bill 2003* (SAT) during the course of the review. Recommendation 6.2, which requires that before the third anniversary of the commencement of the jurisdiction of SAT, an independent review of the Board under SAT should be undertaken, is accepted. This is regardless of the outcome of the SAT legislation, which is currently before the Legislative Council.
- 4.6 In relation to particular recommendations it is suggested that some form of administrative trial be conducted prior to the recommendation being fully implemented. Although trials may be useful those recommendations are justified and no trial is required.

5.0 Recommendations that are accepted that advance the human rights of persons with mental illness.

- 5.1 It is recommended that there are additional definitions developed for terms used in the Act thereby providing greater clarification for consumers, carers and health professionals (1.2).
- 5.2 It is recommended that the definition of 'mental illness' be revised to accord with internationally accepted standards (1.3).
- 5.3 It is recommended that further exclusions be added ensuring that only persons with mental illness are subject to the Act (1.3).
- 5.4 It is recommended that the objects of the Act are replaced and expanded to include principles relating to Aboriginal and Torres Strait Islanders, the rights of carers and access to health care and support services for carers (1.4).
- 5.5 It is recommended that the role of the Chief Psychiatrist be enlarged to include the care and welfare of voluntary patients as well as involuntary patients; powers to enable direction of services in the monitoring of that service and the provision of an Annual Report, which will include statistical information, information on complaints and reports on specific functions under the Act (2.1).
- 5.6 It is recommended that the Chief Psychiatrist give approval to guidelines to improve treatment and care (2.1).

- 5.7 It is recommended that the criteria for involuntary status be amended to include that *'the person has unreasonably refused treatment'* accepting that persons may quite reasonably refuse treatment and should not be made subject to involuntary status (3.1).
- 5.8 It is recommended that the referral process be amended to ensure that when a person is referred to another place for examination a psychiatrist is available to conduct that examination (3.2).
- 5.9 It is recommended the requirement of the referrer be changed from *'personally examine'* to *'personally assess'*, thereby implying a wider range of inquiry before referral (3.1).
- 5.10 It is recommended that a Form is provided to the referred person to inform them as to why the referral is occurring and what the expectations of the referral are (3.2).
- 5.11 It is recommended that section 37(1)(c) be amended to clearly indicate that if no order is made then the person can no longer be detained thereby clarifying the right of the person to leave the hospital (3.4).
- 5.12 It is recommended that a psychiatrist may be able to examine the person by audiovisual means thereby ensuring that persons are not unnecessarily transferred from a rural to a metropolitan hospital (3.4).
- 5.13 It is recommended that guidelines be published for the optimal use of mental health beds, which will ensure that there is a system-wide response when facilities in a particular authorised hospitals are inadequate to meet the needs of the patient (3.6).
- 5.14 It is recommended that there is a reduction in the maximum time a person is maintained as an involuntary detained patient from 28 to 21 days and in relation to extension of the order from 6 months to 3 months (3.7).
- 5.15 It is recommended that the issue of a breach of a community treatment order (CTO) be clarified in line with natural justice for persons on CTOs (3.11).
- 5.16 It is recommended that there is a service agreement with the Northern Territory to ensure that persons with a mental illness in the Kimberley area receive a service regardless of the constraints imposed by the border (4.5).
- 5.17 It is recommended that the definition of treatment be expanded to allow a wider range of therapeutic intervention (5.1).

- 5.18 It is recommended that the statement regarding informed consent is expanded placing expectations on services to obtain informed consent (5.2).
- 5.19 It is recommended that there is a requirement that voluntary patients give informed consent (5.3).
- 5.20 It is recommended that a carer's involvement in treatment be expanded leading towards a partnership model of care (5.4A).
- 5.21 It is recommended that the Chief Psychiatrist publish guidelines to ensure that a second opinion provided by the psychiatrist is 'independent' (5.7).
- 5.22 It is recommended that emergency psychiatric treatment is restricted so as not to include electroconvulsive therapy (ECT), (5.8 & 5.12).
- 5.23 It is recommended that it will be required that all persons admitted to an authorised hospital receive a complete medical as well as mental health assessment. (5.9).
- 5.24 It is recommended that sterilisation and long-acting chemical contraception be permissible medical treatments only with the patient or a guardian's consent bearing in mind the legislative constraints on the guardian in relation to sterilisation (5.11A).
- 5.25 It is recommended that a mandatory review by the Mental Health Review Board (MHRB) will be conducted within 35 days rather than 56 days as under present legislation. This will ensure that persons who do not need to be maintained as involuntary patients may be discharged from involuntary status by the MHRB earlier (6.1B).
- 5.26 It is recommended that patients, carers and representatives are provided with information about their rights and entitlements (7.1).
- 5.27 It is recommended that, with appropriate restrictions, legal representatives may have access to a patient's records for the MHRB review (7.2).
- 5.28 It is recommended that the maximum penalty for the offence of ill treatment be raised (7.4).
- 5.29 It is recommended that aids to daily living are exempt from entitlements which may be restricted in an authorised hospital, except in particular circumstance (7.6).

- 5.30 It is recommended that a new section be included in the Act that orders that a psychiatrist must inform a person who has been refused admission of the grounds for that refusal (7.7).
- 5.31 It is recommended that in the part of the Act dealing with community support services, prominence is given to the importance of discharge planning and that this is defined (8.1).
- 5.32 It is recommended that the duties and powers of the Council of Official Visitors (COV) be extended to include the referring of environmental matters to the Licensing Standards and Review Unit and the Chief Psychiatrist (9.1).
- 5.33 It is recommended that there is involvement of the Chief Psychiatrist in managing complaints from the Head of the COV (9.1).
- 5.34 It is recommended that the meaning of 'affected person' be extended to persons referred to an authorised hospital for examination, voluntary patients and those patients subject to the *Criminal Law (Mentally Impaired Defendants) Act 1996* (9.2).
- 5.35 It is recommended that police action be an issue of last resort (10.0A).
- 5.36 It is recommended that Aboriginal Police Liaison Officers be authorised to exercise limited police powers enabling a culturally appropriate intervention (10.1).
- 5.37 It is recommended that any restrictions on the capacity to vote be removed (10.2).
- 5.38 It is recommended that there is a further Review of the legislation after five (5) years (10.7).
- 5.39 It is recommended the Act has a specific part for dealing with Minors (Y).
- 5.40 It is recommended that the concept of the Mature Minor be introduced into mental health legislation (Y.1).
- 5.41 It is recommended that there are shorter time frames for the MHRB review of minors as well as shorter time frames for involuntary detention (Y.5).
- 5.42 It is recommended that ECT be prohibited for children under 12 and with special restrictions for its use in minors under the age of 18 (Y.6).
- 5.43 It is recommended that the concept of the Youth Advocate be introduced (Y.8).

5.44 It is recommended that a new part of the Act dealing with complaints be introduced (Z.1).

6.0 Recommendations accepted that clarify the Act

6.1 It is recommended that there is a new Act with contemporaneous repeal of the 1996 Act. (A1).

6.2 It is recommended that the criteria of a mental health practitioner be changed to allow an Enrolled Nurse to become a mental health practitioner.

6.3 It is recommended that a medical practitioner or an authorised mental health practitioner be enabled to detain, if necessary a referred person for up to 6 hours. This will lead to greater safety for the disturbed referred person (3.2).

6.4 It is recommended the term 'police assistance' be changed to 'police action', which will recognise the important role of the police in the management of persons with mental illness (3.2).

6.5 It is recommended that the process of detaining a voluntary patient who requires involuntary status while an in-patient in an authorised hospital be changed (3.4).

6.6 It is recommended that section 38 be replaced with a new section akin to section 36 allowing for referred persons to be detained in non-authorised facilities (3.4).

6.7 It is recommended that the Minister for Health have the ability to declare areas in the state where longer time-frames may be allowed for detention which will lead to greater safety for patients and clarity for clinicians (3.5).

6.8 It is recommended that the process of returning involuntary patients absent without leave be changed leading to more efficient use of resources and clarity as to the process (3.8).

6.9 It is recommended that the Criminal Code be changed so that a person who exercises a duty of care to a person with degenerative brain disease will not be liable to section 337 of that Act. This will give clarity to staff working with the elderly who because of wandering present as a safety risk (3.9).

- 6.10 It is recommended that the referral of persons on CTOs to authorised hospitals be changed so that the CTO is suspended (3.2).
- 6.11 It is recommended that the administrative functions of CTOs be changed to clarify duties of practitioners (3.11).
- 6.12 It is recommended that the issue of Interstate Movements be changed to give legislative backing to Interstate agreements (4.0).
- 6.13 It is recommended that issues of medical treatment for persons with mental illness be changed to clarify the use of emergency powers and clarify when intervention of the Guardianship and Administration Board is appropriate (5.10).
- 6.14 It is recommended that the administration of seclusion and mechanical bodily restraint be changed to clarify who may be subject to this intervention and who may not, as well as the keeping of statistical information (5.13 & 5.14).
- 6.15 It is recommended that the role of rural nurses be changed to enable medication to be administered in rural settings (5.15A).
- 6.16 It is recommended that there is a new section to the Act allowing the use of reasonable force by mental health or medical practitioners in relation to disturbed patients (5.16).
- 6.17 It is recommended that there is mandatory reporting to the Chief Psychiatrist of 'notifiable incidents' to allow monitoring of critical incidents (10.5).

7.0 Recommendations not accepted

A few recommendations were contentious and following further discussion some recommendations are not accepted. They include:

- 7.1 That there are changes to the criteria under section 26(b)(i) of the Act is not accepted. The present criterion '*to protect the health and safety*' better reflects the need for involuntary status. Adding '*serious likelihood of immediate or imminent harm*' may lead to the exclusion of persons, who while not being in danger of '*immediate or imminent*' harm, may require treatment for their mental illness and if the treatment is not provided may deteriorate to a degree causing significant harm to their health. The Act is about providing safety and this must be recognised in the criteria (3.1).

- 7.2 That there are changes to section 26 (b) (ii) is not accepted. Changes to this criteria may lead to persons in the community having their safety compromised while clinicians attempt to define the terms '*immediacy*' and '*imminence*' (3.1).
- 7.3 That there are changes to the confirming of a CTO, which allows in certain circumstances that this function may be omitted, is not accepted. In effect it is a reduction in the rights of persons placed on CTOs. A CTO is still an involuntary order and it is important that a second psychiatrist or medical practitioner confirm the order. It would be appropriate for the confirming practitioner to be extended to include a mental health practitioner in addition to the other categories (3.10).
- 7.4 The separation of treatment from detention so that before treatment can commence a body such as the MHRB must review the matter is not accepted. The purpose of involuntary status is to provide treatment. Separating the detention and the treatment process is contrary to the fundamental purpose of involuntary status. If a person is able to give informed consent to treatment they should not be made subject to involuntary status. If they unreasonably refuse or due to their mental illness are unable to consent then they are made involuntary patients in order to receive treatment. The psychiatrist and treating team is in the best position to decide what treatment the patient requires. The concerns raised by the review and the fact that this proposal has been accepted in other jurisdictions is noted. However, it is not accepted that the separation of detaining powers and treatment would be in the best interests of consumers or clinicians (5.4).
- 7.5 That there is a requirement that before treatment is commenced the psychiatrist should be satisfied regarding certain clinical matters is not accepted. In effect these matters relate to good clinical practice and are not required to be part of legislation. They should form part of the policies and procedures of every health service (5.4).
- 7.6 A recommendation that a patient or the representative receive, no later than two (2) days before a MHRB review, all relevant documentation (the patient's file) for the purposes of preparing for that review is not accepted. Access to the medical file for the purposes of a patient reviewing their file need to be separated from access to the file for the purpose of representation before the MHRB. Legislation should give a general right for a person or their representative to receive information, which allows for a fair review. This may include the whole file or part of the file, which is relevant for the review. A right to inspect documentation no later than 2 days before a review is an ideal which is unrealistic, particularly if the file is extensive, the expectations of the patient or the representative are excessive, or persons who have provided information in confidence are

unable to be immediately contacted. It would be preferable for the Regulations to set out details, which will allow access within a reasonable time frame, and in a reasonable manner. These are matters, which require cooperation between the service and the patient or his or her representative (7.2).

- 7.7 That there be inclusion of patient's notations in case records is not accepted. Patients are entitled to make notes of their stay in hospital. At times these notes may be of clinical interest as they give insight into the patient's illness. In those situations the psychiatrist may request that the patient's notations be part of the clinical file. With particular illnesses the patient may make copious notations which are of limited clinical merit and will increase the volume of the clinical file unnecessarily if a patient insists on inclusion of the notations in the file. Essentially the medical file is to inform and guide the treating team and therefore what the file is obliged to contain should have relevance to the medical care of the person plus any essential information required by policies and procedures (10.3).
- 7.8 That carers have a right to information, which may overrule issues of confidentiality, is not accepted. Although the intention of this recommendation is commendable the issues regarding a patient's right to confidentiality need to be maintained. If a patient is unable to give consent the recommendation as outlined may have merit. However, if a patient is adamant that certain information should not be disclosed to a relative that right needs to be upheld (10.4).
- 7.9 The recommendation about the rights of parents or Guardians of a Minor has substantive acceptance. However the 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 is not accepted (Y3).

8.0 Resource Implications of the Review

The majority of the recommendations are cost neutral requiring clinical or administrative change. These recommendations can be met by the Office of Mental Health within existing work programs around quality improvement and policy development and implementation. However, there are resource implications in regard to the following:-

- 8.1 Implementing the new Act includes the development of guides, pamphlets and forms as well as an extensive education and training campaign.

- 8.2 The role of the COV will be substantially expanded in a new Act and there will be further discussion as to the financial management and effective use of resources by the COV.
- 8.3 Expanding the role of Chief Psychiatrist will require the allocation of increased resources to the Office of the Chief Psychiatrist and further discussion will be necessary as to the effective use of resources for the Office of the Chief Psychiatrist.
- 8.4 Implementing shorter time frames for reviews conducted by the MHRB will require further resources as the number of reviews will rise.

9.0 Conclusion

- 9.1 This report, founded on the review recently conducted, gives recognition as to what is required in amending mental health legislation.
- 9.2 The recommendations that have been accepted will strengthen the human rights of persons with mental illness and their carers.
- 9.3 A number of the recommendations, which are accepted, will clarify the intent of the legislation and make the Act more practical in its implementation.
- 9.4 The final result will be an Act, which advances human rights while emphasising the need for treatment of persons with a mental illness.

Acknowledgments

This report acknowledges the considerable body of work completed by Professor D'Arcy Holman and the review team. The conduct of the review was exceptional and was an important opportunity for all persons who have an interest in mental health in Western Australia to contribute to the advancement of the rights of people with mental illness. All the people who gave their time, their expertise and their experience to provide a comprehensive review are acknowledged.

APPENDIX

RECOMMENDATIONS FROM THE REVIEW OF THE MENTAL HEALTH Act 1996

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).

ACCEPTED.

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 authorised*;
- section 119, *Giving of authorisation*;
- section 122, *Mechanical body restraint must be authorised*;
- section 123, *Giving of authorisation*; and
- subsection 159(2), *Affected person to be given copy of order*.

ACCEPTED.

Comment: A wider range of practitioners will be enabled to care for persons with mental illness. Mental health services will become responsible for the development of the skills of qualified practitioners performing these functions under the Act.

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 authorised hospitals subject to orders under the CLMID Act as well as voluntary and involuntary patients.

ACCEPTED.

Comment: The defining of a variety of terms will result in greater clarification of the legislation for consumers, carers and health professionals.

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.

ACCEPTED.

Comment: The linking of the meaning of mental illness to internationally accepted standards will enable flexibility within the legislation as changes in accepted diagnosis may occur. The additional exclusions will further enhance human rights ensuring that only those persons with a mental illness will be subject to the Act.

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.

ACCEPTED.

Comment: The objects and principles of the Act should be comprehensive, as it is these statements which establish the framework from which the legislation operates.

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 authorised 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 authorised 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 authorised hospital.

ACCEPTED.

Comment: The role of the Chief Psychiatrist is pivotal in ensuring that human rights are maintained, with the monitoring of mental health services to ensure quality practice and with the receipt and management of complaints.

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 specialised 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.

ACCEPTED.

Comment: Care issues will be able to be addressed in a number of care settings other than an authorised hospital. The Chief Psychiatrist will be enabled to advocate for patients and ensure that further steps are taken when an unacceptable practice is identified or where an alternative practice is indicated.

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.

ACCEPTED.

Comment: Nurses under Division 2 of the Register (Enrolled Nurses) in a number of circumstances, under supervision, carry out similar tasks to those carried out by Nurses under Division 1 of the Register and would be enabled to contribute in a more significant way to the care of patients subject to functions under the Act. The length of service of a clinician does necessarily reflect appropriate experience.

3 - Involuntary Patients

Criteria for becoming an Involuntary Patient

3.1 The following changes should be made to the criterion 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);*”

NOT ACCEPTED.

Comment: The present criterion ‘to protect the health and safety’ better reflects the need for involuntary status. Adding ‘serious likelihood of immediate or imminent harm’ may lead to the exclusion of persons who while not being in danger of ‘immediate or imminent’ harm may require treatment for their mental illness and if the treatment is not provided may deteriorate to a degree causing significant harm to their health. The Act is about providing safety and this must be recognised in the criterion.

- replace subsection 26(b)(ii) with “to protect any other person from a serious likelihood of immediate or imminent harm;”

NOT ACCEPTED.

Comment: Accepting this criterion may lead to persons in the community having their safety compromised while clinicians attempt to define the terms ‘immediacy’ or ‘imminence’.

- 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”;

ACCEPTED.

Comment: A separate section detailing all the criteria for community treatment orders is required. The criteria for involuntary detention need to be qualitatively different from the criteria for the less restrictive option of community treatment orders.

- 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”;

ACCEPTED.

Comment: Persons may quite reasonably refuse to consent and those persons then should not be subjected to involuntary status.

- 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”.

ACCEPTED.

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 authorised mental health practitioner to refer (as at present) *“and if necessary detain for up to six hours”* a person for examination by a psychiatrist;

ACCEPTED.

Comment: The present referral power which does not explicitly authorise the power to detain, leaves the practitioner with recourse only to common law when faced with the necessity to detain a person who has been referred. The changes will make the referral role for medical and authorised mental health practitioners more acceptable, as well as ensuring that referred persons do not place themselves in unsafe situations.

- amend subsection 29(2)(b) to read *“at some other place where by arrangement the examination can be carried out by a psychiatrist”*;

ACCEPTED.

Comment: This will ensure that the referred person will undergo examination in a timely manner.

- add a third subsection to section 29 to clarify that referral of a person who is on a CTO for assessment in an authorised hospital suspends the operation of the CTO for the duration of that referral;

ACCEPTED.

Comment: An anomaly exists under the present legislation, which leads to some practitioners being uncertain as to how to proceed. The suspending of a CTO gives clarity and ensures that the patient receives the care they require in the authorised hospital.

- 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;

ACCEPTED.

Comment: An ‘assessment’ process indicates more comprehensiveness than the ‘examination’ of a person as it implies that information will be received from a number of sources for the purposes of making a decision. This additional information will assist the practitioner and ensure that a person is not referred if other information indicates that the referral is not required.

- 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”*;

ACCEPTED.

- 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);

ACCEPTED.

Comment: It is sound clinical practice as well as being appropriate from a human rights perspective for the referred person to know why they are being referred for a psychiatric examination. A form, which gives those details in addition to an oral explanation, will indicate to the referred person the reason for the referral.

- replace the words “*any of the facts which have*” with “*the information which has*” in subsection 33(f);

ACCEPTED.

- 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”;

ACCEPTED.

Comment: This change of wording recognises the important role of the police service in the management of persons suspected of having a mental illness. People with mental illness, like all community members, as well as mental health practitioners are entitled to engage the expertise of the police service in appropriate situations.

- add an additional clause to subsection 35(2) that reads “*or until a person referred to a place other than an authorised hospital is examined by a psychiatrist*” to allow for the situation in which referral is not to an authorised hospital.

ACCEPTED.

Comment: Continuing police action until the person is examined in some cases is appropriate risk management. The police service remain responsible for the person whilst the immediate health care of the person is managed by the health service.

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 authorised 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”;

ACCEPTED.

Comment: It allows flexibility on the grounds of safety and more realistically reflects that the practitioner initially involved would be a medical or authorised mental health practitioner rather than a psychiatrist.

- amend subsection 30(3) such that the person-in-charge of the ward may detain the patient for up to six hours to be assessed by a medical practitioner or authorised mental health practitioner, who may then decide to detain the patient for up to 24 hours for examination by a psychiatrist;

ACCEPTED.

Comment: Authority is given appropriately to the person in charge of the ward, to exercise judgment on the grounds of safety for the patient. The time limit is a maximum time to allow for those situations particularly in rural authorised hospitals where mental health staff may not be available at all times. It would be expected that within metropolitan facilities the examination/assessment by the medical or authorised mental health practitioner would be considerably sooner. The referral power is similar for persons in the community and provides consistency.

- delete subsection 30(6) so as to enable the treating psychiatrist, or any other psychiatrist, to conduct the examination following referral.

ACCEPTED.

Comment: This allows the psychiatrist who is most familiar with the patient to decide whether they should be subject to involuntary status. A psychiatrist who does not know the patient well may err on the side of caution and be more restrictive.

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 authorised 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;

ACCEPTED.

Comment: This will assist the COV in identifying their potential clients. This change does not require the COV to intervene without a request from the patient or another person who has genuine concern for the patient and should therefore not require additional resources for the COV.

- amend section 37(1)(c) such that it reads “order that the person be no longer detained”;

ACCEPTED.

Comment: This change reflects the right of the person to leave if they so desire.

- add new subsections to sections 37 and 39 clarifying that a psychiatrist may examine a person by audiovisual means;

ACCEPTED.

Comment: This will provide the opportunity for a more immediate psychiatric examination particularly in rural areas and may prevent the unnecessary transportation of a person from a rural area to a metropolitan authorised hospital for examination. Regulations or protocols clarifying an examination by audiovisual means will be required.

- 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);

ACCEPTED.

Comment: A non-authorised facility will need to consider security issues when persons are referred to that facility.

- amend subsection 41(2) and the title of section 41 such that “police assistance” is replaced by “police action”.

ACCEPTED.

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 authorised mental health practitioner or a medical practitioner and the person is examined by a psychiatrist as soon as practicable;

ACCEPTED.

Comment: This change reflects the practicalities of operating a mental health service in rural and remote areas of the State.

- make consequential amendments to sections 18 and 20, concerning the functions in the Act which may be performed by a medical practitioner or an authorised mental health practitioner; and

ACCEPTED

- 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 authorised 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.

ACCEPTED.

Optimal Use of Beds in Authorised 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 authorised hospital, having regard to the guidelines published by the Director General under section 47, may order that the person be transferred to another authorised hospital specified in the order”;

ACCEPTED.

Comment: Guidelines are necessary to direct facilities and mental health practitioners with regard to the patient’s best interests. It is recognised that the referrer may play a significant part in the referral and transportation process but is not in a position to be responsible for arrangement of the bed.

- add a second subsection to section 46 to read “A psychiatrist or person-in-charge of an authorised hospital ordering a transfer may if required complete a transport order authorising a police officer to take the person to the alternative authorised hospital”; and

ACCEPTED.

Comment: This will facilitate the safe transportation of a person if an authorised hospital is unable to accommodate the person.

- 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 authorised hospitals in the State, including best practice by the referrer in nominating an authorised 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 authorised hospitals”.

ACCEPTED.

Comment: The details of the requirements should be stated in the Regulations.

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;

ACCEPTED.

Comment: A reduction in the maximum period will ensure that a person is examined by a psychiatrist at an earlier time and not maintained on involuntary

status when the status is not required. This strengthens human rights and brings WA legislation more in line with other jurisdictions. The reduction in time for adolescents will further ensure that young people are examined at an earlier time during their stay in hospital.

- 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.

ACCEPTED.

Comment: Forms are to be completed before three (3) months rather than six (6) months thereby enhancing human rights.

- 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.

ACCEPTED.

- 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.

NOT ACCEPTED.

Comment: A trial of this recommendation is not considered necessary in order to demonstrate its efficacy.

Absence Without Leave and Leave of Absence

3.7 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;

ACCEPTED.

Comment: Referred persons who are detained in an authorised hospital who abscond can be returned to the hospital, which is an important issue for patient safety.

- delete subsection 58(1)(a)(ii) so that the qualified person authorised to apprehend need not be employed at the authorised hospital from which the person is absent;

ACCEPTED.

Comment: Community staff, including staff from the Psychiatric Emergency Team can assist with the return of the patient to the authorised hospital.

- delete all of subsection 58(1)(b);

ACCEPTED.

- amend subsection 58(1)(c) to read “*a police officer who is authorised by the person-in-charge of the authorised hospital to apprehend and return the person*”;

ACCEPTED.

- 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—*”;

ACCEPTED.

- delete subsection 58(2)(b);

ACCEPTED.

- amend subsection 60(1) to read “*... the psychiatrist may by order cancel the leave given to the patient*”;

ACCEPTED.

- amend subsection 60(2) to read “*The order is to be served on the patient by or on behalf of the psychiatrist*”;

ACCEPTED.

- add a third subsection to subsection 62(2) to read “*order that the patient be returned to the authorised hospital using the powers in section 58*”;

ACCEPTED.

- amend subsection 63(1)(b) by deleting the words “*written*” and “*authorised*” from the sentence.

ACCEPTED.

Comment: The case manager of the person may not be an authorised mental health practitioner or a medical practitioner, however they may be the best person to offer advice regarding the appropriateness of involuntary detained status for a patient on leave.

Detention of Voluntary Patient with Dementia

3.8 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 misdemeanour under section 337.*”

ACCEPTED.

Comment: Staff exercising their duty of care to persons with dementia should not be liable for an offence under the Criminal Code. This is a matter of dispute and questions as to the rights of people so detained have been raised. However

following the case of *L v Bournewood and Community Mental Health NHS Trust (UK)* the clinician's duty of care to protect a person in these circumstances is clear.

Confirmation of Community Treatment Orders

3.9 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.”

NOT ACCEPTED.

Comment: In effect this would be a reduction in the rights of persons placed on community treatment orders. A CTO is still an involuntary order and it is important that a second psychiatrist or medical practitioner confirm the order. It would be appropriate for the confirming practitioner to be extended to include a mental health practitioner additional to the other categories. Practitioners require a guide as to the term ‘confirmation’.

Supervision of Community Treatment Orders

3.10 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”;

ACCEPTED.

Comment: This would clarify the steps that are required in order for breach proceedings to occur. It further advances the rights of patients on CTOs.

- amend section 71 such that “police assistance” becomes “police action”;

ACCEPTED.

- 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;

ACCEPTED.

Comment: It is an administrative difficulty when a supervising psychiatrist is unable to transfer the care of a patient on a CTO to another psychiatrist due to ill health or unexpected absence from work and this change would provide an appropriate solution.

- add a second new subsection to section 74, enabling the CP to authorise 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;

ACCEPTED.

Comment: The administration process can occur at a local level with the Chief Psychiatrist authorising the process.

- amend section 75 to enable an authorised 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;

ACCEPTED.

Comment: The practitioner responsible for the mandatory report should extend to a mental health practitioner. In the majority of cases the Responsible Practitioner is a mental health practitioner rather than a medical or authorised mental health practitioner. The mental health practitioner, having case management responsibilities is in a better position to conduct the mandatory monthly examination. It will ensure that an accurate report is made to the supervising psychiatrist regarding the progress of the patient and may include an assessment as to whether involuntary status continues to be required.

- amend existing section 77 to enable a psychiatrist to request and act on the report of either an authorised mental health practitioner or a medical practitioner to examine a patient who is subject to a CTO;

ACCEPTED.

- amend sections 75 and 77 to make clear that examinations may be undertaken by audiovisual means;

ACCEPTED.

Comment: This change recognises the practical realities of providing services in rural areas where audiovisual examination is more readily available than a personal examination.

- amend existing section 84 such that “police assistance” is replaced by “police action”;

ACCEPTED.

- make consequential amendments to sections 18 and 20, concerning the functions in the Act that may be performed by a medical practitioner or an authorised mental health practitioner.

ACCEPTED

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.

ACCEPTED.

Comment: Legislative backing is required in order that binding agreements may be made with other states for the care, treatment and return of involuntary patients. The legislation needs to mirror similar legislation in other states to facilitate reciprocal agreements.

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;

ACCEPTED.

Comment: Care for the individual and the wider community needs to be upheld, overriding the strict requirements of confidentiality. It is not required that the person is made automatically an involuntary patient, rather the person should be made subject to a psychiatric examination. Only if the person meets the criteria for involuntary status in another jurisdiction should that State's mental health legislation be invoked.

- 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

ACCEPTED.

Comment: Confidentiality should only be overruled where the clinical state of the person is so serious that safety issues for the person or others is paramount.

- that a psychiatrist is not compelled to make any of these notifications.

ACCEPTED.

Comment: As it is a person's clinical status that dictates the psychiatrist's decision the psychiatrist should have the power not to notify.

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 authorised 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.

ACCEPTED.

Comment: The right for an involuntary patient to move interstate should be upheld and this recommendation details how this might be achieved while still protecting the health or safety of the person or others.

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.

ACCEPTED.

Comment: This addition places a responsibility on a patient subject to a CTO to inform but does not restrict the right of the person to move interstate. If it is clear that mental health care will be required in another State that care can be arranged.

Service Agreement with the Northern Territory

4.7 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.

ACCEPTED.

Comment: This recommendation recognises that for people in the Kimberley area, receiving services from the Northern Territory may be more appropriate than receiving services in Western Australia. Legislative back-up is required in order to legitimise agreements with the Territory on a number of issues of mutual concern.

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.

ACCEPTED.

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.

ACCEPTED.

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 authorised 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.

ACCEPTED.

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 authorised 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.

NOT ACCEPTED.

Comment: The purpose of involuntary status is to provide treatment. Separating the detention and the treatment process is contrary to the fundamental purpose of involuntary status. If a person is able to give informed consent they should not be made subject to involuntary status. If they unreasonably refuse or due to their mental illness unable to consent then they are made involuntary patients in order to receive treatment. The psychiatrist and treating team are in the best position to decide what treatment the patient requires.

- 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.

NOT ACCEPTED.

Comment: Good practice dictates that the matters listed above must be considered by the psychiatrist. If a psychiatrist is failing to consider these matters it may form the basis of a complaint. In effect these matters relate to good clinical practice and are not required to be part of legislation. They should form part of the policies and procedures of every health service.

- 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.

NOT ACCEPTED

Comment: Good practice dictates that the matters listed must be considered by the psychiatrist. If a psychiatrist is failing to consider these matters it may form the basis of a complaint. In effect these matters relate to good clinical practice and are not required to be part of legislation. They should form part of the policies and procedures of every health service.

- 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.

ACCEPTED.

Comment: A patient's clinical file is a record of the treatment the patient receives and must be maintained as fully and comprehensively as possible.

- 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.

ACCEPTED.

Comment: Guardians act on behalf of a patient and should therefore be entitled to exercise all the rights that the patient has.

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 authorised 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.

ACCEPTED.

Comment: Carers play a significant part in the lives of persons with mental illness and if possible should be involved in the care and treatment of the person. Partnership between the professional carers and the non-professional carers will lead to better outcomes for the patient.

Electroconvulsive Therapy

5.3A 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.

ACCEPTED.

Comment: It is recognised that although a well-accepted and effective treatment, ECT does give rise to significant community concern.

The provision of statistical reports, the use of a standard form and the reporting of these matters in an Annual Report will ensure that the concerns raised regarding this treatment are addressed.

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

ACCEPTED.

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

ACCEPTED.

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.

ACCEPTED.

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.

ACCEPTED.

Comment: Stricter criteria as to what is permissible under Emergency Psychiatric Treatment will be an advance for human rights.

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 authorised hospital have documented in their case record the results of a complete medical assessment within a reasonable period following reception to that service.

ACCEPTED.

Comment: The document “Duty to Care” clearly identified that health services can improve their attention to the physical needs and illnesses of persons with mental illness. The high rates of certain physical illnesses in persons with mental illness requires a comprehensive and considered approach. This new section is part of that drive towards ensuring that the physical needs of persons with mental illness are fully met.

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 authorised by a medical practitioner;

ACCEPTED.

Comment: Medical practitioners have a duty of care towards any person who requires urgent medical treatment. That duty of care in these circumstances overrides issues of consent.

- 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*;

ACCEPTED.

Comment: Persons with mental illness are able to give informed consent to medical treatment even though they may at the time be an involuntary patient and consent should be sought. Guardians, as substitute decision makers, are able to give consent on behalf of a patient.

- 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*.

ACCEPTED.

Comment: The argument by the review that in relation to medical treatment involuntary patients should not be treated differently from any other person in the community who is unable to consent to treatment has validity. However under Guardianship legislation the nearest relative is identified as a person who may consent on the person’s behalf. Any amendment should take cognisance of this section and make the psychiatrist a person who may give consent only if the nearest relative is unable to.

- 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.

ACCEPTED.

Comment: The monitoring and reporting of these occurrences will indicate the appropriateness of these changes to legislation and the difficulties that may arise.

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*.

ACCEPTED.

Comment: The seriousness of these medical procedures is recognised as is the importance of the involvement of the Guardianship and Administration Board.

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

ACCEPTED.

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.

ACCEPTED.

Comment: This amendment further clarifies as to when emergency psychiatric treatment may be given and when the exclusion of ECT is appropriate.

Reporting of these matters to the Chief Psychiatrist where they will be addressed in the Annual Report will ensure that this intervention is only used when necessary.

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”*;

ACCEPTED.

Comment: However more attention needs to be paid to a definition that can not be misinterpreted in intent leading to inappropriate complaints.

- amend section 118 so that the person-in-charge of the ward can authorise and revoke seclusion;

ACCEPTED.

Comment: Decisions made by staff in charge on the ward at the operational level would be most appropriate in terms of safety for the patient and others.

- 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”*;

ACCEPTED.

Comment: This amendment recognises that while safety issues are important a decision as to the least restrictive method to manage those safety issues must also be considered.

- 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.

ACCEPTED.

Comment: Seclusion is an intervention that is used to protect the patient and others and it requires strict monitoring due to the nature of the intervention. The Chief Psychiatrist is in the best position to monitor these interventions and report annually.

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*”;

ACCEPTED.

Comment: The previous definition led to confusion as to what constituted mechanical bodily restraint under the Act. This expanded definition will enable health staff to differentiate between mechanical bodily restraint and other types of restraint applied for the safety of, particularly elderly, persons.

The separation of restraints managed by the police from mechanical bodily restraints applied by health staff further clarifies the differentiation.

- amend subsection 123(1) to read “... *unless no other less restrictive method of control is appropriate and it is necessary for – ...*”;

ACCEPTED.

Comment: As with seclusion this amendment requires staff to consider the least restrictive method of control as well as the appropriateness of the control.

- 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;

ACCEPTED.

Comment: Consistency in the format of reporting enables accurate monitoring and the Chief Psychiatrist is best placed to ensure that this occurs.

- 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*”;

ACCEPTED.

Comment: Although restraint may be applied by health staff it is good practice for there to be medical intervention at the earliest opportunity.

- incorporate subsections 61(8) and 61(9) of the NT Act into the WA Act, replacing the term “*authorised 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;

ACCEPTED.

Comment: The overall concern for the safety and care of the patient remains paramount and is the responsibility of the medical practitioner.

- 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.

ACCEPTED.

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 authorised 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;

ACCEPTED.

Comment: Essentially this new section is about the prescription of medication prescribed by a psychiatrist using audiovisual means. Therefore it should apply to any mental health practitioner who is a nurse in division 1 of the register (Nurses Board), rather than confining it only to authorised mental health practitioners.

- a section that defines the conditions as: that the authorised 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 authorises the dispensing of the medication by telephone or electronic transmission; the practitioner documents the psychiatrist's authorisation in the person's case record; and the person gives informed consent to receiving the medication; and a section requiring that when a psychiatrist authorises the giving of medication in this way, they must examine the person personally or by audiovisual means with 72 hours of the authorisation, 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 authorise an individual or class of individuals

to access and use medicines in the circumstances set out in the regulations.

ACCEPTED.

Comment: This is a matter of service delivery, guidelines developed by the Office of Mental Health will assist the nurse in carrying out the requirements of this section. As it is not envisaged that this would be a frequent occurrence, reporting to the Chief Psychiatrist on each occasion should be mandatory. A form devised by the Chief Psychiatrist would assist with this reporting function. Any change in the role of nurses requires further discussion and negotiation with the Nurses Board of WA.

Reasonable Force for Delivery of Treatment

5.16 A new division should be added to part 5A of the WA Act, which authorises 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.

ACCEPTED.

Comment: This new division would clarify the powers of practitioners who are required to manage persons with mental illness who may present as behaviourally disturbed.

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, modelled 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.

ACCEPTED.

Comment: Matters raised regarding research on involuntary patients is complex and requires issues of ethics, consent and purpose to be fully considered. These matters should not be addressed within legislation at this point. It would be advisable for the Office of Mental Health in conjunction with research bodies to consider and report on these matters.

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.

ACCEPTED.

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.

ACCEPTED.

Comment: A mandatory review at an earlier time is not only preferable within a human rights perspective but will assist psychiatrists in better managing involuntary patients. These matters will need to be re-considered if and when the State Administrative Tribunal Bill is passed.

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.

NOT ACCEPTED

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.

ACCEPTED.

Comment: All these matters need to be considered by the State Administrative Tribunal when it comes into operation. All matters concerning structure and procedure need to be consistent with the other administrative structures introduced by the Tribunal. Specific consideration will be given to the particular issues raised by the review as it is recognised that the review of involuntary status is different from some of the other functions of the Tribunal.

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.

ACCEPTED.

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, modelled 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.

ACCEPTED.

Comment: The provision of relevant information is an important human right. The extension of informing patients of their rights as referred persons will be an additional advance from a human rights perspective.

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*".

NOT ACCEPTED

Comment: Access to the medical file for the purposes of a patient reviewing their file needs to be a separate process to that of access to the file for the purpose of representation before the MHRB. Legislation should give a general right for a person or their representative to receive information that will allow for a fair review. This may include the whole file or part of the file depending on what information is relevant for the review. A right to inspect documentation no later than 2 days before a review is an ideal, which may be unrealistic, particularly if the file is extensive. It would be preferable for the Regulations to set out details to allow access within a reasonable time frame and in a reasonable manner. These are matters which require cooperation between the service and the patient or his or her representative.

- 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*”;

PARTIALLY ACCEPTED.

Comment: The definition of a ‘*suitably qualified person*’ needs to be limited to those class of persons who have a professional duty to abide by legislation. Extending this definition to all representatives may well mean that persons such as other patients or relatives who the patient wishes to be their representative will have similar powers of access to the medical file. For reasons of confidentiality and appropriateness this is unacceptable.

- 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.

ACCEPTED.

Comment: This recommendation requires further discussion as it is in conflict with information provided by the Law Society which essentially states that a lawyer has a primary duty of disclosure to his or her client.

Copies of Orders

- 8 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.

ACCEPTED.

Comment: It is a basic human right for a person to be informed as clearly as possible as to what involuntary processes they are being made subject to and reasons for those processes

Offence of Ill-Treatment

7.4 The maximum penalty for a person with responsibility who ill-treats or wilfully 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.

ACCEPTED.

Comment: The increase in the punishment for committing this offence is in line with human rights and community expectation.

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*”.

ACCEPTED.

Comment: This allows for distinguishing between the status of a person in hospital as opposed to a patient in the community.

Possessions, Postal Articles, Telephone and Visitors

7.5 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;

ACCEPTED.

Comment: Being an involuntary detained patient does not preclude the person their right to live as normally as possible with all the aids to daily living they require.

- 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*”;

ACCEPTED.

- 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*”;

ACCEPTED.

Comment: It is recognised that in exceptional circumstances even everyday articles of daily living may pose a risk to the patient or others. In those very particular circumstances the right may need to be curtailed.

- 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;

ACCEPTED.

- 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;

ACCEPTED.

Comment: The MHRB will be required to have a procedure whereby these denials of entitlement can be reviewed quickly. A prolonged delay in these reviews will be a further denial of a patient's rights.

- 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.

PARTIALLY ACCEPTED.

Comment: That the COV should be informed of a denial of entitlement is accepted, however if the matter must be reported on each occasion it may well become cumbersome and ineffective. Restrictions are required to be reviewed daily and daily reporting to the COV will be an administrative burden for the service and the COV. It would be preferable if Regulations can further prescribe how this reporting can be conducted so as not to impose a burden on services or the COV while still upholding patient's rights.

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*, modelled 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 authorised 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.

ACCEPTED.

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 modelled on section 89 of the NT Act, making specific reference to the requirement for liaison with community support services and carers.

ACCEPTED.

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).

ACCEPTED.

Comment: It is emphasised that Official Visitors do not have a case management role and guidelines agreed by the COV and the Office of Mental Health would need to be developed to clarify this set of recommendations.

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 authorised 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 authorised 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.

ACCEPTED.

Comment: The extension of the role of the COV to voluntary patients and mentally impaired defendants has major resource implications. It should be emphasised that the major role for Official Visitors is advocacy for involuntary patients and involvement with voluntary patients should only occur when notified of a breach of a patient's rights.

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.

ACCEPTED.

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 authorised under sections 34, 41, 71 or 84, it is only to be authorised if, in the opinion of the person authorising 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.

ACCEPTED.

Comment: The new section would not be dissimilar from the present Act, which states that the '*condition of the person*' requires police intervention, though it does highlight that in most cases of referral police action is not required and the least restrictive option should be used.

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 authorise 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.

ACCEPTED.

Comment: It is culturally appropriate to involve law enforcement officers who can communicate effectively with Aboriginal people with mental illness. It is recognised that Aboriginal police liaison officers will require education and training to perform the role.

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.

ACCEPTED.

Comment: Involuntary patients should have the right to vote as any other member of the community.

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 authorised 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 labelled as such and does not constitute a part of the hospital's account of the patient's treatment and care.

NOT ACCEPTED.

Comment: Essentially the medical file is to inform and guide the treating team and therefore what the file is obliged to contain should have relevance to the medical care of the person plus any essential information required by policies and procedures. Patients are entitled to make notes of their stay in hospital. At times these notes may be of clinical interest as they give insight into the patient's illness. In those situations the psychiatrist may request that the patient's notations be part of the clinical file. With particular illnesses the patient may make copious notations which are of limited clinical merit and will increase the volume of the clinical file unnecessarily if a patient insists on inclusion of the notations in the file.

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.

PARTIALLY ACCEPTED.

Comment: Issues regarding a patient's right to confidentiality generally override the disclosure of information about them to other parties. If a patient is unable to give consent the recommendation as outlined has merit. However if a patient is adamant that certain information should not be disclosed to a relative that right needs to be upheld, despite the views of the carers.

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 authorised hospital or to an involuntary patient: death; any medication error in an authorised 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.

ACCEPTED.

Comment: The new division will allow for improved monitoring of certain incidents by the Chief Psychiatrist with the aim of action being taken that will result in improvements to the quality of psychiatric care. The details within this recommendation set out the legislative basis, however protocols will need to be devised.

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.

ACCEPTED.

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.

ACCEPTED.

Comment: Regular review of this type of legislation ensures that human rights are re-considered on a regular basis and can be shaped to the changing needs of consumers and services.

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.

ACCEPTED.

Comment: It is recognised that special provision should be made for children and adolescents receiving treatment which legislate for more frequent reviews and reduced time frames.

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 authorised 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.

ACCEPTED.

Comment: This new part would define a process for managing the difficulties arising for persons under the age of 18 who may be competent to choose particular options in health care.

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.

PARTIALLY ACCEPTED.

Comment: The importance of the involvement of parents and guardians in the care of minors is supported with this inclusion. It gives rights, which recognise the primary importance of parents and guardians in the overall care of children and adolescents. However the second parental right requires further clarification, Having decided a person under 18 is a mature minor and competent to make decisions in their own best interests it is essential that this extends to other decisions such as confidentiality. This recommendation has the potential to undermine the decision-making ability of the mature minor.

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 authorised 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.

ACCEPTED

Comment: In respect to the parent or guardian applying for discharge of the minor, if discharge is not in the minors best interests the medical practitioner would need to consider other legislative alternatives such as Guardianship, wards of court or involuntary status.

If the medical practitioner has decided that the minor is competent to make decisions in their own best interests, informing parents or guardians should only be made with the permission of the mature minor. If it is clear that the minor is unable to make appropriate informed decisions the medical practitioner may need to review whether the minor is mature enough to warrant that category.

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.

NOT ACCEPTED.

Comment: It may be in the long term benefit of the child for them to be subject to Child Welfare legislation, however in managing the mental illness of the minor the preferred intervention should be through mental health legislation. Involvement of the Child Welfare Act directs mental health matters in the direction of the justice system which may be inappropriate. There is also an expectation that mental health professionals will have a detailed knowledge of other legislation which may not be met.

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 authorised 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.

ACCEPTED, however the matter requires further clarification.

Comment: The section outlines the preferred way that minors should receive treatment, however at times this may not be possible. Sound clinical practice that is directed by service guidelines determines the care minors receive in authorised facilities. Legislating in this area may give rise to unintended breaches when there may be no other alternative than caring for a minor in a facility with adults. An alternative way of managing this issue would be that the Chief Psychiatrist conduct a review of the minors admission when the agreed guidelines are unable to be complied with.

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.

ACCEPTED.

Comment: Child and adolescent psychiatrist's are a rare resource and to have them appointed as MHRB members may leave the Board unable to conduct reviews if the psychiatrist was not available. Whilst the preferred person should be a child and adolescent psychiatrist there needs to be other options if this type of specialist is not available

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.

ACCEPTED.

Comment: ECT is recognised as an effective treatment however this recommendation reflects community concern about the unregulated use of ECT with minors. While permitting the use of the treatment the caveats suggested by the recommendation will ensure that it is used appropriately and with the decision being confirmed by an expert in the area. If the psychiatrist prescribing the treatment is a Child and Adolescent Psychiatrist the confirming second psychiatrist need not have that specialty background.

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

ACCEPTED.

Comment: There is limited evidence that ECT would be beneficial for children under the age of 12 and community concern would indicate that ECT for children under 12 should be prohibited.

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 specialised training for that role;

ACCEPTED

- require that for every minor (child, adolescent or competent minor) admitted to psychiatric inpatient care in a hospital (whether an authorised 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;

PARTIALLY ACCEPTED.

Comment: Mature minors may decide that they wish no involvement with parents, guardians or youth advocates and if competent to make decisions they may exercise that right. With adolescents and children it is imperative that either parents or guardians are involved. A Youth Advocate may additionally offer their services.

- 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;

ACCEPTED.

- require that if a minor (child, adolescent or competent minor) is received at an authorised hospital, or admitted to any other form of psychiatric inpatient care, they must be visited by a youth advocate as soon as practicable;

ACCEPTED.

Comment: The decision to involve a Youth Advocate should ultimately lie with the mature minor, the child or adolescent or the parent or guardian. As with the COV a patient should have the right not to involve a Youth Advocate in their care. As part of the treatment plan a psychiatrist may suggest the involvement of a Youth Advocate but the choice as to whether the services of a Youth Advocate are accessed lies with the patient, his or her parents or guardians.

- 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;

PARTIALLY ACCEPTED.

Comment: The role of the Youth Advocate should be similar to that of an Official Visitor. Although they may have training in the role the Youth Advocate may not have the degree of expertise to assist the treating team in making decisions regarding treatment and discharge planning. As an advocate they may present to the team the views of the patient and assist the patient in understanding the reasons for particular treatment approaches. It is not the purpose of the role to be another health worker or member of the treating team. The role is confined to the principles of advocacy. If social work intervention is required a social worker with those appropriate skills should be appointed. If referral is necessary for welfare considerations then that referral should be to the Department of Community Development. The role as described by this recommendation requires further review.

- state that a youth advocate is not a legal guardian of a minor.

ACCEPTED.

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.

ACCEPTED.

Comment: Avenues of complaint for consumers and carers constitute sound customer practice and result in improvement to the quality of the service 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:

- authorised 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.

ACCEPTED.

Comment: It is essential that each service have a transparent, detailed policy and procedure to manage complaints. Part of that policy needs to consider the monitoring and evaluation of the complaints management. Regular audits by the service are required to ensure that quality issues are advanced.

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.

PARTIALLY ACCEPTED.

Comment: The restriction that the Office of Health Review manages complaints regarding the failure to recognise the rights given by the Act is limiting to consumers. Consumers may choose to have this type of complaint investigated by the Office of Health Review because that Office may be viewed as more independent than other complaints bodies within the Department of Health. The Office of Health Review may consult with other bodies in their investigation but consumers should have the right to take their complaint to the complaints body of their choice.

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 recognise 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.

ACCEPTED.

Comment: Further discussion is required with the SAT as to the appropriateness of certain of these recommendations.

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 authorised 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.

ACCEPTED.