MENTAL HEALTH BILL 2013:

Explanatory Memorandum

Outline

An important stage in the mental health reform agenda in Western Australia is the introduction of the Mental Health Bill 2013. It is intended that the Mental Health Bill 2013 (referred to in this document as 'the Act') repeal and replace the *Mental Health Act 1996* (the 1996 Act).

This part of the reform agenda involves the overarching purposes of bringing the mental health legislation into line with current community expectations; codifying good practice from an Australian and international perspective; and to further emphasise the importance of human rights, particularly given that Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities (2006). In relation to the importance of human rights it is important to note that a human rights approach requires transparency whenever human rights are limited by the State – a fundamental aspect reflected throughout the Act.

The Act primarily involves treatment, care, support and protection of a very small number of people experiencing mental illness – people who are so unwell that their behaviour becomes a risk to themselves or another person, to the extent that they need to be detained in hospital to be provided with treatment, or to be involuntarily treated whilst living in the community. Importantly, the Act also provides for recognition of the important roles of families and carers in providing care and support to people experiencing mental illness. The Act provides clinicians with clarity and certainty as to their powers and duties; particularly in areas in relation to which the 1996 Act is silent.

Whilst the Mental Health Bill 2013 will repeal the 1996 Act, there will also be a related Bill, shortly to be introduced, which is intended to be read cognately, that makes consequential amendments to various connected legislative provisions, provides for transitional provisions and makes some minor amendments to the 1996 Act to cover the period until this Bill becomes operational and replaces the 1996 Act.

Long title

The long title is a formal description of the purposes of the Act, as denoted in the introduction.

Part 1 Preliminary matters

Clause 1 sets out how the Act may be cited.

Clause 2 sets the dates for commencement of *clauses1-2* of the Act, being the date upon which the Act receives Royal Assent. The remainder of the Act will commence on a day fixed by proclamation. This will allow time for the implementation process, which includes establishment of new bodies; preparation of guides, pamphlets and forms; and education and training for clinicians.

Clause 3 states that the Act binds the State and, to the extent permitted, the Crown.

Part 2 Terms and concepts

Division 1 - Definitions and notes

Clause 4 governs how terms and concepts used in the Act are to be interpreted and applied. These terms are central to understanding the Act, and must be read in conjunction with those defined in various other provisions throughout the Act – that is, the contrary intention may appear in a particular provision. One of the terms used is 'mental health service'. Firstly, a hospital is a mental health service to the extent that it provides treatment (pursuant to the definition of treatment in *clause 4*) to people who have or may have a mental illness. A hospital means an authorised hospital or a general hospital. An authorised hospital is defined in *clause 537*, but essentially means a hospital that can detain and treat involuntary patients. A general hospital is defined in *clause 4* and, importantly, this definition includes private psychiatric hospitals that are not authorised hospitals, and public hospitals and parts of public hospitals which accept voluntary inpatients, amongst others. That is, duties created throughout the Act extend beyond staff at authorised hospitals. Secondly, a community mental health service means a service that conducts assessments or examinations for the purposes of the Act or provides treatment in the community, but does not include the private practice of a medical practitioner or mental health practitioner. Finally, a service, or any service in a class of service, may be prescribed in the Regulations for the purposes of the definition of mental health service. To clarify, *clause 4* states that a mental health service does not include a private psychiatrist, hostel or a declared place as defined in section 23 of the *Criminal Law (Mentally Impaired Accused) Act 1996*. Some provisions in the Act specifically state that the term mental health service, for the purpose of specified provisions, includes private psychiatrist hostels. Declared places are excluded on the basis that the Act is not intended to govern service delivery in declared places; however this does not purport to limit the ability of treatment, care and support to be provided to people experiencing mental illness who are residents of declared places. Another term defined in *clause 4* is 'treatment'. Treatment means the provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with other interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness, and does not include bodily restraint, seclusion or sterilisation. This broad definition encourages a holistic approach to treatment, capturing a range of ways of facilitating recovery. However, the ability to provide some of these treatments to a resistant patient will of course be difficult. The definition of treatment, whilst excluding interventions and sterilisation, does include electroconvulsive therapy (ECT) and psychosurgery. It is noted that there are more stringent safeguards in Part 14 of the Act in relation to treatments that are, or are seen to be, more intrusive than other treatments such as

oral or intramuscular medication. The reason that bodily restraint and seclusion are expressly referred to in *clause 4* is because the scope of the ability to use these interventions is inherently different to treatments. It is envisaged however that bodily restraint and seclusion may have therapeutic value in some circumstances, such as reducing external stimuli causing distress, or preventing deliberate self harm. The reason that sterilisation is expressly referred to in *clause 4* is to remove any doubt as to whether or not sterilisation can be performed pursuant to the Act. The Act itself does not have the power to prohibit sterilisation under other written laws however it expressly provides that sterilisation cannot be performed under the Act. It is important to note the provision in the definition of treatment in *clause 4* in relation to treatment to alleviate or prevent the deterioration of a condition that is a consequence of mental illness. It is intended that this include short term side effects of treatment for mental illness, such as an adverse reaction to a medication or combination of medications; and conditions suffered by a person because of their mental illness, for example due to self harm. It is envisaged that it could in some circumstances include intravenous feeding of a person with an eating disorder or catatonia, for example. A sufficient nexus between the mental illness and the condition is required, and it is not intended that this cover, for example, longer term conditions caused by treatment for mental illness, such as low blood pressure or high cholesterol. It is a matter for clinical judgment and where there is doubt it would be appropriate for the medical practitioner to seek to obtain informed consent from the patient or the person authorised by law to consent on the patient's behalf. In more urgent circumstances, *clause 242* in relation to the provision of urgent non-psychiatric treatment can be relied upon.

Clause 5 clarifies that a note or example located in the text is provided to assist understanding and does not form part of the Act.

Division 2 - Mental illness

Clause 6 sets out the broad circumstances in which a person is said to be experiencing mental illness, for the purposes of the Act, at that point in time. A person must not be considered to have a mental illness merely by reason of one or more circumstances listed in subclause (2) being present. However, the presence of one or more of the listed circumstances does not prevent a person from being considered to have a mental illness. The intention is to ensure that only those people with a mental illness for whom the application of the Act may be appropriate are brought within the scope of the Act. The list of circumstances also ensures that persons falling within one or more of the circumstances are not inadvertently diagnosed with a mental illness (and made subject to potentially unwarranted treatment or detention) when exhibiting behaviours which may in fact be due to life choices, for example; whilst still ensuring that people who require treatment, care and support are not overlooked. For

example, a person may have been provided with treatment or care for mental illness in the past (being one of the listed circumstances), but this alone, or in combination with other circumstances listed in subclause (2), is not enough to find that the person is experiencing mental illness now. To that end, the inclusion of intellectual disability and use of alcohol or other drugs on the list of circumstances is not intended to imply that a person who has an intellectual disability or is using alcohol or other drugs cannot also be considered to have a co-occurring mental illness, or that such people are ineligible to access mental health services. The Act emphasises the need for effective treatment, care and support where a person has co-occurring needs. To clarify, dementia may constitute a mental illness if the requirements in subclause (1) are met. *Clause 6* also states that a decision as to whether or not a person has a mental illness must be made in accordance with the internationally accepted standards prescribed in the Mental Health Regulations. These will initially include the American Psychiatric Association's Diagnostic and Statistical Manual V and the World Health Organization's International Classification of Diseases 10. It is noted that internationally accepted standards are currently undergoing revision and accordingly the title of the publications may change prior to the Act coming into operation.

Division 3 - Best interests of a person

Clause 7 relates to circumstances in which a person or body is required to decide what is or is not in the best interests of a person. This principle is primarily retained for people who lack capacity. The Act leaves 'best interests' as a matter for clinical judgment, but the person or body must consider the person's wishes, to the extent that it is practicable to ascertain those wishes; the views of the person's personal support persons; and any other matter the person or body considers relevant to making the decision. *Clause 4* defines 'personal support person' as a person referred to in the relevant part of *clause 7*. The personal support persons listed in *clause 7* are, in relation to an adult, a guardian, enduring guardian, carer, close family member or nominated person; or in relation to a child, a parent, guardian, carer, close family member or nominated person. A parent or guardian of a child is the person who has parental responsibility (as defined in section 68 of the *Family Court Act 1997*) for the child, as stated in *clause 4*. Where a person has a guardian or enduring guardian, best practice would be for the relevant clinician to sight the guardianship order to ensure that the person has authority in relation to treatment decisions, and file a copy of the guardianship order or the enduring power of guardianship.

Division 4 - Wishes of a person

Clause 8 relates to circumstances in which a person or body is required to ascertain a person's wishes. Wishes may be contemporaneous, or they may be expressed in an adult's advance health directive (AHD) or enduring power of guardianship (EPG). A

child may not make an AHD or EPG. An AHD may be in any of the forms described in *clause 4.* To clarify, a directive made under the common law may be written or verbal. The person or body may consider anything else that they consider to be relevant to ascertaining the person's wishes. The terminology used in the Act is 'wishes' of a person, generally the patient; and 'views' of other persons, for example personal support persons.

Division 5 - Communicating with a person

Clause 9 requires any communication under the Act to be in a language, form of communication and terms that the person is likely to understand, using any means of communication that is practicable and using an interpreter if necessary and practicable. Some of the things that this applies to are provision of any advice, explanation, information, notification or reasons. Further, it is intended that a person's circumstances will be taken into account, for example where they are more distressed than usual or where they are highly sedated. In such circumstances the communication should take into account that the person's ability to comprehend information will fluctuate and information should be provided again later, unless the time for doing so has passed.

Part 3 Objects

Clause 10 sets out a comprehensive list of Objects, to which a person or body performing a function under the Act must have regard. The Objects underpin how the provisions in the Act are to be interpreted and applied. Specifically, in relation to subclause (1), (a) which refers to ensuring people who have a mental illness are provided with the best possible treatment and care emphasises the importance of providing a person experiencing mental illness with what they need to recover, but only with the least possible restriction of their freedom, the least possible interference with their rights, and with respect for their dignity. This is consistent with international human instruments which require treatment and care to be provided in the least restrictive environment consistent with the patient's circumstances at the time. Objects (b) and (c), in relation to families, carers and nominated persons, recognise that support persons are presently often excluded from the treatment, care and support of people experiencing mental illness, and that their awareness and involvement, in most cases, will contribute to the person's recovery. Object (d) acknowledges that mental illness, and receiving treatment for mental illness, whether that be in detention or in the community, undoubtedly impacts on family life, particularly the care of children and other dependants. Object (e) relates to protection of people who have or may have a mental illness in terms of protecting these people who can be particularly vulnerable, from abuse and violation of their rights. Object (e) is intended to operate alongside Object (f). That is, protection of the people who have or may have a mental illness, and protection of the community. Both must be balanced with Object (a) in relation to the least possible restriction, least possible interference with rights, and with respect for dignity.

Part 4 Charter of Mental Health Care Principles

Clause 11 provides a statutory basis for Schedule 1, the Charter of Mental Health Care Principles (the Charter). The clause requires a person or body performing a function under the Act to have regard to the Charter. The Charter is an aspirational document, where compliance can only be measured subjectively, and therefore appears in a Schedule to the Act rather than the body of the Act.

Clause 12 requires mental health services, which for the purposes of this clause includes private psychiatric hostels, to make every effort to comply with the Charter when providing treatment, care and support to patients.

Part 5 Decision making capacity and informed consent

Division 1 - Decision making capacity generally

Division 1 relates to decision making capacity for the purposes of the Act generally. For example, a person's decision regarding admission, or a voluntary patient's decision regarding discharge, or a patient's decision as to whether or not to involve a personal support person in treatment and care. Division 1 sets out the determinants of decision making capacity.

Clause 13 relates to an adult making a decision about a matter with respect to himself or herself. The Act creates a presumption that an adult has decision making capacity, unless shown not to have that capacity. Whether an adult has the requisite capacity to make a decision under the Act is a decision for the person or body making a determination under *clause 15.* Where an adult does not have decision making capacity, there can be reliance on any AHD; or a guardian or an enduring guardian with capacity may make the decision on their behalf. It is noted that there is nothing preventing a person or the person who gave consent on their behalf from withdrawing consent, as is the case throughout the Act where informed consent was required and provided.

Clause 14 relates to decisions made in relation to a child. The Act does not stipulate a minimum age at which a child (a person under the age of 18) may make a decision pursuant to the Act. The Act creates a presumption that a child does not have decision making capacity, unless shown to have that capacity. This takes account of different levels of maturity and developmental stages, and reflects the common law competent minor principle. Whether a child has the requisite capacity to make a decision under the Act is a decision for the person or body making a determination under *clause 15.* Where a child does not have decision making capacity, a parent or guardian with capacity may make the decision on their behalf. In relation to a parent, the intention is to provide authority for a parent to provide consent for a child who lacks decision making capacity generally. The intention is not to compel a parent to provide informed consent, nor is it to prevent consent from being obtained from both parents. If one parent provides informed consent there is nothing preventing them from withdrawing that consent; however, if two parents provide informed consent and one parent withdraws consent the withdrawal will be ineffective.

Clause 15 is a threshold test in that it sets out the requirements for a person to be considered to have capacity to make decisions under the Act that are not treatment decisions. The intention is to require decision makers to consider whether or a not a person who is being asked to make a treatment decision understands the nature and consequences of the decision they are being asked to make. If an adult does not meet

the requirements in *clause 15,* then the presumption in *clause 13* is rebutted in relation to that adult, ie they do not have decision making capacity. If a child does meet the requirements in *clause 15* then the presumption in *clause 14* is rebutted in relation to that child, ie they do have decision making capacity. *Clause 15* also requires that a person's decision be made freely and voluntarily.

Division 2 - Informed consent to treatment

Division 2 sets out safeguards in the process by which a person with capacity to make a treatment decision may give informed consent to treatment. The intention is that people should make their own decisions wherever possible and, if they need help, they should be provided with the support that they need to make decisions. That is, a treatment decision may be made by a substitute decision maker where a valid contemporaneous decision cannot be made (and where there is no relevant treatment decision in a person's AHD).

To clarify, Division 2 is about a person's decision whether to accept or refuse treatment in general, in addition to whether or not to accept or refuse a particular proposed treatment; for example, a voluntary patient choosing whether or not to take a particular medication or to receive ECT. It applies not only to persons to whom it is proposed to provide treatment, but also to their substitute decision makers; for example a parent of a child deciding whether to consent to a particular treatment for their child who does not have capacity to make a treatment decision for themselves.

Clause 16 sets out the requirements for a person to be considered to have given informed consent, whether that is a person to whom it is proposed that treatment be provided, or a substitute decision maker. It also makes clear that consent is only valid if it is free and voluntary and is active consent rather than a mere failure to offer resistance.

Clause 17 governs who can provide informed consent in relation to a particular treatment decision. Firstly, a patient with capacity may give informed consent at that particular point in time or they may have given prior informed consent at a time when they had capacity, in the form of an AHD. Alternatively, where the person does not have capacity to make a treatment decision for themselves, another person may make the decision on that person's behalf. The persons who can make a treatment decision on the other person's behalf are, in relation to an adult, a guardian or an enduring guardian with the authority to make treatment decisions; and, in relation to a child, the child's parent or a guardian with authority to make treatment decisions.

Clause 18 sets out the requirements under Division 2 for a person to be considered to have capacity to make a treatment decision at the point in time where the person is being asked to make a treatment decision (recognising that capacity can fluctuate

below the level necessary to make a particular decision at the relevant time). *Clause 18* applies to persons to whom it is proposed to provide treatment, and extends to substitute decision makers. A person can only make a decision in relation to themselves or another person if they meet the requirements set out in *clause 18*, in addition to being the person's substitute decision maker. *Clause 18* is slightly different from *clause 15* to incorporate the more specific nature of a treatment decision, *clause 18* requires a person to positively demonstrate the capacity to make a treatment decision. The intention is to require decision makers to consider whether or a not a person who is being asked to make a treatment decision understands the nature and consequences of the decision they are being asked to make.

Clause 19 emphasises the importance of the content of the information provided to a person in order for them to make a treatment decision; and the importance of quality communication with the person. It requires a thorough and coherent explanation of proposed treatment to be given before informed consent can be considered to have been obtained. *Clause 19* applies to persons to whom it is proposed that treatment be provided, and substitute decision makers. One of the requirements is that the person be given sufficient information to enable the person to make a balanced judgment about the treatment. The amount of information to be given is largely a decision for the person providing the information, and would depend on the nature of the treatment. For example more information would need to be given in relation to a treatment decision about whether to consent to ECT than in relation to a small dose of a mild antidepressant. Subclause (3), which states that subclause (1) applies despite any privilege claimed by a person, emphasises the legal requirement for clinicians, particularly psychiatrists and other medical practitioners, to provide adequate information before seeking consent.

Clause 20 promotes a supported decision making approach, requiring that persons making a treatment decision for themselves or another person be given sufficient time to consider the matters involved in making a treatment decision. It extends to requiring a person making a treatment decision being given a reasonable opportunity to discuss matters with the medical practitioner or other health professional who is proposing the treatment, and a reasonable opportunity to obtain any other advice or assistance in relation to the treatment decision that the person wishes. *Clause 20* promotes two-way communication between persons making treatment decisions and clinicians proposing the provision of the treatment. Persons making treatment decisions should be encouraged to ask questions, disclose priorities, and express concerns material to them, and have these issues addressed by the person proposing the provision of the treatment both orally and in writing. Best practice would require that, where a substitute decision maker is making a treatment decision on behalf of a

person, that person must be involved in the conversation to the extent that that is possible.

Part 6 Involuntary patients

Division 1 - When a person will be an involuntary patient

Clause 21 defines an involuntary patient to be a person on an involuntary treatment order, which may be an inpatient treatment order or a community treatment order (CTO).

Clause 22 describes an inpatient treatment order and identifies provisions in the Act under which an inpatient treatment order may be made. An inpatient treatment order allows detention of a person at either an authorised hospital or a general hospital.

Clause 23 describes a CTO and identifies the provisions in the Act under which a CTO may be made. A CTO allows a person to be provided with treatment in the community without a requirement for informed consent. 'Treatment in the community' is defined in *clause 4* to mean treatment that can be provided to a patient without detaining the patient at a hospital under an inpatient treatment order.

Clause 24 sets out the requirements that must be met for an involuntary treatment order to be made. Only a psychiatrist may make an involuntary treatment order, recognising the specialist training and skills of a psychiatrist and the restrictive nature of an involuntary treatment order. A psychiatrist can only make an involuntary treatment order in accordance with the Act, which incorporates requirements such as the psychiatrist conducting an examination in accordance with Division 3, for example. The psychiatrist must consider the criteria in *clause 25* in deciding whether or not a person is in need of an involuntary treatment order. *Clause 24* is consistent with the Objects of the Act in *clause 10*, including the least restrictive means of providing treatment and care with the least interference with their rights. An involuntary treatment order must be in force as brief a period as practicable; be reviewed regularly; and be revoked as soon as practicable after the person no longer meets the criteria for the order in *clause 25*. The term 'as soon as practicable' as used here and in numerous other clauses in the Act is intended to provide workability and flexibility; however, there are mandated maximum timeframes against which compliance can be measured objectively.

Clause 25 delineates the criteria for involuntary treatment orders, and separates the criteria for inpatient treatment orders as distinct from CTOs. It is essential that there be clear, objective and consistent criteria in relation to when an involuntary treatment order can lawfully be made. The criteria for making an inpatient treatment order are of a higher threshold than for making a CTO, reflecting the more restrictive nature of an inpatient treatment order. Subclause (1) relates to inpatient treatment orders. The first requirement is that the person has a mental illness for which the

person is in need of treatment. Whether or not a person has a mental illness is determined under *clause 6*. This criterion is included to ensure that an involuntary treatment order is made only with respect to persons for whom the powers under the Act are appropriate. Secondly, there is a requirement for risk as a result of the mental illness. There must be a significant risk to the health or safety of the person or to the safety of another person; or a significant risk of serious harm to the person or another person. The concept of 'serious harm' is not detailed in the Act itself because it must be determined by a psychiatrist on a case by case basis, using the appropriate clinical tools. As examples, the harm may be to property, finances, reputation, or relationships. The intention is to balance the need for intervention with the need to ensure that only those persons for whom the mechanisms available under the Act are needed are placed on an involuntary treatment order, given the extent to which an involuntary treatment order may infringe on the rights of the person subject to the order. Thirdly the person must not have the capacity required by *clause 18* to make a treatment decision about the provision of treatment to himself or herself or, alternatively, the person must have unreasonably refused treatment. A person may have capacity but, in the clinical judgment of the psychiatrist, unreasonably refuse treatment that the psychiatrist considers to be essential. There is a requirement that treatment in the community cannot reasonably be provided to the person, which may be for reasons such as geographical location or extreme resistance to compliance with a treatment regime. Finally in relation to inpatient treatment orders there is a requirement the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order. Again, this incorporates the Objects of the Act expressed in *clause 10*. Subclause (2) sets out the criteria for the making of a CTO. The requirement for a mental illness for which the person is in need of treatment is the same as for an inpatient treatment order. The requirement for risk is broadened to include a significant risk of the person suffering serious physical or mental deterioration, promoting earlier intervention. The requirement around incapacity or unreasonable refusal is the same. Treatment in the community needs to be reasonably able to be provided to the person. The final requirement in relation to a CTO is that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a CTO. *Clause 25* also states that a decision whether or not a person is in need of an inpatient treatment order or a CTO must be made having regard to the Chief Psychiatrist's guidelines under *clause 543*. *Clause 25* notes that the Mental Health Tribunal reviews involuntary treatment orders.

Division 2 - Referrals for examination

Prior to a psychiatrist determining whether or not a person needs to be made an involuntary patient, there needs to be an assessment and a referral for examination. There may also need to be detention for assessment, a transport order, and detention for examination, depending on the person's resistance and other individual circumstances.

An examination has more stringent requirements than an assessment (conducted by a medical practitioner or authorised mental health practitioner (AMHP)), because an assessment is an initial stage in potentially protecting the person and/or the community, and other more stringent safeguards must be met before an involuntary treatment order may be made. Medical practitioners and AMHPs are often the first health professionals contacted by relatives or other concerned persons.

An assessment may be conducted, and a referral may be made, by a medical practitioner, who may or may not be a psychiatrist, or by an AMHP. An AMHP is a registered nurse, psychologist, occupational therapist or social worker with at least three years' experience in the management of people with mental illness, authorised by the Chief Psychiatrist.

It is noted that even if the assessment is completed by a psychiatrist, there still needs to be a referral and the examination needs to be conducted by a different psychiatrist.

The terms 'assessment' and 'examination' are explained below.

Clause 4 provides that a voluntary patient is a person to whom treatment is being, or is proposed to be, provided by a mental health service but who is not an involuntary patient or a mentally impaired accused required under the *Criminal Law (Mentally Impaired Accused) Act 1996* to be detained at an authorised hospital (referred to in this document as 'mentally impaired accused' unless stated otherwise). Therefore, referred persons are voluntary patients for the purposes of the Act. *Clause 4* also notes that a mentally impaired accused who is released from an authorised hospital (whether unconditionally or on conditions) under a release order made under section 35 of the *Criminal Law (Mentally Impaired Accused) Act 1996* can also be a voluntary patient for the purposes of the Act.

Subdivision 1: Person suspected of needing involuntary treatment order

Clause 26 provides for a referral for examination at an authorised hospital or other place of a person in relation to whom a medical practitioner or AMHP reasonably suspects that an involuntary treatment order is needed; or an involuntary community patient in relation to whom a medical practitioner or AMHP reasonably suspects that

an inpatient treatment order is needed. It does not apply to a voluntary inpatient in an authorised hospital or to a person on an inpatient treatment order. A referral to a place that is not an authorised hospital can only be made where the referring practitioner believes that it is an appropriate place to conduct the examination, having regard to the guidelines published by the Chief Psychiatrist under *clause 543*, and where the referring practitioner has made any arrangements that are necessary for the examination to be conducted at that other place. Examples of where this may occur are where a medical practitioner or AMHP working in a hospital or in the community could refer a person for an examination at an emergency department, general hospital, or community mental health service.

Clause 27 requires a referred person to be taken to the specified authorised hospital or other place as soon as practicable and, in any event, before the referral expires. In a metropolitan area a referral lasts 72 hours from the time it was made, pursuant to *clause 44*. Outside a metropolitan area a referral may be extended in accordance with *clause 45*. The length of the referral is up to 72 hours (or the extended period) whether or not a transport order is made in respect of the person. That is, any transport order must be undertaken before the referral expires. Timeframes are included throughout the Act to ensure timeliness of functions and powers being carried out, and to ensure accountability where the timeframe is not achieved.

Clause 28 allows for an order for detention to enable a person to be taken to an authorised hospital or other place. Such an order can only be made by a medical practitioner or AMHP, and only in circumstances where the practitioner is satisfied that, because of the person's mental or physical condition, the person needs to be detained to enable the person to be taken to the authorised hospital or other place. This new approach, enshrining what is now done in reliance on a duty of care, creates certainty and clarity for decision makers as to the limit of their powers and, most importantly, protects referred persons from indeterminate detention. The detention order can be made for a period of up to 24 hours. Before the 24 hours is due to expire, a medical practitioner or AMHP who assesses the person in accordance with Subdivision 4 may order a further period of detention of up to 24 hours where, as a consequence of the assessment, the practitioner is satisfied that, because of the person's mental or physical condition, the person still needs to be detained to enable the person to be taken to the authorised hospital or other place. This process can be repeated one more time. That is, a person cannot be detained under orders made pursuant to *clause 28* for a continuous period of more than 72 hours. There is nothing preventing an order made under *clause 28* from being made by a different practitioner from the practitioner who made the order under *clause 26*, recognising the practice issues that arise (this applies throughout the Act, unless specified elsewhere). An order made under *clause 28* comes with procedural requirements and

other safeguards to ensure accountability, transparency, protection and good outcomes for the referred person. One of safeguards is that the practitioner who made the order under *clause 28* must ensure that the person has the opportunity and means to contact any personal support person and the Chief Mental Health Advocate as soon as practicable after the order is made and at all reasonable times while the person is detained under the order. Where the period for detention that is authorised under *clause 28* ends and the person has not been either apprehended under a transport order made under *clause 29*, or taken to an authorised hospital or other place, the person cannot continue to be detained – that is, the person must be allowed to leave. As with orders made under the Act limiting a person's rights, an order made under *clause 28* must be made in the approved form and must include the reasons for making the order, amongst other things. The making of an order under *clause 28* is a notifiable event. That is, Part 9 requires reasonable efforts to be made to notify at least one of the person's personal support persons, subject to a best interests exception.

Clause 29 allows a medical practitioner or AMHP to make an order to transport a referred person to the specified authorised hospital or other place. Other clauses in the Act related to different situations require a transport order to be made by a psychiatrist; however, at referral stage, the person is not under the care of a psychiatrist. Such an order can only be made where the practitioner is satisfied that, because of the person's mental or physical condition, the person needs to be taken to the authorised hospital or other place; and no other safe means of taking the person is reasonably available. Transport orders are dealt with in more detail in Part 10. The making of a transport order under *clause 29* is a notifiable event.

Clause 30 sets out the effect of a referral on a CTO. A CTO is suspended during the period of a referral order, primarily so that a psychiatrist can determine whether an inpatient treatment order would be more appropriate, and because a person may not be able to comply with a CTO whilst they are on a referral and would otherwise be considered to be in breach. *Clause 30* has relevance in ensuring that a patient is not subject to both a referral order and a CTO at any one time, avoiding separate conflicting processes.

Clause 31 allows a medical practitioner or AMHP to make an order revoking a referral under *clause 26* if satisfied that the referred person is no longer in need of an involuntary treatment order. This could be done at any stage in the referral process. Where the medical practitioner or AMHP is not the practitioner who made the referral order, the medical practitioner or AMHP must consult with the prior practitioner about whether or not to revoke the referral, unless reasonable efforts have been made to contact the other practitioner and that other practitioner could not be

contacted. This clause, as well as other clauses throughout the Act, requires consultation as opposed to an agreement between the two practitioners, because the subsequent practitioner may be in a better position to make a decision to revoke the referral order. The consultation will give the referring practitioner the opportunity to express their views; however, in line with the principle of least restriction, a referral order may still be revoked. There are procedural requirements following a decision to revoke a referral order, including giving a copy of the revocation to the previously referred person. The revocation of a referral order under *clause 31* is a notifiable event.

Subdivision 2: Voluntary inpatient admitted by authorised hospital

Clause 32 states that Subdivision 2 applies to a voluntary inpatient who is admitted by an authorised hospital.

Clause 33 sets out the effect of admission as a voluntary inpatient in an authorised hospital on a CTO. A CTO is suspended during the period of admission as a voluntary inpatient in an authorised hospital. The position stated in *clause 33* is in line with the *clause 4* definition of treatment in the community and the criteria in *clause 25*. A CTO can only be made if treatment in the community can reasonably be provided to the person, and treatment in the community means treatment that can be provided to a patient without detaining the patient at a hospital under an inpatient treatment order. To clarify, a CTO remains in force whilst a person is a voluntary inpatient at a general hospital, including a private or public psychiatric hospital. Further, CTOs are not suspended when a person becomes a resident at a private psychiatric hostel, because the definition of mental health service in *clause 4* excludes private psychiatric hostels.

Clause 34 applies where a voluntary inpatient admitted by an authorised hospital wants to leave the authorised hospital against medical advice and the person in charge of the ward, having regard to the criteria in *clause 25*, reasonably suspects that the voluntary inpatient is in need of an involuntary treatment order. The person in charge of the ward may make an order that the voluntary inpatient be assessed by a medical practitioner or AMHP. The patient can be detained at the authorised hospital for up to six hours from the time when the order was made for that assessment to be conducted. During this time the person must be given the opportunity and means to contact personal support persons and the Chief Mental Health Advocate. The assessment must be conducted in accordance with Subdivision 4. Various safeguards are in place, in line with those in *clause 28*. The patient must be allowed to leave if, by the end of the six hour period, the assessment has not been completed, or the assessment has been completed but a referral has not been made in respect of the patient.

Clause 35 allows the person in charge of the ward who made an order under *clause 34* to revoke the order before the assessment is conducted, if satisfied that the patient is no longer in need of an involuntary treatment order. At this point the patient can no longer be detained.

Clause 36 applies where a voluntary inpatient has been assessed by a medical practitioner or an AMHP at an authorised hospital (either because of an order for assessment made under *clause 34*, or in the course of the voluntary inpatient's treatment while admitted by the authorised hospital). The medical practitioner or AMHP can refer the patient to a psychiatrist at that authorised hospital for an examination if the practitioner reasonably suspects that the patient is in need of an involuntary treatment order, having regard to the criteria in *clause 25*. The requirements for referral in Subdivision 3 apply in relation to the referral.

Clause 37 allows a medical practitioner or AMHP to revoke a referral in relation to a voluntary inpatient if satisfied that the patient is no longer in need of an involuntary treatment order. The voluntary inpatient is then allowed to leave. Where the medical practitioner or AMHP is not the practitioner who made the referral order, the medical practitioner or AMHP must consult with the prior practitioner about whether or not to revoke the referral, unless reasonable efforts have been made to contact the other practitioner and that other practitioner could not be contacted.

Subdivision 3: Requirements for referral

Clause 38 states that Subdivision 3 applies where a medical practitioner or AMHP has made a referral under *clause 26* or *clause 36* for a person to be examined by a psychiatrist.

Clause 39 states that a practitioner can only make a referral after assessing a person and that Subdivision 4 applies in relation to an assessment.

Clause 40 sets out the maximum period of time that may elapse between an assessment being conducted and a referral being made. In relation to a person who is not a patient in an authorised hospital, the maximum period of time is 48 hours. In relation to a voluntary inpatient in an authorised hospital, the assessment must have been conducted immediately before the referral is made.

Clause 41 requires a referral to be in the approved form and lists what is required in that form, including reasons for making the order. The form must distinguish between information obtained during the assessment by the referring practitioner and any information obtained from another person or from the person's medical record.

Clause 42 requires the practitioner who makes a referral to provide the information in the form under *clause 41* to the referred person. However, the practitioner does not have to provide information that was provided by someone other than the referred person where the person who provided the information to the practitioner provided it on the condition that the information would not be provided to the person being assessed.

Clause 43 requires the practitioner who makes a referral to put the document on the person's medical record, in line with the definition of 'file' in *clause 4*.

Clause 44 applies to a referral made under *clause 26*. The referral can remain in force for up to 72 hours from the time when it was made, subject to it being extended in accordance with *clause 45*.

Clause 45 relates to referrals that are made outside of a metropolitan area. Such a referral can be extended by 72 hours beyond the length of time specified in *clause 44*, but cannot be extended more than once. That is, the maximum length of a referral (including the extension) is six days. The referral can only be extended where the person responsible for taking the referred person to the place where the examination will be conducted forms the opinion that the referral is likely to expire before the person is received into the hospital or other place. The person responsible for taking the referred person to the place where the examination will be conducted may orally request an extension of the referral from the persons listed in *clause 45* or, if they are a medical practitioner or AMHP themselves and there is no other medical practitioner or AMHP reasonably available, they may extend the referral themselves. *Clause 45* recognises the practical difficulties associated with providing treatment, care and support to persons in rural and remote areas in Western Australia, and these difficulties are partially overcome by the use of audiovisual means described below.

Clause 46 also recognises practical difficulties involved in taking a person to a place for examination, by allowing a medical practitioner or AMHP to make an order changing the place specified in a *clause 26* referral in relation to where the examination will be conducted. The practitioner must first consult with a medical practitioner or AMHP at the place where, if the change is made, the examination will be conducted. Further, if the place for examination in a referral is an authorised hospital, the referral may be changed to take the person to another place. Alternatively, if the place for examination in a referral is a place other than an authorised hospital, the referral may be changed to take the person to an authorised hospital.

Subdivision 4: Conduct of assessment

Clause 47 states that Subdivision 4 applies in relation to the conduct of an assessment by a medical practitioner or AMHP that is required by, or has been ordered under, the specified clauses.

Clause 48 describes an assessment. It must be conducted in the least restrictive way, and least restrictive environment, practicable. Unless the assessment is being conducted by audiovisual means, the practitioner and the person must be in one another's physical presence or, if that is not practicable, be able to hear one another without using a communication device. For example, when a person refuses entry to their home and the practitioner is not able to actually see the person but is able to hear and communicate with the person through a door. *Clause 48* enables assessments using audiovisual means in some circumstances. Firstly, the person being assessed needs to be outside a metropolitan area. Secondly, it can only be in circumstances where it is not practicable for the practitioner and the person being assessed to be in one another's physical presence or be able to hear one another without using a communication device. Thirdly, circumstances need to be such that the person and a prescribed health professional are in one another's physical presence or are able to hear one another without using a communication device. Prescribed health professionals are listed in *clause 48*. An assessment conducted using audiovisual means is taken to be conducted, and any referral made as a result of the examination is taken to be made, at the place where the person is assessed when the assessment is conducted. The use of audiovisual communication is a progressive tool with the potential to prevent unnecessary delays in providing specialist consultation, assessment and advice; prevent unnecessary delays in administering treatment to reduce risk and improve the person's condition; ensure that a person is only transferred from their community to an authorised hospital or other place where this is absolutely necessary, in accordance with Objects of the Act in relation to providing the best possible treatment and care in the least restrictive way; and to facilitate transfer and handover of care.

Clause 49 sets out the information to which the practitioner may have regard in conducting an assessment. Information obtained by the practitioner from the person, including information obtained by observing the person and asking them questions, may be considered. The practitioner may form a reasonable suspicion based on this information alone that the person is in need of an involuntary treatment order. Information from other sources may also be considered, but is not sufficient in itself for a practitioner to form a reasonable suspicion that the person is in need of an involuntary treatment order. The other sources of information which can be considered, but are insufficient in themselves, are those obtained from any other person or from the person's medical records. For example, where a person

experiencing mental illness attends a medical centre, a general practitioner, in conducting an assessment can consider information obtained by anyone who saw the person before he or she was seen by the general practitioner, and consider the person's medical records, but cannot form the requisite reasonable suspicion based on that information only, that the person is in need of an involuntary treatment order, without having conducted an assessment in person.

Clause 50 seeks to ensure that the particular needs and circumstances of patients of Aboriginal or Torres Strait Islander descent are taken into account. Assessments must be conducted in collaboration with listed groups of people, such as elders, traditional healers from the patient's community and Aboriginal mental health workers to the extent practicable and appropriate.

Division 3 - Examinations

Subdivision 1: Examination at authorised hospital

Clause 51 states that Subdivision 1 applies to a person referred to an authorised hospital for examination.

Clause 52 provides for detention of a referred person in an authorised hospital for up to 24 hours. During this time the person must be given the opportunity and means to contact personal support persons and the Chief Mental Health Advocate. Various other protections are in place, in line with those in *clause 28*. *Clause 52* clarifies that being received at an authorised hospital under that clause is not an admission. The person cannot be received into the authorised hospital if the referral has expired. The person cannot continue to be detained if, by the end of the 24 hour period, the examination has not been completed, or the examination has been completed but an order under *clause 55* has not been made in relation to the person.

Clause 53 allows a person who is referred under *clause 36* to be detained at the authorised hospital for up to 24 hours for an examination to be conducted. During this time the person must be given the opportunity and means to contact personal support persons and the Chief Mental Health Advocate. Various other safeguards are in place, in line with those in *clause 28*. The person cannot continue to be detained if, by the end of the 24 hour period, the examination has not been completed, or the examination has been completed but an order under *clause 55* has not been made in relation to the person.

Clause 54 states that Subdivision 6 applies to the conduct of examinations under *clause 52* and *clause 53*.

Clause 55 requires a psychiatrist conducting an examination to make one of the orders specified in the clause. The psychiatrist may make an inpatient treatment order at the authorised hospital; a CTO; an order for continued detention; or an order that the person cannot continue to be detained. An order for continued detention made by a psychiatrist following examination is an order that the person can be detained at the authorised hospital for a further period specified in the order, up to a further 72 hours (which cannot be repeated) from the time the person was received, to enable a further examination. This recognises that at times, due to intoxication, effects of medication, or the episodic nature of mental illness, it may not be possible for a psychiatrist to, during the examination, determine whether the person requires an involuntary treatment order. The making of an order under *clause 55* is a notifiable event.

Clause 56 states that, where an order is made under *clause 55* continuing detention for a further examination, the order is in effect until an involuntary treatment order is made following an examination; or an order is made that the person can no longer be detained; or when the 72 hour time limit expires.

Subdivision 2: Examination at a place that is not authorised hospital

Clause 57 states that Subdivision 2 applies in relation to a person referred under *clause 26* for an examination to be conducted by a psychiatrist at a place that is not an authorised hospital.

Clause 58 provides for detention of a referred person in a place other than an authorised hospital for up to 24 hours from the time when the person was received at the place. During this time the person must be given the opportunity and means to contact personal support persons and the Chief Mental Health Advocate. Various other safeguards are in place, in line with those in *clause 28*. The person cannot be received at the place if the referral has expired. The person cannot continue to be detained if, by the end of the 24 hour period, the examination has not been completed, or the examination has been completed but an order under *clause 61* has not been made in relation to the person and, if the place is outside a metropolitan area, an order continuing the person’s detention has not been made under *clause 59*.

Clause 59 allows a person to be detained for an additional 48 hours where the place for examination is outside of a metropolitan area and it is not practicable to complete the examination within the 24 hour period provided for in *clause 58*. During this time the person must be given the opportunity and means to contact personal support persons and the Chief Mental Health Advocate. Various other safeguards are in place, in line with those in *clause 28*. The person cannot continue to be detained if, by the end of the 24 hour period or if the order is extended by the further 48 hours, the

examination has not been completed, or the examination has been completed but an order under *clause 61* has not been made.

Clause 60 states that Subdivision 6 applies to the conduct of the examination. That is, the examination must be conducted in the same way whether it is at an authorised hospital or at some other place.

Clause 61 requires a psychiatrist conducting an examination to make one of the orders specified in the clause. The psychiatrist may make an order authorising the person's detention at a general hospital; a CTO; an order authorising the person's reception at an authorised hospital and the person's detention there, to enable an examination to be conducted by a psychiatrist; or an order that the person cannot continue to be detained. The psychiatrist may only make an order authorising the person's detention at the general hospital where satisfied that attempting to take the person to, or to detain the person at, an authorised hospital poses a significant risk to the person's physical health, and where the Chief Psychiatrist consents to the order being made. The requirement for the Chief Psychiatrist's consent in *clause 61* recognises capacity constraints in general hospitals and a concern that such provision may be misused. *Clause 65* creates further procedural requirements in this regard. The Chief Psychiatrist may have delegated this power to another psychiatrist under *clause 534*. The making of an order under *clause 61* is a notifiable event.

Clause 62 applies where a psychiatrist makes an inpatient treatment order under *clause 61* authorising the person's detention in a general hospital, or an order under *clause 61* authorising the person's reception at an authorised hospital and the person's detention there, to enable an examination to be conducted by a psychiatrist. A medical practitioner or AMHP may, if satisfied that because of the person's mental or physical condition the person needs to be detained to enable the person to be taken to the general hospital or authorised hospital, make an order continuing a person's detention for up to 24 hours from the time of the psychiatrist's order in *clause 61*. This can be continued for a further 24 hours following assessment by a medical practitioner or AMHP immediately before the end of the detention period. During this time the person must be given the opportunity and means to contact personal support persons and the Chief Mental Health Advocate. Various other safeguards are in place, in line with those in *clause 28*. The assessment must be conducted in accordance with Division 2 Subdivision 4. This continuation order can only be made where, following the assessment, the medical practitioner or AMHP is satisfied that because of the person's mental or physical condition the person still needs to be detained to enable the person to be taken to the hospital. This may be repeated once more, so that in total the person can be detained for not more than 72 hours under *clause 62*. The person cannot continue to be detained if, by the end of

the detention period authorised under *clause 62*, the person has not been taken to hospital; has not been apprehended under a transport order under *clause 63*; and an order continuing the person's detention has not been made or cannot be made.

Clause 63 allows the psychiatrist making an order under *clause 61* to make an order to transport the referred person to the authorised hospital or general hospital. Only a psychiatrist can make a transport order under *clause 61*. Such an order can only be made where the psychiatrist is satisfied that, because of the person's mental or physical condition, the person needs to be taken to the hospital specified in the order made under *clause 61*, and no other safe means of taking the person is reasonably available. Given that the making of an order under *clause 61* is a notifiable event, the making of a transport order under *clause 63* is not a notifiable event. That is, the personal support person will already have the information.

Subdivision 3: Inpatient treatment order authorising detention at general hospital

Clause 64 states that Subdivision 3 applies to a person who is admitted to a general hospital under an inpatient treatment order.

Clause 65 requires the treating psychiatrist of the involuntary inpatient to report to the Chief Psychiatrist every seven days. The matters to be included in the report are the involuntary inpatient's mental and physical condition; any treatment as defined in *clause 4* being provided; and any other medical or surgical treatment being provided to the involuntary inpatient. Whilst the ability for a person to be detained in a general hospital because of their physical condition recognises the realities of some mental illness, such as deliberate self harm, *clause 65* recognises the clear need for safeguards against unwarranted detention, and resource constraints in relation to all hospitals.

Clause 66 requires the involuntary inpatient to be transferred from a general hospital to an authorised hospital when attempting to take the involuntary inpatient to, or detain the involuntary inpatient at, an authorised hospital no longer poses a significant risk to the inpatient's physical health. In this situation the treating psychiatrist must make a transfer order to the authorised hospital specified in the order. Alternatively, Part 7 Division 3 allows involuntary patients to be discharged, and the patient's psychiatrist can also consider whether or not to make a CTO. The making of a transfer order under *clause 66* is a notifiable event (in addition to notifiable events detailed below in relation to Part 7).

Clause 67 relates to an inpatient with respect to whom a transfer order has been made under *clause 66*. A psychiatrist may make a transport order in respect of the inpatient where the psychiatrist is satisfied that no other safe means of taking the person is reasonably available. Given that the making of a transfer order under *clause*

66 is a notifiable event, the making of a transport order under *clause 67* is not a notifiable event.

Clause 68 relates primarily to Subdivision 6, which sets out some circumstances where an examination may be conducted by a psychiatrist without being in the physical presence of the person. *Clause 68* applies where the psychiatrist who conducted the examination for the purpose of making an involuntary treatment order and the involuntary inpatient were not in one another's physical presence at the time of the examination; and since that examination was conducted, there has been no further examination of the involuntary inpatient conducted by a psychiatrist during which the psychiatrist and the involuntary inpatient were in one another's physical presence. The examination must always be conducted in accordance with Subdivision 6. In the circumstances outlined above and detailed in *clause 68*, the inpatient treatment order must be confirmed by a psychiatrist at the authorised hospital within 24 hours of the involuntary inpatient being admitted to the authorised hospital in accordance with the transfer order. A psychiatrist cannot confirm the inpatient treatment order without examining the involuntary patient. In this situation, the involuntary inpatient and the psychiatrist must be within one another's physical presence. An inpatient treatment order made in circumstances set out in *clause 68* that is not confirmed under *clause 68* is no longer in force. The 24 hour period cannot be extended. The release of a person under *clause 68* is a notifiable event.

Subdivision 4: Order for further examination at authorised hospital

Clause 69 states that Subdivision 4 applies to a person examined at a place other than an authorised hospital, where the psychiatrist orders that they be received and detained at an authorised hospital to be examined by a psychiatrist at the authorised hospital.

Clause 70 allows a person to whom Subdivision 4 applies to be detained at an authorised hospital for up to 24 hours from the time when the person is received at the authorised hospital. During this time the person must be given the opportunity and means to contact personal support persons and the Chief Mental Health Advocate. Various other safeguards are in place for the referred person, in line with those in *clause 28*. The person cannot be received at the authorised hospital more than 72 hours after the time when the order was made under *clause 61*. The person cannot continue to be detained if, by the end of the 24 hour period, the examination has not been completed, or the examination has been completed but an order has not been made under *clause 72* in respect of the person. The 24 hour period cannot be extended. *Clause 70* clarifies that reception at an authorised hospital under that clause is not admission by the hospital under the Act. This event is not a notifiable event because the default position is that the referred person's personal support

person will already have been informed of the order for further examination pursuant to *clause 61*.

Clause 71 states that Subdivision 6 applies in relation to the conduct of an examination.

Clause 72 requires a psychiatrist conducting an examination to make one of the orders specified in the clause. Those orders are an inpatient treatment order authorising the person's detention at an authorised hospital; a CTO; or an order that the person cannot continue to be detained. The making of an order under *clause 72* is not a notifiable event because the default position is that the referred person's personal support person will already have been informed of the order for further examination pursuant to *clause 61*.

Subdivision 5: Examination without referral

Clause 73 states that Subdivision 5 applies if a person is examined without a referral having been made in relation to the particular examination.

Clause 74 states that Subdivision 6 applies in relation to the conduct of the examination.

Clause 75 gives a psychiatrist completing an examination under Subdivision 5 the discretion to make a CTO. That is, an inpatient treatment order cannot be made without a referral because, for accountability, it is considered necessary for two practitioners to be involved in the determination of whether or not a person needs to be made subject to an inpatient treatment order; and recognises the more restrictive nature of an order allowing detention. There are additional protections in respect of CTOs in *clause 76*.

Clause 76 is a safeguard in relation to *clause 75*. Because there has not been a referral by a medical practitioner or AMHP in relation to a CTO made under *clause 75*, confirmation of the CTO by another practitioner (preferably a psychiatrist, but alternatively a medical practitioner or AMHP if another psychiatrist is not reasonably available) is required within 72 hours of the CTO having been made. The order ceases to be in force if it is not confirmed by the other practitioner within the 72 hours.

Subdivision 6: Conduct of examination

Clause 77 sets out the clauses in relation to which an examination is required.

Clause 78 relates to referrals for examination at an authorised hospital or other place pursuant to *clause 26* and referrals for examination at an authorised hospital pursuant

to *clause 36*. *Clause 78* clarifies that where the referring practitioner was a psychiatrist, the examination cannot be conducted by the same psychiatrist.

Clause 79 describes an examination. It must be conducted in the least restrictive way, and least restrictive environment, practicable. *Clause 79* refers to a practitioner, in addition to a psychiatrist, because *clause 77* refers to some examinations under Part 8 in relation to CTOs, where a medical practitioner or AMHP may conduct an examination. Some of the examinations referred to in *clause 77* must be conducted with the psychiatrist or other practitioner and the person in one another's physical presence. Others can be conducted where the psychiatrist or other practitioner and the person are able to hear one another without using a communication device, for example by being able to hear one another through a door. Alternatively, some examinations may be conducted using audiovisual means, where the following requirements are met. Firstly, the person being examined needs to be outside a metropolitan area. Secondly, it can only be in circumstances where it is not practicable for the psychiatrist or other practitioner and the person to be in one another's physical presence. Thirdly, circumstances need to be such that the person and a prescribed health professional are in one another's physical presence or are able hear one another without using a communication device. Prescribed health professionals are listed in *clause 79*. Finally, some examinations may be conducted where the psychiatrist or other practitioner and the person are able to see and hear the other while the other is speaking. An examination conducted using audiovisual means is taken to be conducted, and any order made as a result of the examination, is taken to be made at the place where the person is examined when the examination is conducted.

Clause 80 sets out the information to which the psychiatrist or other practitioner may have regard in conducting an examination. Information obtained by the psychiatrist or other practitioner from the person, including information obtained by observing the person and asking them questions, may be considered. This is the only information that can be relied on in itself or in combination with other information in order for the psychiatrist or other practitioner to conclude that the person is in need of, is still in need of, or is no longer in need of, an involuntary treatment order. If the person is of Aboriginal or Torres Strait Islander descent, information may be obtained from an Aboriginal or Torres Strait Islander mental health worker or a significant member of the person's community, such as an elder or traditional healer. Further, information may be obtained from another person, and from the patient's medical record.

Clause 81 seeks to ensure that the particular needs and circumstances of patients of Aboriginal or Torres Strait Islander descent are taken into account. Examinations

must be conducted in collaboration with listed groups of people, such as elders and traditional healers from the patient's community and Aboriginal mental health workers to the extent practicable and appropriate.

Part 7 Detention for examination or treatment

Division 1 - Preliminary matters

Clause 82 states that Part 7 does not apply to a person who is a mentally impaired accused.

Division 2 - Detention at authorised hospital or other place for examination

Clause 83 lists the clauses in Part 6 in relation to which detention is authorised, and enables a person to be received at an authorised hospital or other place, and to be detained there for the period authorised by Parts 6 and 7. In broad terms, *clause 83* applies to persons who are under an order to be detained or continue to be detained at an authorised hospital, and persons who are under an order to be detained or continue to be detained at a place other than an authorised hospital. *Clause 83* is a prescribed provision for the purposes of *clause 172*. That is, the relevant referral or order authorises a person prescribed in the Regulations for that paragraph in the Act to exercise the powers under *clause 172* for the purpose of detaining the person there, being the use of reasonable force and obtaining reasonable assistance. This enshrines what is already done at common law, creating certainty and clarity for persons who are involved in detaining a person under Part 7.

Division 3 - Detention at hospital under inpatient treatment order

Clause 84 states that Division 3 applies to an involuntary inpatient at an authorised hospital or a general hospital.

Clause 85 defines some of the terms used in Division 3, namely continuation order and detention period.

Clause 86 provides a statutory basis for an involuntary inpatient's admission to, and detention in, the authorised hospital or general hospital specified in the inpatient treatment order, and any other hospital to which the person is transferred in accordance with Parts 6 and 7. It also states that the inpatient treatment order authorises a person prescribed in the Regulations for that paragraph in the Act to exercise powers under *clause 172* for the purpose of detaining the involuntary inpatient there.

Clause 87 specifies the time limits for an inpatient treatment order. For an adult the period is up to 21 days; and up to 14 days with respect to a child.

Clause 88 sets out when an inpatient treatment order ends, being when the person becomes subject to a CTO; when the psychiatrist revokes the inpatient treatment order; or upon the expiry of the inpatient treatment order (subject to a continuation

order having been made under *clause 89*), whichever is first. Note that there are specific provisions in relation to the Mental Health Tribunal having power to revoke an inpatient treatment order.

Clause 89 requires an involuntary inpatient to be examined within seven days before the detention period ends. The clause requires the psychiatrist conducting the examination, who may or may not be the patient's treating psychiatrist (taking account of staff leave and similar practicalities), to make one of the following orders, having regard to the criteria in *clause 25*. Firstly the psychiatrist may, if satisfied that the involuntary inpatient is still in need of an inpatient treatment order, make a continuation order. Secondly, the psychiatrist may make a CTO. Alternatively, the psychiatrist may decide that the involuntary inpatient is no longer in need of an involuntary treatment order and revoke the inpatient treatment order. Where a continuation order is made, the timeframe specified in the order must not exceed three months in relation to an adult; or 28 days in relation to a child. The release of a person under *clause 89* is a notifiable event.

Clause 90 clarifies that where a person, in the opinion of a psychiatrist at the authorised hospital, no longer meets the criteria in *clause 25,* the psychiatrist may change the involuntary inpatient's status, either by making a CTO or by revoking the inpatient treatment order. In line with the Object of the least restrictive options, the psychiatrist may make one of these orders with or without examining the person. The making of an order under *clause 90* is a notifiable event.

Clause 91 applies in relation to an involuntary inpatient who is detained at an authorised hospital. The treating psychiatrist or, if the treating psychiatrist is not reasonably available, another psychiatrist at the authorised hospital, may make a transfer order authorising the involuntary inpatient's transfer from the authorised hospital to another authorised hospital specified in the order. A transfer is subject to safeguards for the involuntary inpatient, including a requirement that the involuntary inpatient be given a copy of the transfer order which includes reasons for the transfer. Examples of reasons for transfer include locating the involuntary inpatient closer to their family, where there is conflict with another patient in the same ward at the initial authorised hospital, or where there is a bed shortage at the initial authorised hospital. Further, the making of a transfer order under *clause 91* is a notifiable event.

Clause 92 enables a psychiatrist to make a transport order to facilitate a transfer order. The psychiatrist cannot make the transport order unless satisfied that no other safe means of taking the involuntary inpatient to the authorised hospital is reasonably available.

Clause 93 requires an involuntary inpatient to be advised upon the expiry of an inpatient treatment order, and advised of consequences, including that the patient may remain, with the psychiatrist's permission, as a voluntary patient or be discharged from the hospital. The expiry of an inpatient treatment order is a notifiable event.

Division 4 - Release from hospital or other place

Clause 94 is the application provision for Division 4. Division 4 applies to persons detained for assessment; referred persons whether or not they are being detained; involuntary inpatients; and patients on a CTO detained at a place specified in an order to attend under *clause 130*.

Clause 95 requires a person to be allowed to leave when they cannot continue to be detained. The patient must be advised in writing by a medical practitioner or mental health practitioner. This is not a notifiable event because the default position is that the person's personal support person will already have been informed of the event resulting in the person no longer being able to be detained.

Clause 96 creates an exception to *clause 95*. Where the involuntary inpatient must be delivered into custody pursuant to another law, they must not be allowed to leave the hospital or other place until they have been delivered into that custody.

Division 5 - Absence without leave from hospital or other place

Clause 97 prescribes the circumstances in which a person is considered to be absent without leave. Absence without leave from a hospital or other place is a notifiable event.

Clause 98 enables an apprehension and return order to be made in respect of a person who is absent without leave. The intention is that an apprehension and return order will be an option of last resort, and that steps should first be undertaken to return the person to the hospital or other place. Therefore, *clause 98* requires that the order only be made where the person in charge of the hospital or other place or a medical practitioner is satisfied that no other safe means of returning the person to the hospital or other place is reasonably available. The order must specify the reasons for making the order, and the hospital or other place to which the person is to be returned, amongst other things. The Act allows a person who is absent without leave to be returned to a different place. For example, circumstances may be such a person absent without leave from an authorised hospital needs to be returned to a general hospital for medical treatment.

Clause 99 describes the operation of an apprehension and return order and refers to the powers that a police officer or person prescribed by the Regulations who is

carrying out the order with respect to the person who is absent without leave. A police officer or person prescribed in the Regulations may also exercise the powers under *clause 172* for the purpose of apprehending the person.

Clause 100 specifies that the maximum period of an apprehension and return order is 14 days and that this period cannot be extended.

Clause 101 provides for the revocation of an apprehension and return order when it is no longer necessary. The person in charge of the hospital from which the person is absent without leave or a medical practitioner may only make a revocation order if satisfied that the apprehension and return order is no longer needed. The revocation order must include the reasons for the revocation, amongst other things.

Clause 102 provides a safeguard in a situation where the person is apprehended under an apprehension and return order and the order expires or is revoked before the person has been returned to the place where the order specifies that the person is required to be returned. In that situation, the person must be returned to the place where the person was apprehended, or to a place reasonably nominated by the person.

Division 6 - Leave of absence from detention at hospital under inpatient treatment order

Subdivision 1: Preliminary matters

Clause 103 is the application clause in relation to Division 6, which applies to an involuntary inpatient detained in an authorised hospital or general hospital.

Clause 104 defines leave of absence.

Subdivision 2: Grant, extension or cancellation of leave

Clause 105 enables a psychiatrist to grant an involuntary inpatient a leave of absence in certain circumstances. Firstly, the psychiatrist must be satisfied that granting the leave of absence will be likely to benefit the involuntary inpatient’s recovery from mental illness or to benefit the inpatient’s mental health in some other way, or enable the involuntary inpatient to obtain medical or surgical treatment or be likely to benefit the inpatient’s physical health in some other way. Secondly, the granting of the leave of absence must not be inconsistent with the involuntary inpatient’s need to be provided with treatment in response to a risk set out in the criteria in *clause 25* in relation to which an inpatient treatment order was made. The psychiatrist must first consult with, or ensure that reasonable efforts have been made to consult with, the involuntary inpatient’s personal support persons as to whether or not to make the order and what the appropriate period would be and under what conditions, if any.

Examples of conditions include conditions about the involuntary inpatient residing at a specific place, receiving specific treatment (as defined in *clause* 4), and attending at a specific place and remaining there as specified in the order to enable the involuntary inpatient to be provided with specified treatment. There are exceptions where the best interests exception applies, as detailed below. Further, the psychiatrist must first consider whether or not it would be more appropriate to make a CTO in place of the inpatient treatment order, or revoke the inpatient treatment order. The granting of a leave of absence under *clause 105* is a notifiable event.

Clause 106 enables an extension or variation of conditions of leave granted under *clause 105*. The order for extension or variation must include the reasons for making the order, amongst other things. The making of the order for extension or variation under *clause 106* is a notifiable event. The person notified pursuant to Part 9 must be notified of variations to conditions, because the involuntary inpatient may not be in a position to comply with the conditions without the assistance of the person notified, given that the person currently satisfies the criteria that justifies involuntary inpatient status and is therefore likely to be acutely unwell or still recovering.

Clause 107 requires the involuntary inpatient on a leave of absence to comply with the conditions imposed pursuant to *clause 105* or *clause 106*.

Clause 108 applies where an involuntary inpatient is on a leave of absence for more than 21 consecutive days. The treating psychiatrist must consider whether or not it would be more appropriate to substitute the inpatient treatment order with a CTO, or to revoke the inpatient treatment order. The patient does not need to be examined for this purpose, in line with the principle of least restriction and given that the person will generally not be at the hospital.

Clause 109 allows the treating psychiatrist to change an involuntary inpatient's status whilst the involuntary inpatient is on a leave of absence. This requires a written opinion from a medical practitioner or mental health practitioner that this would be appropriate, and can be done without an examination by a psychiatrist. For example, the general practitioner may report to the patient's treating psychiatrist that the involuntary inpatient is no longer in need of an inpatient treatment order. In such circumstances the treating psychiatrist may substitute the inpatient treatment order with a CTO, or revoke the inpatient treatment order.

Clause 110 allows a psychiatrist to cancel an involuntary inpatient's leave of absence if he or she forms the reasonable belief that it is inappropriate for the involuntary inpatient to continue to be away from the hospital. The order must specify the

reasons for that belief, amongst other things. There is no requirement for an examination, given that the involuntary inpatient will generally be residing, or otherwise located, in the community at the time when the leave of absence is cancelled. The psychiatrist must orally advise the involuntary inpatient that the leave of absence has been cancelled, so that the patient can return to the hospital. The cancellation of leave of absence is a notifiable event.

Subdivision 3: Transport to and from hospital

Clause 111 states that Subdivision 3 applies to an involuntary inpatient on a leave of absence (which may be from an authorised hospital or general hospital, though it will usually be an authorised hospital) for the purposes of obtaining medical or surgical treatment; and to an involuntary inpatient with respect to whom a leave of absence has been cancelled. In relation to the latter, the involuntary inpatient may be required in the order to return to hospital from which leave was granted, or to an authorised hospital to which the involuntary inpatient's transfer has been ordered under a transfer order made under *clause 66* or *clause 91*.

Clause 112 enables a psychiatrist to make a transport order where no other safe means of taking the involuntary inpatient to the hospital is reasonably available. The making of a transport order under *clause 112* is a notifiable event.

Part 8 Community treatment orders

Division 1 - Preliminary matters

Clause 113 defines some of the terms used in Part 8, including a supervising psychiatrist, who supervises the treatment of an involuntary community patient (distinct from the treating psychiatrist for an inpatient treatment order), and treating practitioner (medical practitioner or mental health practitioner) who is responsible for ensuring the treatment is delivered in accordance with the CTO.

Division 2 - Making order

Clause 114 sets out the things that a psychiatrist must be satisfied of before making a CTO. *Clause 114* is to be distinguished from *clause 25* which sets out the criteria for a person's need to be provided with treatment and involves a clinical decision with respect to an individual patient. *Clause 114* articulates other factors which need to be in place for a CTO to be operative, such as the availability of a supervising psychiatrist and treating practitioner, and that the treatment that is proposed is consistent with the need for an involuntary treatment order. For example, if the patient lives in a region where the proposed treatment cannot be provided, then it may not be appropriate to impose a CTO on a person.

Clause 115 sets out the terms which must be included in a CTO such as the names of the supervising psychiatrist and treating practitioner; when the order will come into force; the expectation that the patient will comply with the treatment proposed; and any requirement that the patient inform the supervising psychiatrist of any change of address or of any plan to go interstate or overseas. The term of the CTO must not be more than three months. The list of terms in a CTO listed in *clause 115* is non-exhaustive, however it is intended that the terms be incidental to the patient's treatment, care and support. This may extend to the patient being treated for a particular general health condition, or where the person must reside, for example.

Division 3 - Operation of order

Clause 116 sets out when a CTO ends, which is when an inpatient treatment order is made by a psychiatrist for the patient to be detained in an authorised hospital or a general hospital; when the CTO is revoked and the person is no longer an involuntary patient; or when the treatment period expires and has not been continued under a continuation order. As stated above in relation to Part 6 Division 2, CTOs are suspended during specified times commencing when a person becomes a referred person (voluntary patient) or a voluntary inpatient admitted by an authorised hospital.

Clause 117 requires the supervising psychiatrist to advise the involuntary community patient in writing of when and where treatment is to be provided under the CTO. The supervising psychiatrist is allowed up to 14 days for this information to be provided to the involuntary community patient and must include details of their first appointment, so as to allow time for arrangements to be made to ensure attendance.

Clause 118 requires monthly examinations of an involuntary community patient. Where the supervising psychiatrist is unavailable, or where the supervising psychiatrist makes such a request, the involuntary community patient can be examined by another medical practitioner or mental health practitioner. A practitioner who is not the supervising psychiatrist who examines the involuntary community patient must provide a written report of the examination to the supervising psychiatrist and an important aspect of the examination is to determine whether the CTO continues to be required (having regard to the criteria in *clause 25*). A recommendation is required to be in the report. No more than two months can go past from the day of the last examination by the supervising psychiatrist without there being an examination by the supervising psychiatrist. The provisions about the conduct of an examination in Part 6 apply in relation to an examination under *clause 118*, whether it be conducted by a psychiatrist, other medical practitioner, or mental health practitioner. As detailed above, examinations by audiovisual means are permitted in certain circumstances outside a metropolitan area. The position in relation to circumstances where there is a change in the supervising psychiatrist is dealt with in *clause 135*. The ability for a medical practitioner who is not the supervising psychiatrist, or a mental health practitioner, to carry out the examination is considered to be most flexible and workable. It is considered that the safeguards in *clause 118* will protect patients from unwarranted involuntary treatment.

Clause 119 enables the supervising psychiatrist to request another medical practitioner or a mental health practitioner to examine the involuntary community patient, in accordance with *clause 118*. When the supervising psychiatrist makes the request, in the approved form, he or she may specify additional requirements for carrying out the examination or preparing the report, or both.

Clause 120 requires the supervising psychiatrist to, following an examination by himself or herself, or a report on examination from another medical practitioner or a mental health practitioner, consider whether or not the involuntary community patient is still in need of an involuntary treatment order. The supervising psychiatrist may decide to keep the person on the CTO. Alternatively, the supervising psychiatrist may make an inpatient treatment order authorising the detention of the patient in an authorised hospital, or may revoke the CTO. Where the decision to make an inpatient treatment order is based on a report, the supervising psychiatrist must first examine

the involuntary community patient himself or herself. The provisions about the conduct of an examination in Part 6 apply in relation to an examination under *clause 120*. The supervising psychiatrist may make an order revoking a CTO making the person no longer involuntary based on an examination conducted by himself or herself, or without having examined the person himself or herself based on a report provided by another medical practitioner or by a mental health practitioner. The making of an order under *clause 120* is a notifiable event.

Clause 121 provides for a continuation order in relation to a CTO, with various protections for the involuntary community patient. The supervising psychiatrist may make an order (not exceeding three months), on or within seven days before a CTO is due to expire, and continuing from the end of the prior treatment period. The supervising psychiatrist must first examine the involuntary community patient himself or herself before or during that seven day period. The involuntary community patient may request in writing the supervising psychiatrist to obtain a further opinion from another psychiatrist as to whether or not a continuation order is appropriate. If the further opinion is not obtained on or within 14 days after the day on which the request was received by the supervising psychiatrist from the involuntary community patient, the continuation does not come into force or ceases to be in force, as the case requires. If the further opinion does not confirm that a continuation order is appropriate, the continuation order does not come into force or ceases to be in force, as the case requires. If the involuntary community patient does not attend the examination required for provision of the further opinion, the order remains in force. *Clause 182* in relation to the process for requesting a further opinion applies in relation to *clause 121*. *Clause 184* also applies, enabling the Chief Psychiatrist to request reconsideration of treatment.

Clause 122 takes into account the practicalities in relation to the changes to the involuntary community patient's circumstances, including the progress of their recovery, enabling the supervising psychiatrist to vary the terms of a CTO. For example the supervising psychiatrist can vary the frequency of attendance by the involuntary community patient at a community mental health service for treatment. A patient's rights must not be restricted to any greater degree than is necessary. The order, which must be given to the involuntary community patient, must specify the reasons for the variation, amongst other things.

Clause 123 sets out options and procedures in relation to an involuntary community patient who may require an inpatient treatment order, or may no longer require an involuntary treatment order. *Clause 123* is unlike *clause 120* in that the latter is in relation to consideration of the involuntary community patient's status following an examination. *Clause 123* applies at any time, for example when the involuntary

community patient attends a community mental health service for treatment. The supervising psychiatrist must examine the involuntary community patient before making an inpatient treatment order. The provisions about the conduct of an examination in Part 6 apply in relation to an examination under *clause 123*. The supervising psychiatrist may make an order revoking a CTO with or without having examined the involuntary community patient. However, the supervising must have regard to any information about the involuntary community patient which is obtained from either or both of the involuntary community patient himself or herself (including information obtained by observing the patient and asking the patient questions); and any other person; in addition to information from the involuntary community patient's medical record. For example, a supervising psychiatrist is required to have regard to information provided by the patient's family member in support of or against making an inpatient treatment order, before making an inpatient treatment order. *Clause 123* clarifies that there is no requirement for the involuntary community patient to have been in breach of the CTO under *clause 126* or for the supervising psychiatrist to have given the involuntary community patient a notice of a breach of the CTO under *clause 127* or to have made an order to attend under *clause 128*. The making of an order under *clause 123* is a notifiable event.

Clause 124 relates to the provisions that allow audiovisual examination, providing safeguards for a situation in which an involuntary community patient is placed on an inpatient treatment order without having been in the physical presence of a psychiatrist whilst an examination was being conducted. In such a situation the inpatient treatment order must be confirmed by a psychiatrist at the authorised hospital within 24 hours from the involuntary inpatient being admitted to the authorised hospital. A psychiatrist cannot confirm the inpatient treatment order without having examined the involuntary inpatient in accordance with the provisions in Part 6 in relation to the conduct of an examination, but in this case the involuntary inpatient and the psychiatrist must be in one another's physical presence. An inpatient treatment order made in circumstances set out in *clause 124* that is not confirmed under *clause 124* is no longer in force. The 24 hour period cannot be extended. The release of a person under *clause 124* is a notifiable event.

Clause 125 requires an involuntary community patient to be advised upon the expiry of a CTO, and advised of consequences. The expiry of a CTO is a notifiable event.

Division 4 - Breach of order

Clause 126 prescribes the circumstances where an involuntary community patient will be considered to be in breach of a CTO.

Clause 127 sets out procedures that a supervising psychiatrist must follow to record a breach of a CTO, including giving notice of the breach to the involuntary community patient, as well as information about the consequences of further non-compliance.

Clause 128 makes provision for an order to attend – being an order for the involuntary community patient to attend a specified place at a specified time, where failure to attend may result in a transport order being made whereby the patient is apprehended and brought to a place for treatment.

Clause 129 relates to an involuntary community patient who has not complied with an order to attend under *clause 128*. A medical practitioner or mental health practitioner may make a transport order in respect of the involuntary community patient where the practitioner is satisfied that no other safe means of ensuring the involuntary community patient attends the place is reasonably available. The supervising psychiatrist is not required to be the person making the transport order, however only the supervising psychiatrist can make the order to attend.

Clause 130 prescribes the circumstances in which an involuntary community patient can be detained at a place specified in an order to attend and how long they can be detained there for. *Clause 130* stipulates that a person prescribed in the Regulations for the relevant subclause is authorised to exercise the powers under *clause 172* for the purpose of detaining the involuntary community patient at the place. The patient can leave after treatment has been provided. Alternatively, the supervising psychiatrist may revoke the CTO and make an inpatient treatment order. If neither has occurred within six hours of the person being received at the place, the person can no longer be detained. The release of a person under *clause 130* is a notifiable event.

Clause 131 provides an alternative to the order to attend process whereby, if an involuntary community patient remains non-compliant with a CTO following a notice of breach, the supervising psychiatrist may either revoke the CTO or make an inpatient treatment order for the patient to be detained at a specified authorised hospital or a general hospital. The process used will vary depending on the involuntary community patient's mental health and other individual circumstances. Such an order can only be made after examining the person in accordance with the provisions about the conduct of examination in Part 6. The making of an order under *clause 131* is a notifiable event.

Division 5 - Transport to hospital

Clause 132 states that Division 5 applies where the supervising psychiatrist makes an inpatient treatment order with respect to an involuntary community patient.

Clause 133 enables a medical practitioner or mental health practitioner to make a transport order with respect to a patient referred to in *clause 132* where the practitioner is satisfied that no other safe means of taking the involuntary community patient to the hospital is reasonably available. The supervising psychiatrist is not required to be the person making the transport order, however only the supervising psychiatrist can make an inpatient treatment order.

Division 6 - Supervising psychiatrist and treating practitioner

Clause 134 requires the supervising psychiatrist under the CTO to carry out the CTO, and clarifies that the supervising psychiatrist is not required to be the psychiatrist who made the CTO.

Clause 135 allows the supervising psychiatrist, the Chief Psychiatrist, or a person specifically authorised in *clause 135* to transfer the responsibility of the supervising psychiatrist under a CTO to another psychiatrist. An example of the former is where the supervising psychiatrist transfers patients to another supervising psychiatrist due to extended leave. An example of the latter would be where a supervising psychiatrist may become unable to perform his or her functions due to illness in circumstances where he or she has not had the opportunity to transfer the care of patients to another supervising psychiatrist. The involuntary community patient must be advised in writing.

Clause 136 states the role of the treating practitioner under a CTO and makes clear that the treating practitioner must be a medical practitioner or mental health practitioner and may be the supervising psychiatrist.

Clause 137 allows the supervising psychiatrist to transfer a practitioner's responsibility as a treating practitioner to another practitioner. The involuntary community patient must be advised in writing.

Part 9 Notifiable events

Part 9 emphasises the importance of other people, such as family members, carers or other personal support persons, being aware of what is happening with regard to the person, and places a duty on staff to inform by notification of these people when certain events occur. In particular, matters relating to a person's physical location and treatment status are of critical importance to families, carers, and other personal support persons. In accordance with *clause 4* (which refers to *clause 7*), personal support persons include the parent or guardian of a child, of the guardian or enduring guardian of an adult, in addition to the person's carer, close family member and nominated person. The intention is to ensure that at least one other person is aware of the patient's location or impending location and, to enable this to occur in certain circumstances, despite any object raised by the patient (unless a best interests exception applies, detailed below).

Division 1 - Preliminary matters

Clause 138 states that Part 9 applies where a provision in the Act requires notification under Part 9, and that refers to Schedule 2. Schedule 2 stipulates for each notifiable event who is responsible for ensuring the notification occurs and the provision which applies. The person responsible for notification varies throughout the Act, depending on the nature of the event and who made the relevant order.

Division 2 - Notification of carers, close family members and other personal support persons

Clause 139 creates a default position that it is the right of a carer, close family member or other personal support person to receive notification of any event to which Part 9 applies, as soon as practicable. The exception is in relation to the best interests exception under *clause 142* (an exception that will not apply to a parent or guardian of a child, or a guardian or enduring guardian of an adult).

Clause 140 stipulates that the person responsible must ensure that, as soon as practicable after the notifiable event occurs, at least one of the following persons is notified of the event – the carer, close family member, or other personal support person. The best interests exception applies here in relation to a carer, close family member or nominated person.

Clause 141 creates a further exception, which is intended to apply in limited circumstances – where reasonable efforts have been made to notify a carer, close family member or other personal support person, and none of these persons can be contacted for the purposes of notifying them. The purpose of *clause 141* is not to limit the requirements in *clause 140*; rather, it acknowledges that in some instances a

person may not have a carer, close family member or support person who is able to be contacted. There are extensive procedural requirements in such a situation, promoting accountability.

Clause 142 provides for the situation where it may be deemed (by the medical practitioner or AMHP who made the order) to not be in the best interests of a person to notify a carer, close family member or nominated person of a notifiable event as per *clause 139*. As referred to above, for the purposes of *clauses 142-144*, a parent or guardian of a child, or a guardian or enduring guardian of an adult, do not apply. This provision and the relevant provisions in Parts 16 and 17 recognise that there can be circumstances where the involvement of a particular person may constitute a danger to the person, for example in cases where there has been ongoing sexual or other abuse by a carer, close family member or nominated person. For that reason, it is not appropriate to have an absolute rule requiring that these persons will always be informed and involved. *Clause 142* must be read in conjunction with *clause 7*, which describes the concept of best interests. There are extensive procedural requirements where the best interests exception under *clause 142* is invoked, including provision of a record of the decision with reasons to the Chief Mental Health Advocate. The intention is not for the Chief Mental Health Advocate to notify the carer, close family member or nominated person; but for the person to be offered additional advocacy support where required.

Clause 143 stipulates that where a practitioner or psychiatrist has exercised their discretion not to notify a carer, close family member or nominated person of a notifiable event as per *clause 142*, that if a carer, close family member or nominated person requests to be notified that the practitioner or psychiatrist must advise them of the decision not to notify and the reasons for that decision.

Clause 144 enables a psychiatrist or other medical practitioner, or an AMHP, to revoke a decision not to notify a carer, close family member or nominated person of a notifiable event at any time, if satisfied that the reasons for making the prior decision no longer apply. Subsequently the carer, close family member or nominated person must be notified of the notifiable event and the decision and reasons for the revocation must be recorded. Where a carer, close family member or nominated person previously requested to be advised of a notifiable event, and a decision not to notify has been revoked, then the carer, close family member or nominated person must be notified of the notifiable event and a record of the notification kept, filed, and a copy given to the carer, close family member or nominated person.

Division 3 - Notification of other persons and bodies

Clause 145 provides for automatic notification of the Chief Mental Health Advocate and the Mental Health Tribunal where an involuntary treatment order is made. Where the person is a mentally impaired accused, the Mentally Impaired Accused Review Board must also be notified. Available information about the patient's carer, close family member and other personal support persons must also be provided in addition to information about notification of these persons. A copy of a revocation order and details of any expired order must also be provided. *Clause 145* is essential to ensure that the Chief Mental Health Advocate and the Mental Health Tribunal are able to carry out their functions in Parts 20 and 21, respectively.

Part 10 Transport orders

Part 10 delineates the circumstances in which transport orders may be made, as well as the powers exercisable under transport orders, and the procedures for making, extending and revoking transport orders. Extensive procedural requirements are intended to promote greater accountability, clarity and transparency.

Clause 146 lists the circumstances in which a transport order may be made. Provisions in Part 10 governing transport orders apply to all of these situations.

Clause 147 provides for a new class of person, a transport officer. It is intended that the Regulations will authorise classes of persons or individuals as transport officers and specify requirements for such authorisation. Transport officers are intended to provide a safe and appropriate means for transporting involuntary patients and referred persons. The Act does not remove the possibility for police officers to also transport people under transport orders where appropriate.

Clause 148 sets out the information which must be recorded on a transport order, including requirements to record certain decisions in which discretion may be exercised by the person making the transport order, including why a transport order is needed and, where the transport order is to be carried out by a police officer, why it cannot be carried out by a transport officer. These requirements are intended to ensure a high level of accountability and transparency in the decision making process. This information must always be made available to the person with respect to whom the transport order is made.

Clause 149 governs the operation of transport orders, who may conduct the transport order and the powers of which the person carrying out the transport order. The powers relate to the apprehension, transportation and detention of the person with respect to whom the transport order is made. These powers include the power under *clause 172*. In line with the requirement to use the least restrictive option appropriate in the circumstances, a police officer should only be used where there is further risk, as detained in *clause 149*. In addition to promoting the least restriction, this is more workable and flexible, allowing police to focus on ‘priority’ matters where there is greater risk or acuity, for example. It is noted that, where transport officers are unavailable and police officers are not, the person may be transported by police if the delay before a transport officer can carry out a particular transport is likely to result in a significant risk of harm to the person being transported or another person.

Clause 150 makes provision for the period for which a transport order remains in force, if it is not extended under *clause 151* or *clause 152*. Transport orders made

under *clause 29*, for the purpose of transporting a person referred for examination by a psychiatrist, are intended to expire when the referral itself expires. In a metropolitan area, the referral can remain in force for up to 72 hours under *clause 44*, and it is intended that at the time that these 72 hours lapse the transport order will also lapse. These two powers are explicitly linked because it is intended that the power to transport should not outlast the time period of a referral. It is noted that *clause 45* provides that outside a metropolitan area a referral for examination may be extended for a maximum of a further 72 hours, recognising the particular difficulties that a person transporting a referred person may face in remote areas where communications may be limited. *Clause 151* provides that where a referral is extended in these circumstances the transport order is similarly extended. *Clause 150* goes on to make provision for transport orders made under *clause 63*, where either an inpatient treatment order or an order for further examination has been made. In these cases the transport order lapses 72 hours after the previous order was made. In the remaining circumstances set out in *clause 150* the transport order lapses 72 hours after having been made.

Clause 151 is discussed above in relation to *clause 150*, allowing a transport order to be extended where they relate to referrals for examination.

Clause 152 allows for an extension order of up to 72 hours where the person is being transported from outside a metropolitan area. Further requirements must be met, and procedural safeguards followed, once again recognising the clear practical difficulties in transporting a person from outside a metropolitan area. That is, ensuring protections from unwarranted detention, in addition to providing access to treatment, care and support for the person with respect to whom the transport order is made.

Clause 153 provides that, if a referral order is revoked under *clause 31*, then a transport order made in respect of the referral order is also revoked.

Clause 154 enables a medical practitioner or AMHP to revoke a transport order if satisfied that it is no longer needed. The person revoking the order is not required to be the same person who made the transport order. This is intended to take account of circumstances where the person who made the order is not available or is not in a position to revoke the order. It is expected that in the normal course of events the person who revokes the order will be the same person who made the order. Where that is not possible it is anticipated that the person revoking the order would consult with the person who made the order.

Clause 155 deals with a situation where a person is being transported and where the transport order expires or is revoked before the person is received at the place where

they were to be transported. In this case it is intended that the person being transported is able to elect whether they would prefer to be taken back to the place where they were transported from or to another place reasonably nominated by them. In this situation the transport officer or police officer is obliged to take reasonable steps to ensure that the person is taken to the place chosen by the person. This is intended to protect the person from being left in an inconvenient place, but not impose an unreasonable burden on the transport officer or police officer. *Clause 155* also advances protections for the person being transported by clarifying that the clause does not require the person to be taken to a place if to do so poses a serious risk to the safety of the person or another person. This is in relation to the place itself and any person who may be there, and not in relation to the risk of releasing the person.

Part 11 Apprehension, search and seizure powers

Division 1 - Apprehension powers

Clause 156 permits a police officer to apprehend a person where the person has a mental illness; and because of the mental illness, needs to be apprehended to protect the health or safety of the person or the safety of another person, or prevent the person causing, or continuing to cause, serious damage to property. That is, there must be a perceived causal connection between mental illness and the risk, which provides an additional safeguard against unnecessary apprehension. It is noted that damage to property is not one of the express criteria for an involuntary treatment order being made under *clause 25*. The inclusion of damage to property in *clause 156* recognises the difficulties that police face when responding to incidents involving people who have a suspected mental illness. In the absence of a clinician, the decision about whether criteria in *clause 25* are met is challenging. The continued inclusion of a power to apprehend to prevent damage to property is intended to respond to a need identified by consumers and their families for police to be able to act in such circumstances. For the purposes of apprehending a person, a police officer may exercise the powers in *clause 159*. *Clause 156* requires a police officer exercising the powers of apprehension to arrange for an assessment of the person, and allows the police officer to detain the person until the person is received at the place where the assessment is to be conducted; the person is delivered into the care of the practitioner who will assess the person; or the police officer is satisfied that the grounds for suspecting that the person needs to be apprehended no longer exist. This is intended to take account of situations such as where it initially appears that a person has a mental illness, but after apprehension it emerges that the person had been affected by drugs for example, which lose their effect and remove the grounds for apprehension. Nothing in *clause 149*, or anywhere else in the Act, prevents a person from being charged with an offence. Part 12 in regard to principles relating to detention and ancillary powers of reasonable assistance and force and directions apply with respect to Part 11.

Clause 157 applies where a police officer arrests a person whom the police officer reasonably suspects has a mental illness for which the person is in need of immediate treatment. The police officer must arrange for an assessment to be conducted.

Clause 158 applies where a police officer arranges an assessment, and the practitioner who conducts the assessment decides not to refer the person for an examination; or where the person has been referred for examination, but cannot continue to be detained under the Act; for example where the referral has expired. A police officer must be informed and information about the police being informed

must be included on the person's medical record. This is intended to provide continuity of information for the police, who may need to know the person's whereabouts if charges need to be laid or an investigation conducted.

Clause 159 applies to a person who has not been arrested, but where the person can be apprehended for another reason. Firstly, where a police officer or person prescribed is authorised to carry out an apprehension and return order under Part 7 Division 5. Secondly, where a transport officer or police officer is authorised to carry out a transport order under *clause 149*. Thirdly, where a police officer is authorised to apprehend a person suspected of having a mental illness under *clause 156*. *Clause 159* lists the powers of the relevant police officer, person prescribed, or transport officer, in apprehending the person, which include powers to enter premises (limited to prescribed premises in relation to transport officers), and the search and seizure powers detailed below.

Division 2 - Search and seizure powers

Clause 160 defines 'approved form' for the purposes of Division 2, being a form approved by the Commissioner of Police under *clause 169*, or a form approved by the Chief Psychiatrist under *clause 541*.

Clause 161 stipulates that the Regulations may authorise a person (an authorised person) to exercise powers under Division 2.

Clause 162 allows a search of a person when admitted or detained, and periodically throughout admission or detention, in circumstances where a police officer, or authorised person, reasonably suspects that the patient has an article listed in *clause 164*. A search can only be conducted in accordance with *clause 163* which, to clarify, allows reasonable force and other ancillary powers under Part 12.

Clause 163 sets out strict requirements in relation to how searches must be conducted. The provision is in accordance with the Objects of the Act, and balances the importance of safety, dignity and privacy of the person being searched; and the safety of the person conducting the search and other persons who may be placed at risk by an item found on or with the person being searched. This clause is intended to ensure that searches are as consistent as possible with the safeguards provided in other legislation, such as the *Criminal Investigation Act 2006*.

Clause 164 identifies the articles that may be seized from a person. In broad terms, they are items that may create a risk to the person or another person. Further, the person conducting the search may seize any article which he or she believes is likely to materially assist in determining any question in relation to the person that is likely to

arise for determination under this Act. For example, seizure of a large amount of medication from a person is likely to assist a practitioner in determining whether or not the person has a mental illness and is at risk.

Clause 165 sets out stringent recording requirements following the exercise of search or seizure powers, which are considered to be necessary for transparency.

Clause 166 delineates the options for dealing with seized articles when a person is apprehended. If the person is received at a mental health service or other place, or delivered into the care of a medical practitioner or authorised mental health practitioner, the article must be given to the staff member of the mental health service or other place in accordance with the clause. If the person is released without being taken to a mental health service or other place and without being delivered into the care of a practitioner specified in the clause, the article must be returned to the person upon release. As an alternative to both of these options, the article may be dealt with according to a law other than the Act, such as the *Misuse of Drugs Act 1981* (WA) or the *Crimes Act 1914* (Cth).

Clause 167 provides for the return of an article which has been given to, or seized by, a mental health service. Such an article must be returned to the person or another person or stored, as required by the clause. Where an item has been stored for more than six months from the release or discharge of the person, it may be destroyed or otherwise disposed of. The method of disposal of the article must be recorded in the approved form and that form must be placed on the person's medical record.

Clause 168 applies where an article was given to a practitioner pursuant to *clause 166* and the practitioner decides not to refer the person for an examination under *clause 26*. The practitioner must return the article to the person, or have the article otherwise dealt with according to law, as soon as practicable. A record of how the article was dealt with must be put on the person's medical record and a copy of the record of how the article was dealt with must be given to the person.

Clause 169 allows the Commissioner of Police to approve forms for use by a police officer under Division 2. This is intended to remove the need for police officers to record searches and seizures more than once, by providing for common forms across police and mental health legislation. It is noted that, for persons other than police officers, *clause 541* allows the Chief Psychiatrist to approve forms for use under Division 2.

Part 12 Exercise of certain powers

Division 1 - Detention powers

Clause 170 enshrines principles relating to detention. These principles are consistent with the Objects.

Division 2 - Ancillary powers: reasonable assistance and force and directions

Clause 171 sets out the prescribed provisions for the purposes of Division 2. There are separate provisions in Part 14 Division 6 in relation to bodily restraint in narrower circumstances, which are not restricted or supplanted by Part 12.

Clause 172 permits a person exercising a power under a prescribed provision to request another person to give the person reasonable assistance in exercising that power. It is considered inappropriate for the legislation to require a person to assist upon request. *Clause 172* also permits the person exercising the power or assisting the person exercising the power to use reasonable force. Use of unreasonable force may be punished under other clauses in the Act, in addition to criminal law and other civil laws.

Clause 173 applies where a person is assisting in the exercise of a power under a prescribed provision. The person must obey all lawful and reasonable direction of that person. A failure to do so is an offence with a fine of $6,000. *Clause 173* is the first of a number of offence provisions in the Act. Such provisions are intended to promote compliance and accountability, ensuring the protection of people experiencing mental illness for example by protecting safety, liberty and legal rights – all promoting recovery from mental illness and safeguarding against unjustifiable detention. To clarify, as with all offence provisions in the Act, the specified penalty is the maximum penalty. It is intended that prosecutions be commenced in accordance with the relevant provisions in the *Criminal Procedure Act 2004*.

Clause 174 provides that a prescribed provision does not affect any other written law relating to apprehension or search of a person or the seizure of an article from a person. For example, powers under the *Criminal Investigation Act 2006* (WA) and the *Crimes Act 1914* (Cth) can be exercised in relation to a person experiencing mental illness.

Part 13 Provision of treatment generally

Division 1 - Voluntary patients

As mentioned above, *clause 4* defines 'voluntary patient' to mean a person to whom treatment is being, or is proposed to be, provided by a mental health service, but who is not an involuntary inpatient or a mentally impaired accused required under the *Criminal Law (Mentally Impaired Accused) Act 1996* to be detained at an authorised hospital. Therefore, referred persons and persons detained for assessment or examination are voluntary patients for the purposes of the Act.

Clause 175 states that a voluntary patient cannot be provided with treatment without informed consent being given to the provision of the treatment. This is in accordance with provision of medical treatment in general health. This is not relevant to ECT, emergency psychiatric treatment, psychosurgery, or treatment that is prohibited by *clause 210*. The more specific provisions in Part 14 apply to those treatments. As stated above, seclusion, bodily restraint and sterilisation are not considered to be treatment for the purposes of the Act, because they are expressly excluded from the definition of treatment in *clause 4*.

Clause 176 requires informed consent that has been given to be recorded on the voluntary patient's medical record. The *Guardianship and Administration Act 1990* is relevant here, in that a patient can provide consent in the form of an AHD or EPG. A person authorised by law to give consent on the patient's behalf may provide informed consent in relation to the types of treatments to which *clause 175* applies (ie not including the treatments where the Act makes more specific provision for them).

Division 2 - Involuntary patients and mentally impaired accused

Clause 177 is the application provision for Division 2, being in relation to an involuntary patient (on an inpatient treatment order or a CTO) or a person who is a mentally impaired accused.

Clause 178 stipulates that a patient to which Division 2 applies may be provided with treatment without informed consent being given to the provision of the treatment. Again, this does not apply to the treatments where the Act makes more specific provision for them.

Clause 179 requires a patient's psychiatrist to ensure that a medical practitioner, in deciding what treatment will be provided to the patient, has regard to the patient's wishes in relation to the provision of treatment, to the extent that it is practicable to ascertain those wishes. *Clause 179* sets out administrative procedures to be followed

subsequent to obtaining the patient's wishes. It is noted that, generally, regard must also be had to the views of the patient's personal support persons. *Clause 8* stipulates the matters relevant to ascertaining a person's wishes. The patient's wishes are not binding. However, stringent procedural requirements follow a medical practitioner's decision that is inconsistent with an AHD or EPG. These include providing a copy of reasons to the patient, their personal support persons, the Chief Psychiatrist, and the Chief Mental Health Advocate. That is, even though the exact terms of an AHD or EPG are not binding, there are protections in place for the patient. Further, it is anticipated that the procedural requirements will encourage medical practitioners for follow AHDs and EPGs where it is appropriate in the person's circumstances. In any case, the requirements will provide accountability and transparency. *Clause 179* balances the competing imperatives of preserving the integrity of advance planning and the importance of choice and control; with the need for safety and wellness of the person experiencing mental illness. *Clause 179* contemplates the fact that people may include terms in an AHD or EPG such as a refusal of all treatment, or consent only to herbal treatment for example, where compliance with the AHD or EPG would clearly increase risk to the health or safety of the person or the safety of others. It is anticipated that a medical practitioner would be reasonable in deciding which treatment or treatments to prescribe, and seek the views of personal support persons as to the circumstances in which particular treatment decisions had been made and the reasons for those treatment decisions. It is important to note here that the definitions of advance health directive and enduring power of guardianship have specific meanings in *clause 4*, whereby an invalid AHD or EPG is not binding. AHDs and EPGs are only valid where made by a person with full capacity and witnessing requirements have been fulfilled. In any case, it would be difficult and potentially unworkable for a medical practitioner to decide whether or not the AHD was valid and therefore binding, and also whether or not there had been a change of circumstances meaning that the AHD or EPG was no longer operative. In any case, *clause 179* reflects the fact that treatment and care needs to be responsive to a patient's particular needs at the time that a treatment decision is being made.

Clause 180 creates a requirement whereby the patient's psychiatrist must ensure that the patient is given the same information, time for consideration, and opportunities to discuss and obtain advice or assistance, as would be required with respect to a voluntary patient being asked to make a treatment decision about the provision of the treatment. The rationale for *clause 180* is that obtaining the patient's wishes without them having been given the opportunity to adequately consider the information would be less meaningful. All of this needs to be done to the extent that is practicable to do so. This is based on a supported decision making approach, despite the fact that informed consent is not required. It is considered to be important that the patient

have as much of a say about the treatment as they would if they were an involuntary patient, even though they do not have real choice or complete control.

Clause 181 requires the patient's psychiatrist to ensure that the patient's medical record includes a record of the treatment provided to the patient. There is no corresponding provision in the Act relating to voluntary patients as this is dealt with in policies and protocols external to mental health legislation, which is considered to be more appropriate.

Clause 182 gives patients and personal support persons broad rights to request a further opinion from a psychiatrist other than the treating or supervising psychiatrist. The intention is to provide patients and their support persons the opportunity to express any concerns in relation to their treatment and care to another, independent, psychiatrist; and to be given confidence in relation to treatment, or to be given treatment options to find the treatment most conducive to recovery, or both. The request may be made to the patient's psychiatrist or to the Chief Psychiatrist, and the initial request from the patient or their personal support person need not be in writing (however an oral request must be recorded and filed and a written request must be filed). The request must be complied with unless refused pursuant to *clause 183* or, if the request was made by a personal support person of the patient, the patient objects to the further opinion being obtained. The latter exception is included because it is considered that the examination required for the provision of a further opinion would be meaningless if the patient is resistant to the process. If a further opinion is to be obtained, the request must be complied with as soon as practicable. No express timeframe is specified, providing flexibility that is necessary to prevent possible abuse of the entitlement and to accommodate contingencies that may delay the provision of a further opinion. *Clause 182* requires the patient's psychiatrist or the Chief Psychiatrist to have regard to the guidelines published by the Chief Psychiatrist about the independence of further opinions. This is intended to ensure that there is no actual or perceived bias in the further opinion. Specified administrative procedures must be complied with in relation to recording the request and related matters. Importantly, in providing treatment to the patient following the receipt of a further opinion, the patient's psychiatrist must have regard to the further opinion, including any recommendations made by the psychiatrist providing the further opinion. The further opinion is intended to include any recommendations about the treatment being provided, and related matters, but this does not prevent comment on matters such as whether or not the person should continue to be an involuntary patient, or the physical condition of the patient, for example.

Clause 183 authorises the patient's psychiatrist to refuse to comply with a request for a further opinion if satisfied that, having regard to the guidelines published by the

Chief Psychiatrist, provision of the additional opinion is unwarranted. However, the reasons for any refusal must be provided to the patient and, in certain circumstances where the patient has requested the further opinion from his or her treating psychiatrist, additional psychiatric opinions may be provided at the discretion of the Chief Psychiatrist. The intention is to limit the provision of further opinions to circumstances where it is appropriate, ensuring that resources are not diverted towards a patient who is making repeated, unfounded or frivolous requests. This clause, in addition to a number of other provisions in the Act, recognises underlying concerns with the equitable distribution of health resources.

Clause 184 applies where a further opinion has been obtained and the person who requested it remains dissatisfied. The Chief Psychiatrist may request reconsideration by, and a report from, the patient's psychiatrist. The patient's psychiatrist must comply as soon as practicable and provide the report to the Chief Psychiatrist and the patient and, if another person made the request, that other person. The Chief Psychiatrist has additional powers under Part 23 Division 2 enabling him or her to affirm, vary, revoke or substitute a decision by a psychiatrist in relation to an involuntary patient.

Division 3 - Treatment, support and discharge planning

Clause 185 is the application provision for Division 3, being in relation to an involuntary patient (on an inpatient treatment order or a CTO) or a mentally impaired accused. There is no corresponding requirement in relation to a voluntary patient because in some cases it would be unworkable to prepare treatment, support and discharge plans with respect to referred persons, for example, due to short timeframes. In relation to a voluntary inpatient, best practice would support the preparation of such a plan.

Clause 186 enshrines a requirement for treatment, support and discharge planning and sets out the general requirements for a treatment, support and discharge plan. This approach is consistent with both the Act's focus on maximising the involvement of people experiencing mental illness, and with recognising the roles of carers and families. Division 3 attempts to balance patient autonomy with the need to involve carers and family members in a patient's treatment and care. It is intended that the specific requirements will promote a collaborative, holistic and recovery oriented approach. It is anticipated that this will include any plan in relation to seclusion or bodily restraint or both, even though these interventions do not fall within the definition of treatment in *clause 4*. The intention is that what is required will depend on the medical, social and personal circumstances of the person, and the decisions and preferences they express with respect to those particular circumstances. It is intended that providing the patient and persons involved with some knowledge of

what to expect from treatment, care and support provided by mental health services, and to ensure, as far as possible, continuity of care following discharge, will be most conducive to recovery.

Clause 187 requires treatment, support and discharge plans to be prepared and reviewed regularly, and revised as necessary, which takes into account the fact that a patient's circumstances will invariably change. For example, it recognises the largely episodic nature of mental illness and that the patient's response to different types of treatment is invariably difficult to predict. *Clause 187* notes that the patient's psychiatrist may for example consider it appropriate to give a copy of the plan to a community mental health service. This may be done in accordance with *clause 570*. Further, information may be given to the patient's general practitioner or their private psychiatrist with the consent of the patient.

Clause 188 identifies who should be involved in preparation and review of the plan and in what circumstances. Patients, whether or not they have capacity, must always be involved and, generally all of the patient's personal support persons. The involvement of the patient reflects and acknowledges the fact that a person who is affected by a decision is best placed to calculate the consequences of it. Further, *clause 188* recognises the fundamental role of families and carers in the lives of people experiencing mental illness. It is important to note here that *clause 283* states that where there is one carer or close family member, it is sufficient that one carer and one close family member is involved. It is intended that, generally, where both parents have parental responsibility in relation to a child, both parents will be involved. However, legislation of course cannot provide for all family circumstances, and this will ultimately be a matter of clinical judgment taking into account the wishes of the patient and the views of relevant personal support persons. Other persons may also be involved, for example clinicians and other persons in the community such as staff at a recovery or rehabilitation centre who will play a part in the aftercare of the patient (with the consent of the patient unless the patient is on a CTO).

Division 4 - Provision of treatment to patients of Aboriginal or Torres Strait Islander descent

Clause 189 seeks to ensure that the particular needs and circumstances of patients of Aboriginal or Torres Strait Islander descent are taken into account. Treatment must be provided in collaboration with listed groups of people, such as elders and traditional healers from the patient's community and Aboriginal mental health workers to the extent practicable and appropriate.

Division 5 - Compliance with standards and guidelines

Clause 190 requires the person in charge of a mental health service to ensure that the standards published under *clause 543* in relation to treatment and care provided by mental health services to people who the Chief Psychiatrist is responsible for the treatment and care of under *clause 512* are complied with.

Clause 191 requires the person in charge of a mental health service to ensure that, where the Chief Psychiatrist has published any guidelines under *clause 543* that are applicable to the treatment and care of the patient, that regard is had to those guidelines in the provision of treatment and care. For example, the Chief Psychiatrist may issue guidelines in relation to the use of a particular kind of medication on children, but is not required to do so.

Part 14 Regulation of certain kinds of treatment and other interventions

Division 1 - Electroconvulsive therapy

Division 1 is founded on clinical evidence that ECT has valid therapeutic application in appropriate circumstances. However safeguards are in place that are more stringent than in relation to most other kinds of treatment, for example oral and intramuscular medications.

Clause 192 defines ECT.

Clause 193 prohibits the performance of ECT except in accordance with *clauses 194-199*. The penalty is a fine of $15,000 and two years imprisonment.

Clause 194 prohibits the performance of ECT on children under 14 years of age, reflecting clinical advice that ECT may not be the most appropriate treatment for younger children. To clarify, *clause 199* relating to emergency ECT does not create an exception to *clause 194* because emergency ECT can only be performed with respect to an adult patient who is not a voluntary patient.

Clause 195 stipulates the requirements for ECT to be performed on a child aged 14 to 18 years who is a voluntary patient for the purposes of receiving ECT. Informed consent is required. As emphasised in Part 5, if the child has capacity to provide informed consent then they may provide informed consent for themselves. However, if the child does not have capacity their parent or guardian, as defined in *clause 4* may provide informed consent. As a further safeguard, the approval of the Mental Health Tribunal is required. That is, even if there is informed consent, there will be oversight by the Mental Health Tribunal and they can decide, for example, that the consent is not valid, or that ECT would not be appropriate in the circumstances because other treatments need to be tried first. The guidelines published by the Chief Psychiatrist relating to performance of ECT must be had regard to. It is noted that, as with similar clauses in Divisions 1 and 3, the relevant time when the person is a patient is the time when the treatment is provided. Therefore, there is no reason why a person who is not currently a voluntary or involuntary patient could be provided with ECT where they later become a patient and where the other requirements are satisfied. That is a person who sees a private psychiatrist as an outpatient (and is therefore not an existing patient of a mental health service for the purposes of *clause 4*) could have ECT recommended to them and they would be able to be admitted to a mental health service approved under *clause 540* for the performance of ECT if the relevant requirements were met.

Clause 196 stipulates the requirements for ECT to be performed on a child aged 14 to 18 years who is an involuntary patient or mentally impaired accused. Informed consent is not required. The approval of the Mental Health Tribunal is required.

Clause 197 stipulates the requirements for ECT to be performed on an adult who is a voluntary patient. Informed consent is required from the patient or their guardian or enduring guardian. Informed consent may also be in the form of an AHD. *Clause 197*, unlike the other clauses authorising ECT, requires ECT to be performed at a mental health service approved by the Chief Psychiatrist under *clause 540* for the performance of ECT. The other clauses do not expressly include this requirement because the Mental Health Tribunal can only approve ECT if the requirement is met. That is, the requirement is placed in Part 21 Division 6 in relation to ECT approvals.

Clause 198 stipulates the requirements for ECT to be performed on an adult who is an involuntary patient or mentally impaired accused. Informed consent is not required. The approval of the Mental Health Tribunal is required, unless the ECT is performed as emergency ECT described in *clause 199*.

Clause 199 provides for emergency ECT on adult involuntary patients and mentally impaired accused, in exceptional circumstances set out in the clause. Approval from the Mental Health Tribunal is not required, but approval must be obtained from the Chief Psychiatrist. It is anticipated that obtaining approval from the Chief Psychiatrist will be a more expeditious process than obtaining the approval of the Mental Health Tribunal (particularly given that the Chief Psychiatrist can delegate to other psychiatrists), and that the former is the more appropriate process in emergency circumstances. *Clause 199* is intended to be used as an interim mechanism to manage extreme risk and, before or immediately after ECT has commenced, the patient's psychiatrist would generally seek approval from the Mental Health Tribunal for longer term use of ECT (pursuant to *clause 187*). *Clause 199* also provides an interim option where the Mental Health Tribunal seeks to engage or appoint a person with relevant knowledge or experience pursuant to *clause 439*. In any case, it is envisaged that the Mental Health Tribunal would prioritise a matter such as this. In the meantime, emergency ECT would generally be able to continue if the involuntary treatment and emergency ECT requirements continue to be met (or that the person continues to be a mentally impaired accused and the emergency ECT requirements continue to be met, as the case may be).

Clause 200 requires performance of ECT on a person who is a mentally impaired accused to be reported to the Mentally Impaired Accused Review Board as soon as practicable after the ECT has been performed. Although it is considered to be essential that the Mentally Impaired Accused Review Board have access to this information, failure to provide the information under *clause 200* is not an offence in

clause 193. It is considered inappropriate for the mental health service to be subject to a penalty for what may be a mere delay or oversight. However, a compliance notice may be issued by the Mental Health Tribunal for example under Part 21 Division 8, or the Chief Psychiatrist may intervene.

Clause 201 will apply in relation to a mental health service which the Chief Psychiatrist has approved the performance of ECT in accordance with *clause 540*. *Clause 201* reflects the importance of recording information about ECT. Mental health services performing ECT must report statistics to the Chief Psychiatrist monthly. *Clause 201* sets out 11 matters that must be reported, including details of any serious adverse event that occurred during or after ECT being performed on a patient. This is essential to ensure data efficacy, promote transparency and allow the Chief Psychiatrist to consider trends at particular mental health services and for other purposes. *Clause 530* requires statistics on ECT to be included in the Chief Psychiatrist's annual report.

Division 2 - Emergency psychiatric treatment

Clause 202 describes emergency psychiatric treatment for the purposes of Division 2. Emergency psychiatric treatment may be given to any person, even if they are not a patient, by a medical practitioner, under the exceptional circumstances set out in *clause 202*. It is anticipated that this will primarily be psychotropic medication. It can only include psychiatric treatment, so medical treatment would have to be provided in accordance with *clause 242* in relation to urgent non-psychiatric treatment. It cannot be ECT, psychosurgery, a prohibited treatment, or anything that is not a treatment. It is intended that this clause will primarily cover persons early in the referral process. However, it can also be relied upon in relation to an involuntary patient or mentally impaired accused. For example, the patient's psychiatrist can rely on *clause 202* rather than immediately and urgently going through the procedure in *clause 179* and *clause 280* in relation to ascertaining and having regard to the patient's wishes.

Clause 203 permits a medical practitioner to administer emergency psychiatric treatment without informed consent, and despite any refusal by the person. It is noted that the additional requirements in the *Guardianship and Administration Act 1990* regarding urgent treatment do not apply to emergency psychiatric treatment.

Clause 204 requires comprehensive records of emergency psychiatric treatment provided to a patient to be kept and provided to the person, the Chief Psychiatrist and, if the person is a mentally impaired accused, the Mentally Impaired Accused Review Board. *Clause 530* requires statistics on emergency psychiatric treatment to be included in the Chief Psychiatrist's annual report.

Division 3 - Psychosurgery

Clause 205 defines psychosurgery. This treatment is included in the Act based on clinical advice of the safety and therapeutic value of emerging treatments, particularly Deep Brain Stimulation. It is considered that it would be inappropriate to deny patients access to such treatment. However, it is also considered that safeguards beyond those in relation to treatments such as oral and intramuscular medication are essential for a treatment that may be or perceived to be more invasive than other treatments.

Clause 206 prohibits the performance of psychosurgery except in accordance with *clauses 207-208*. The penalty is five years imprisonment.

Clause 207 prohibits the performance of psychosurgery on children under 16 years of age, reflecting clinical advice that psychosurgery may not be the most appropriate treatment for younger children.

Clause 208 stipulates the requirements for psychosurgery to be performed. Informed personal consent (where the person has the capacity to give informed consent) is always required, together with approval from a specially constituted Mental Health Tribunal which includes a neurosurgeon. Informed consent in the form of an AHD is sufficient, but informed consent from a parent of a child or a guardian or enduring guardian is insufficient.

Clause 209 requires the performance of psychosurgery to be reported to the Chief Psychiatrist and, if the person is a mentally impaired accused, it must also be reported to the Mentally Impaired Accused Review Board as soon as practicable after the psychosurgery has been performed. *Clause 530* requires statistics on psychosurgery to be included in the Chief Psychiatrist’s annual report.

Division 4 - Deep sleep and insulin coma therapy

Clause 210 creates an offence for performance of deep sleep therapy, insulin coma therapy or insulin sub-coma therapy, on any person. The offence is prescribed to be a crime with a penalty of five years imprisonment.

Division 5 - Seclusion

Clause 211 defines some of the terms used in Division 5, namely oral authorisation and seclusion order.

Clause 212 describes seclusion, which is in line with definitions in national polices. Division 5 applies to any person who is being provided with treatment or care at an authorised hospital, therefore it may include a voluntary patient, in addition to

involuntary patient or mentally impaired accused. It is important to note that Division 5 only applies in authorised hospitals, so it does not apply in general hospitals.

Clause 213 creates an offence for secluding a person except in accordance with an oral authorisation or a seclusion order. The penalty is a fine of $6,000.

Clause 214 sets out the requirements for an oral authorisation for seclusion by a medical practitioner or mental health practitioner at an authorised hospital or the person in charge of a ward at an authorised hospital and refers to the criteria for seclusion in *clause 216*. There are stringent procedural requirements throughout Division 5, amongst other Divisions, which reflect the fact that seclusion deprives a person of freedom, dignity and autonomy. In relation to oral authorisation, the intention is that, in an emergency, an oral authorisation may be given rather than a written seclusion order. Seclusion under an oral authorisation can be for up to two hours.

Clause 215 sets out the requirements for a seclusion order (which must be in the approved form), including the reasons for the order and reasons for urgency if the seclusion order was not made by a medical practitioner. Although seclusion is usually in response to a crisis, there may be sufficient time to make a written order. Alternatively, the seclusion order may be made where a person is secluded under an oral authorisation and it is anticipated that the person may still need to be secluded after the two hours permitted under the oral authorisation have expired. If a seclusion order is made by a mental health practitioner or the person in charge of a ward then within two hours a medical practitioner must be informed even if the person has since been released. This reflects that it is necessary for a medical practitioner to be aware when seclusion is being used, particularly given that *clause 223* requires a subsequent medical examination, and that the use of seclusion in one or more instances will generally inform future treatment, care and support. A seclusion order can be made for up to two hours but this can be extended pursuant to c*lause 218* under specified circumstances.

Clause 216 delineates the criteria for making an oral authorisation or a seclusion order. The circumstances in which a person can be secluded are exceptional, and will only be where the person is so distressed that they are behaving in a way that is a risk to the physical safety of the person or another person, or where the person is persistently causing serious damage to property, and where there is no less restrictive way of preventing the injury or damage. The seclusion order can be for no longer than two hours, but this can at times be extended in accordance with *clause 218*.

Clause 217 applies where the person has a treating psychiatrist (taking account of referred persons who do not have a treating psychiatrist) and the treating psychiatrist

does not already know that the person is or was in seclusion via the processes in *clauses 214-215*. The treating psychiatrist must be informed within two hours. It is intended that this will maintain the involvement of treating psychiatrists in the day to day care of patients at authorised hospitals. It is not mandatory for the treating psychiatrist to attend.

Clause 218 allows a seclusion order (but not an oral authorisation) to be extended by a further two hours from the end of the prior seclusion order. A seclusion order may be extended more than once. The order can only be made by a medical practitioner and this can only be done where the medical practitioner examines the person in accordance with *clause 222* immediately before making the order extending seclusion. This takes account of the fact that sometimes the initial two hour order (or two hour orders after that) may not be sufficient time for the person to have recovered to the point that they no longer meet the criteria in *clause 216*.

Clause 219 sets out how a seclusion order may be revoked if the person no longer needs to be in seclusion. With or without medication, a person's mental state and behaviour may improve more rapidly than expected and at any time the person may be ready to be released from seclusion.

Clause 220 stipulates that, where a seclusion order is revoked or expires, a medical practitioner or mental health practitioner must inform the person and ensure that the person is released from seclusion. The intention is to keep people fully aware of their rights and use the least restrictive means, in accordance with the Objects of the Act in *clause 10*.

Clause 221 requires the medical practitioner or mental health practitioner to keep a record of the seclusion order expiring, promoting compliance with other clauses, and ensuring transparency.

Clause 222 sets out the requirements for proper attention of a person in seclusion. A mental health practitioner or a nurse must observe the person at least every 15 minutes and a medical practitioner must examine the person at least every two hours. There is no definition of 'observe' in the Act; however the requirement is that the person be observed in the physical presence of the person or, more likely, through a door to a seclusion room. It is insufficient for compliance with the Act to watch a person on Closed Circuit Television, for example. However, that may be used for continuing additional observation as part of best practice. The person must be provided with bedding and clothing, sufficient food and drink, access to toilet facilities, and any other care appropriate to the person's needs.

Clause 223 requires a person who has been released from seclusion to be provided with a physical examination by a medical practitioner within six hours of being released. If the person is to be released or discharged or wants to leave against medical advice, the person must first be offered a physical examination by a medical practitioner, to be conducted before the person leaves. The medical practitioner must record, amongst other things, any complication or deterioration in the person's mental state or physical condition that is a result of or may be a result of the person having been secluded. This clause acknowledges that seclusion may be a traumatic experience and that a medical review by a medical practitioner is required. It is important to note that *clause 223* and the other provisions in Division 5 are the mandatory requirements, and best practice may involve additional requirements; for example the use of de-escalation techniques prior to seclusion and a post-seclusion interview.

Clause 224 applies whenever a person is released from seclusion under an oral authorisation or seclusion order. The Chief Psychiatrist must be provided with a copy of the relevant orders and records. Where the person is a mentally impaired accused, these documents must also be provided to the Mentally Impaired Accused Review Board. *Clause 530* requires statistics on seclusion to be included in the Chief Psychiatrist's annual report.

Clause 225 is a prescribed provision for the purposes of *clause 172*. That is, a person prescribed in the Regulations for *clause 225* can request another person to give the person reasonable assistance in exercising that power; and the person requesting or the person assisting may use reasonable force.

Division 6 - Bodily restraint

Clause 226 defines some of the terms used in Division 6, being bodily restraint order and oral authorisation.

Clause 227 defines bodily restraint. Bodily restraint may be physical or mechanical. Division 6 applies to any person who is being provided with treatment or care at an authorised hospital, therefore it may include a voluntary patient, in addition to an involuntary patient or mentally impaired accused. It is important to note that Division 6 only applies in authorised hospitals, so it does not apply in general hospitals. 'Physical restraint' and 'mechanical restraint' are also separately defined in *clause 227*. The definition is intended to differentiate between bodily restraint and other types of restraint applied for the safety of patients, particularly elderly patients. *Clause 227* states that bodily restraint does not include physical or mechanical restraint by a police officer acting in the course of duty, or physical restraint by a person exercising a power under *clause 172*.

Clause 228 sets out principles relating to the use of bodily restraint which are that the degree of force used to restrain the person must be the minimum that is required in the circumstances and while the person is restrained there must be the least possible restriction on the person's freedom of movement and the person must be treated with dignity and respect. Use of restraint can be very distressing to all those involved and all effort must be made to minimise its effect, which is the rationale behind the inclusion of *clause 228*.

Clause 229 creates an offence for using bodily restraint on another person except in accordance with an oral authorisation or a bodily restraint order. The penalty is a fine of $6,000.

Clause 230 sets out the requirements for an oral authorisation for bodily restraint by a medical practitioner or mental health practitioner at an authorised hospital or the person in charge of a ward at an authorised hospital and refers to the criteria for bodily restraint in *clause 232*. There are stringent procedural requirements throughout Division 6, amongst other Divisions, which reflect the fact that bodily restraint deprives a person of freedom, dignity and autonomy. In relation to oral authorisation, the intention is that, in an emergency, an oral authorisation may be given rather than a written bodily restraint order. Bodily restraint under an oral authorisation can be for up to 30 minutes.

Clause 231 sets out a process for making a bodily restraint order which is similar to the process in relation to a seclusion order as detailed in *clause 215* above. A bodily restraint order can be for up to 30 minutes but this can be extended pursuant to *clause 234* under specified circumstances.

Clause 232 sets out the criteria for making an oral authorisation or a bodily restraint order. The circumstances in which a person can be subject to bodily restraint under Division 6 are narrow, being that the person needs to be restrained to be provided with treatment, to prevent them from physically injuring themselves or another person, or preventing the person from persistently causing serious damage to property. Further, the circumstances must be such that there is no less restrictive way of providing the treatment or preventing the injury or damage. Finally, bodily restraint can only be used if it is unlikely to pose a significant risk to the person's physical health. The criteria anticipate that bodily restraint will be used as an intervention of last resort.

Clause 233 applies where the person has a treating psychiatrist (taking account of referred persons who do not have a treating psychiatrist) and the treating psychiatrist does not already know that the person is or was subject to bodily restraint via the processes in *clauses 230-231*. The treating psychiatrist must be informed within 30

minutes. It is intended that this will maintain the involvement of treating psychiatrists in the day to day care of patients at authorised hospitals. It is not mandatory for the treating psychiatrist to attend.

Clause 234 allows a bodily restraint order (but not an oral authorisation) to be extended or shortened, and to allow a different restraint device to be used. The bodily restraint order can be extended by a further 30 minutes from the end of the prior bodily restraint order. A bodily restraint order may be extended more than once. Restraints are usually for short periods but if a person is significantly unwell and behaviour is an extreme risk then restraint, particularly mechanical restraint, may need to be used for a longer period. *Clause 234* does not contemplate a person subject to mechanical bodily restraint then becoming physically restrained, as it is not anticipated that this would occur. A person who is released from mechanical restraint may again create risk and in these circumstances a new oral authorisation or bodily restraint order could be made.

Clause 235 sets out how a bodily restraint order may be revoked if bodily restraint is no longer required; for example where a person's mental state or behaviour improve more rapidly than expected, as a result of treatment or otherwise.

Clause 236 stipulates that, where a bodily restraint order is revoked or expires, a medical practitioner or mental health practitioner must inform the person and ensure that the person is released from bodily restraint.

Clause 237 requires the medical practitioner or mental health practitioner to keep a record of the bodily restraint order expiring which will be one component of the bodily restraint form.

Clause 238 sets out the requirements for proper attention of a person upon whom bodily restraint is being used. A mental health practitioner or a nurse must be with the person at all times and record any observations he or she makes about the person. Actual physical presence is required. If the person remains restrained for more than six hours, a psychiatrist must review the use of the restraint. The person must be provided with bedding and clothing, sufficient food and drink, access to toilet facilities, and any other care appropriate to the person's needs.

Clause 239 requires a person who has been released from bodily restraint to be provided with a physical examination by a medical practitioner within six hours of being released. If the person is to be released or discharged or wants to leave against medical advice, the person must first be offered a physical examination by a medical practitioner, to be conducted before the person leaves. The medical practitioner must record, amongst other things, any complication or deterioration in the person's

mental state or physical condition that is a result of or may be a result of the person having been restrained. This clause recognises that bodily restraint is not only a distressing experience, but that physical conditions may result from the use of physical force and from the use of bodily restraint (even though it was to minimise or eliminate the risks identified above in *clause 232*).

Clause 240 applies whenever a person is released from bodily restraint under an oral authorisation or bodily restraint order. The Chief Psychiatrist must be provided with a copy of the relevant orders and records. Where the person is a mentally impaired accused, these documents must also be provided to the Mentally Impaired Accused Review Board. *Clause 530* requires statistics on bodily restraint to be included in the Chief Psychiatrist's annual report.

Part 15 Health care of people in hospitals

Division 1 - Examination to assess person's physical condition

Clause 241 relates to the physical condition of people who are admitted to, or received at, an authorised hospital or a general hospital. It includes voluntary inpatients in authorised hospitals and general hospitals to the extent that they are a mental health service (by virtue of the definition of 'voluntary inpatient' in *clause 4*). A physical examination must be offered within 12 hours of admission or receival at the hospital. The physical examination may include the taking of specified samples. In relation to a voluntary patient, the physical examination can only be conducted with informed consent of the patient themselves or the person authorised at law to consent on their behalf. In relation to an involuntary patient or a person who is a mentally impaired accused, a physical examination may be conducted, and specified samples taken, without a requirement for consent. The results of the examination must be recorded, including the results of tests on samples taken from the examination. The prevalence of certain physical illnesses in persons with a mental illness has been shown to be a significant health issue and *clause 241* is intended to promote the physical health of people experiencing mental illness. Further, the occurrence of mental illness caused by use of alcohol and other drugs can necessitate physical examinations, including the taking of samples, to assist in examination and providing appropriate treatment. An initial physical examination also provides a benchmark with respect to the person's health, including basic observations such as blood pressure. This can be used to determine the impact of treatment.

Division 2 - Urgent non-psychiatric treatment for involuntary inpatients and mentally impaired accused

Clause 242 applies to involuntary inpatients and persons who are mentally impaired accused. It reiterates the position in the *Guardianship and Administration Act 1990*, but creates additional requirements. Firstly, a report must be provided to the Chief Psychiatrist. *Clause 530* requires statistics on urgent non-psychiatric treatment to be included in the Chief Psychiatrist's annual report. Secondly, where the person is a mentally impaired accused, a report must be provided to the Mentally Impaired Accused Review Board. Further, the provision of urgent non-psychiatric treatment under *clause 242* is a notifiable event. It is important to distinguish between urgent non-psychiatric treatment and non-urgent non-psychiatric treatment, which is a clinical judgment. The Act itself does not provide for non-urgent non-psychiatric treatment, except to the extent that it is a condition which is a consequence of mental illness, explained above in relation to *clause 4*. Where the condition is not a consequence of mental illness (and *clause 242* does not apply), treatment should be

provided in the same way that conditions are dealt with in general health – with the consent of the person or the person authorised at law to consent on their behalf.

Part 16 Protection of patients' rights

Division 1 - Patients' rights generally

Subdivision 1: Explanation of rights

Clause 243 sets out the persons to whom Subdivision 1 applies. In broad terms, this includes inpatients both voluntary and involuntary, in authorised hospitals and general hospitals, people on CTOs, and referred persons.

Clause 244 requires the person responsible pursuant to *clause 246* to explain a person's rights to them. As with similar provisions throughout the Act, *clause 9* applies here – requiring the explanation to be in a language, form of communication and terms that the person is likely to understand. This may involve the use of an interpreter if necessary and practicable.

Clause 245 requires the person responsible pursuant to *clause 246* to explain a person's right to another person, being a carer, close family member or other personal support person. Again, this must be communicated in accordance with *clause 9*.

Clause 246 places an onus on persons identified in the clause such as psychiatrists and other medical practitioners to ensure that the above explanations are provided.

Subdivision 2: Access to records about patients and former patients

Clause 247 explains what a relevant document means for the purposes of Subdivision 2. It is important to note that a relevant document may be a whole or a part of a record of another document about a person.

Clause 248 gives a person who is being provided with, or was being provided with treatment or care by a mental health service, the right to inspect and be provided with a copy of any relevant document that the mental health service has. The mental health service may refuse to provide access in circumstances set out in *clause 249*. The right in Subdivision 2 is intended to supplement rights that exist under other laws, such as the *Freedom of Information Act 1992* (WA) and the *Privacy Act 1988* (Cth).

Clause 249 sets out the circumstances in which a person is not entitled to be given access to a relevant document under *clause 248*. The listed circumstances take account of possible adverse effects that access could have on a patient; as well as the need for protection of personal information regarding other persons, and confidential information, that may be included in a relevant document.

Clause 250 provides an alternative for a person who has been refused access to a relevant document. The person may nominate a medical practitioner or a legal practitioner or both, who can have access to the relevant document.

Clause 251 creates an offence for the medical or legal practitioner to disclose the information to which the person has been refused access. This offence is in addition to any disciplinary proceedings which may be undertaken against the person for their conduct in relation to medical or legal practice.

Subdivision 3: Duties of staff of mental health services towards patients

Clause 252 defines mental health service to include a private psychiatric hospital, for the purposes of Subdivision 3. Therefore, *clauses 253-254* apply to residents of private psychiatric hostels, in addition to patients of other mental health services and referred persons, being a broad application.

Clause 253 creates an offence in relation to a staff member of a mental health service who ill-treats or willfully neglects a person referred to in *clause 252*. The penalty is a fine of $15,000 and imprisonment for two years. As with other offence provisions, the offence in the Act may be in addition to offences and legal actions under other written laws. For example, a person may be found criminally and civilly liable in negligence or for an assault.

Clause 254 establishes a mandatory reporting requirement in relation to serious incidents. A staff member of a mental health service must report any reasonable suspicion of unlawful sexual contact, or unreasonable use of force by a staff member against a person referred to in *clause 252*. Unreasonable use of force goes beyond reasonable force used in the exercise of powers under Part 12, and also beyond day to day interactions and functions carried out in the course of duty by staff in relation to patients. The report must be made to the person in charge of the mental health service or the Chief Psychiatrist, or both. The penalty for not reporting is a fine of $6,000.

Division 2 - Additional rights of inpatients in hospitals

Subdivision 1: Admission of voluntary inpatients by authorised hospitals

Clause 255 states that a voluntary patient can only be admitted as an inpatient of an authorised hospital by a medical practitioner, which includes a psychiatrist. This is intended to make mental health services accessible and enable them to deliver timely and responsive consultation, treatment and care. There is nothing preventing a person who presents to become a voluntary inpatient from being made an involuntary patient in accordance with Part 6.

Clause 256 provides that, if the medical practitioner who admitted the voluntary inpatient into the authorised hospital under *clause 255* is not a psychiatrist, the admission must be confirmed by a psychiatrist.

Clause 257 reflects the fact that admission of a person seeking voluntary admission to an authorised hospital is not always possible because of resourcing implications and because the authorised hospital may not be the most appropriate place to provide treatment, care and support to the person. *Clause 257* is included with the intention of ensuring that people who are seeking admission to an authorised hospital are either admitted or provided with reasons why they are not being admitted (or why their admission is not being confirmed by a psychiatrist). Reasons must be provided together with information about the ability to complain to the Health and Disability Services Complaints Office or the Chief Psychiatrist, or both. The information may be provided in oral or written form. If the information is provided orally the psychiatrist or other medical practitioner must tell the person that they can request the information in writing, and if that request is made the psychiatrist or other medical practitioner must comply as soon as practicable. Best practice would involve the psychiatrist or other medical practitioner seeking admission elsewhere or informing the person of other services that may better meet his or her needs.

Subdivision 2: Rights of inpatients generally

Clause 258 states that Subdivision 2 applies to voluntary inpatients in authorised hospitals, involuntary inpatients and mentally impaired accused.

Clause 259 allows inpatients to retain their personal possessions in an authorised hospital, except in circumstances where this may pose a risk of harm to the patient or another person. The Chief Psychiatrist or hospitals may create policies in this regard, for example as to whether or not a person should be able to retain camera devices including mobile phones. *Clause 259* also deals with what happens where a person leaves any possessions when they are discharged from an authorised hospital.

Clause 260 provides inpatients with a right to interviews with a psychiatrist and sets out the relevant process. There is an exception with respect to patients who have a history of making repeated requests in circumstances where the psychiatrist is satisfied that the patient is acting unreasonably in making the request. A record of a refusal must be filed and a copy given to the patient.

Clause 261 gives patients the right of freedom of lawful communication, such as telephone, email and mail, subject to *clause 262*.

Clause 262 enables a psychiatrist to restrict a patient's right under *clause 261* where the restriction is in the patient's best interests. Examples include where an inpatient

is making repeat contact with a person or persons to harass or threaten them; or where a person who is a mentally impaired accused is seeking to call someone who has a misconduct restraining order against them. A restriction may be by means of limits on the right, or a complete prohibition. Visits with a legal practitioner or mental health advocate can only be restricted in the specified exceptional circumstances. As with all provisions in the Act, regard must be had for the Objects of the Act in *clause 10* giving effect to the provision. Where a psychiatrist makes an order under *clause 262* restricting a patient's right under *clause 261*, the Chief Mental Health Advocate must be advised within 24 hours. Part 21 Division 9 confers jurisdiction on the Mental Health Tribunal to review and limit or remove a restriction imposed under *clause 262*.

Division 3 - Nominated persons

Subdivision 1: Purpose and effect of nomination

The scope of Subdivision 1 is not limited – any person can make a nomination at any time, subject to Subdivision 3.

Clause 263 describes the role of the nominated person. A nominated person is a person, such as a family member or friend, who is formally nominated by a person to help ensure that the person's rights are observed and to ensure that the person's interests and wishes are taken into account. The scope of Subdivision 1 is not limited - anyone can make a nomination in accordance with Subdivision 3, at any time.

Clause 264 sets out some of the entitlements of the person in relation to the nominated person, and entitlements of the nominated person themselves. These entitlements include uncensored communications between one another, involvement, and exercising of rights on behalf of the person. A nomination, in itself, does not authorise the nominated person to admit or discharge the person, or to make a treatment decision on the person's behalf. That is, the nominated person is not authorised by law to make decisions on behalf of the person (but may be authorised to do so in another capacity, such as guardian). *Clause 264* is subject to other more specific provisions in Division 3.

Subdivision 2: Right to information, and to be involved in matters, relating to patient's treatment and care

Subdivision 2 applies to patients, as defined in *clause 4*.

Clause 265 states that Subdivision 2 does not apply in relation to notifiable events. That is, a nominated person's entitlements to notifications under Subdivision 2 are in addition to the rights under Part 9.

Clause 266 sets out the information that a nominated person is entitled to, and matters that they are entitled to be involved in, subject to *clause 269*.

Clause 267 places an onus on the patient's psychiatrist to ensure that the nominated person has their entitlements observed, unless another provision in the Act places that onus on another person.

Clause 268 provides for situations where a nominated person cannot be identified or contacted. Reasonable efforts need to be made to identify the nominated person and to provide them with information or to involve them in a matter, as the circumstances provided for in the provision require.

Clause 269 creates an exception where the patient's psychiatrist deems that it would not be in the best interests of the patient for the nominated person be provided with information or involved in matters. There is nothing preventing this exception from being exercised in relation to some information or involvement (ie particular matters) and informing or involving the nominated person in relation to other matters. Procedural requirements follow the best interests exception being invoked, including provision of a copy of the decision and reasons for the decision to the patient and the Chief Mental Health Advocate.

Clause 270 stipulates that where the patient's psychiatrist has exercised their discretion not to inform or involve the patient's nominated person as per *clause 269*, and if the nominated person requests to be informed or involved in relation to the matter, the patient's psychiatrist must advise the nominated person of the decision to not inform or involve them and the reasons for that decision.

Clause 271 enables the patient's psychiatrist to revoke a decision not to inform or involve a nominated person at any time, if satisfied that the reasons for making the prior decision no longer apply. Subsequently the nominated person must be informed or involved (in relation to all or particular matters, as the case may be) and the decision and reasons for the revocation must be recorded. Where a nominated person previously requested to be informed or involved, and a decision not to notify has been revoked, then the nominated person must be informed or involved and a record of when and how the nominated person was provided with the information or involved in the matter must be filed and a copy given to the patient. *Clause 271* states that there is no requirement to involve the nominated person in a matter if the time for doing so has passed.

Clause 272 states that Subdivision 2 does not affect a nominated person's entitlements, under the Act or otherwise, to be provided with information or involved in a matter in another capacity. As discussed above in relation to *clause 264* an

example is where a parent or guardian of a child is the child's nominated person; alternatively, where a guardian or enduring guardian is an adult's nominated person.

Subdivision 3: Making and ending nomination

Clause 273 allows any person, including a child, to make a nomination, provided that they understand the effect of making the nomination. As stated above in relation to Subdivision 1, any person can make a nomination, subject to Subdivision 3. This includes, as examples, residents in private psychiatric hostels, voluntary and involuntary patients at authorised hospitals, persons who are mentally impaired accused, referred persons, and voluntary patients at general hospitals both public and private. However, Subdivision 2 applies in relation to patients as defined in *clause 4*.

Clause 274 stipulates that only an adult can be a nominated person.

Clause 275 lists the formal requirements for making a nomination, including witnessing requirements.

Clause 276 clarifies that a person cannot have more than one nominated person at any point in time.

Clause 277 states that a person who made a nomination can revoke it at any time, by means whatsoever (for example by telling a staff member or destroying the form in the presence of a staff member), including by making another nomination.

Clause 278 allows a nominated person to resign a nomination.

Clause 279 only applies to patients. Where a patient's nominated person resigns the nomination or becomes aware that the patient has revoked the nomination, they must take all reasonable steps to notify any medical practitioner, mental health practitioner or mental health service that the nominated person is aware is providing treatment or care to the patient that the nomination no longer has effect. *Clause 279* notes that Part 21 Division 10 gives the Mental Health Tribunal the jurisdiction to hear and determine applications relating to nominated persons.

Part 17 Recognition of rights of carers and families

Part 17 recognises the essential role that carers and families play in a person's recovery process. It acknowledges that the knowledge acquired by carers and families in their lived experience of supporting a person experiencing mental illness needs to be incorporated into the decision making frameworks surrounding treatment. Provisions promoting increased participation of carers and close family members feature prominently throughout the Act, particularly in Part 17.

Division 1 - Role of carers and families

Clause 280 recognises a number of categories of carer for the purpose of this Act. Carer is defined as per the *Carers Recognition Act 2004* but it is also recognised that carers who should be afforded rights can and do exist beyond this definition. *Clause 280* recognises that even though a family member may be a person's carer, the person may not identify the family member as a carer, or the family member may not identify him or herself as the person's carer.

Clause 281 identifies 'close family members', for the purposes of the Act.

Clause 282 requires acknowledgement of, and respect for, the role of carers and close family members.

Clause 283 requires compliance with provisions in the Act with respect to at least one carer and one close family member. That is, where a person has more than one carer and more than one close family member involved in their treatment, care and support, it is sufficient for a mental health service to inform and involve at least one of each of these people in accordance with Part 17. It is considered unworkable to require more than this, though in some circumstances more than one close family member or more than one carer may be informed or involved, and best practice would prevail.

Division 2 - Information about involvement in patient's treatment and care

Clause 284 stipulates that Division 2 does not apply to the notification of an event to which Part 9 applies. That is, the entitlements in Division 2 are in addition to the rights of a carer and close family member under Part 9.

Clause 285 lists what information carers and close family members are to be provided with, such as the mental illness for which the patient is being treated, and use of any seclusion or bodily restraint; and what matters carers and close family members are entitled to be involved in, such as consideration of treatment options and provision of support. The list is not intended to be exclusive, but a reflection of the minimum information that a carer and a close family member are entitled to. *Clause 285*

stipulates that carers and close family members, subject to the limitations expressed in Division 2, have a right to be involved in matters relating to a patient's treatment and care. Further, it states that carers and close family members are to be provided with information as to a patient's rights and to their rights as carers or close family members. There is also recognition in *clause 285* that a carer or close family member may want to indicate the extent to which they wish to be involved and to receive information. Finally, *clause 285* clarifies the differentiation between the rights of carers and close family members under Part 17 and the more extensive rights of the parent or guardian of a child, or a guardian or enduring guardian of an adult.

Clause 286 states that, where a voluntary patient has capacity to consent, consent is required before information can be provided to the person's carer and close family member, and before the person's carer and close family member can be involved. If consent is provided, then this process must be undertaken. The voluntary patient can indicate the extent to which they consent to informing or involving or both, and whether this applies to their carer or close family member or both.

Clause 287 is the converse of *clause 286*. Where a voluntary patient does not have capacity to consent, the carer and close family member are entitled to be informed and involved despite any refusal, unless it is not in the best interests of the patient. The best interests exception may cover a carer or close family member or both, and may cover informing or involving or both, to a limited or unlimited extent.

Clause 288 applies to involuntary patients and mentally impaired accused who have capacity to consent. The position is in line with *clause 286* above, but there is an exception where the patient's refusal is unreasonable (in the opinion of the patient's psychiatrist). In that case the carer and close family member must be informed and involved.

Clause 289 applies to involuntary patients and mentally impaired accused who do not have capacity to consent. The position is in line with *clause 287* above.

Clause 290 places the responsibility for ensuring provision of information to, and involvement of, a carer and a close family member on the patient's psychiatrist, unless a provision makes another person responsible for this.

Clause 291 describes reasonable efforts which must be made to identify and contact a carer and close family member. A comprehensive record must be kept and filed of all efforts to contact a carer and close family member.

Clause 292 recognises the interface between acknowledging and respecting the rights of carers and close family members, and acting in the best interests of the patient. *Clause 292* gives the patient's psychiatrist discretion to withhold information based on

a reasonable belief that provision of information to, or involvement of, a carer or close family member would not be in the best interests of the patient. In particular, this relates to *clause 287* and *clause 289*, and other provisions throughout the Act that identify *clause 292* as an exception with respect to provision of information or requiring involvement. As a safeguard against a clinician omitting to provide information or to involve carers and close family members where they do not have reasonable grounds for doing so, *clause 292* sets out additional accountability measures. These requirements include filing a record of the decision and reasons for decision, and providing a copy to the patient and the Chief Mental Health Advocate. As referred to above, the matters relevant to a decision about a person's best interests are set out in *clause 7*.

Clause 293 provides a safeguard additional to those in *clause 292* and sets out the position in relation to advising the carer or close family member of the decision made under *clause 292*. Where a decision has been made to exclude a carer or close family member on best interests grounds, and a carer or close family member seeks to be involved, that the psychiatrist must inform them of the decision and the reasons for that decision. If the carer or close family member then requests that this decision and the reasons for it be given in writing the psychiatrist must comply with this request by giving them written confirmation of the decisions and the reason for it, file this decision, and then give a further copy to the patient.

Clause 294 states that the patient's psychiatrist may revoke a decision not to give information to a carer or close family member on best interests grounds if they are satisfied that the reasons for making the decision no longer apply. Procedural requirements follow, including recording the decision and reasons and giving a copy to the patient. If the carer or close family member had previously asked to be involved then they must as soon as practicable be supplied with the information or involved in the matter and a record of this kept. However if the time for doing this has passed then there is no requirement to relay the information or involve the carer or close family member.

Clause 295 states that Division 2 does not supplant any right of a close family member or carer to be informed or involved (under the Act or elsewhere), that the close family member or carer has in another capacity.

Division 3 - Identifying carer or close family member

Clause 296 requires the person in charge of the mental health service to take steps to identify a carer and a close family member who the person being admitted or received into the mental health service consents to provision of information and involvement as set out in *clause 285*. This information must be recorded.

Clause 297 requires a patient who has refused consent under *clause 296* to be asked periodically whether or not they now consent, and requires records to be kept in this regard.

Clause 298 clarifies that a person can, at any time, withdraw or give consent to their close family member or carer (or both) being informed or involved (or both).

Part 18 Children who have a mental illness

Clause 299 enshrines a requirement in the Act whereby, in performing a function under the Act in relation to a child, the best interests of the child must be a primary consideration. The word primary, as opposed to paramount, is used to note the competing interests for family and parents such as issues of safety when the best interests of a child are being considered. *Clause 300* provides that, in performing a function under the Act in relation to a child, regard must be had to the child's wishes, to the extent that it is practicable to ascertain those wishes.

Clause 301 recognises that the role of a child's parent or guardian in the decision making process is central to discussion surrounding treatment, care and support for children experiencing mental illness. The clause provides that, in performing a function under the Act in relation to a child, regard must be had to the views of the child's parent or guardian. Where both parents have parental responsibility in relation to a child, views are to be sought from both parents. However, as stated above in relation to *clause 188*, legislation of this kind cannot provide for all family circumstances. It will ultimately be a matter of clinical judgment taking into account the wishes of the patient and the views of relevant personal support persons.

Clause 302 applies to a child who is a voluntary patient. If the child has the requisite capacity to make an application for admission or discharge for himself or herself, the child may make the application. If the child does not have that capacity, the child's parent or guardian may make an application. The same applies in relation to a treatment decision with respect to a child. It is noted that Part 5 sets out what is required to show that a child has the capacity to make a decision about applying for admission or discharge, or a treatment decision.

Clause 303 relates to children who are inpatients in a mental health service. It extends beyond authorised hospitals to include non-authorised public and private hospitals providing treatment and care to people who have or may have a mental illness. It is preferable for children to receive services in a children's hospital or in a part of the hospital separate from adults. However, if the person in charge of the hospital feels it is appropriate given the child's age, maturity, gender, culture and spiritual beliefs, for them to receive services in a part of the hospital where adults are also admitted then that is allowable. In those circumstances the person in charge of the hospital may take steps such as having a chaperone for the child, or locating the child in a single room easily supervised from the nurses' station. The reason for this flexibility is that there is currently only one authorised hospital specifically catering for children and, for example, where a child is living in a rural area and needs to be admitted to an authorised hospital or general hospital, it may not be in the child's best interests to transport him or her to a metropolitan

area for admission to that hospital. When a child is admitted to a mental health service that is not specifically for children, the person in charge of the mental health service must provide a written report as to why admission to the adult facility was felt to be appropriate and what measures have been taken to protect the child and meet the child's individual needs in relation to treatment and care. The report must be provided to the child's parent or guardian and to the Chief Psychiatrist, amongst other procedural requirements. *Clause 303* notes that Part 17 applies to a child's carer who is not also the child's parent or guardian.

Part 19 Complaints about mental health services

Division 1 - Preliminary matters

Clause 304 defines some of the terms used in Part 19.

Clause 305 describes who a complaint about a mental health service can be made to. *Clause 305* also provides that the person making the complaint does not have to identify themselves as someone who has or may have a mental illness. Similarly, if a carer is making a complaint about a mental health service, the person they are caring for does not have to identify themselves as having a mental illness.

Division 2 - Complaints to service providers

Clause 306 requires services providers to have a complaints procedure in place so that complaints made to that provider follow a clear procedure for investigation. *Clause 306* requires that this procedure is regularly reviewed and revised to ensure it is contemporary. In addition, the most recent version of the procedure must be readily available at the premises of that provider and if a person requests a copy of it, the provider must give the most recent version.

Clause 307 details that service providers who have been prescribed by regulations must give the Director information about complaints received by them at the end of every financial year. The information must be provided in the manner that has been prescribed by the Complaints Office and within the time period prescribed. Further, action taken in response to the complaints must be provided and it must include the action taken up to the date that the data is submitted. The intention of *clause 307* is to enable the Complaints Office to identify common causes of complaints, enhancing its ability to identify systemic issues and trends. The data also provides information about the timeliness of providers' internal complaints procedures and the outcomes achieved as a result of complaints made directly to the prescribed providers.

Division 3 - Complaints to Director of Complaints Office

Subdivision 1: Preliminary matters

Clause 308 states that this Division is to be read with the *Health and Disability Services (Complaints) Act 1995*.

Clause 309 details that a complainant and a respondent can resolve a complaint themselves at any time, with or without the assistance of the Complaints Office. If a complaint is resolved in this way, the complainant must let the Director know as soon as possible and the Director must stop dealing with the complaint if satisfied that it has genuinely been resolved. The intent of stating that the Director must be satisfied

that it has been resolved is to enable the Director to confirm that there has not been any undue pressure put on the complainant to state that the complaint is resolved.

Clause 310 indicates that, unless stated otherwise in Division 3, if a complaint is made by another person or body on behalf of a person and there is a requirement for action to be taken, this action can be taken by the person or body who made the complaint on behalf of another person. In this case, the action taken is deemed to have been taken by the person to whom the complainant made the complaint on the behalf of. For example, if the Director wants the complaint confirmed in writing, the Director can require the person who made the complaint, rather than the complainant, to do so.

Subdivision 2: Director of Complaints Office

Clause 311 sets out the functions of the Director. These include dealing with individual complaints by negotiated settlement, conciliation and investigation, reviewing and identifying causes of complaints, suggesting ways to remove and minimise causes of complaints, investigating matters of general public importance relating to mental health and publishing information about the work of the Complaints Office. When reporting about the work of the Complaints Office, the Director must not identify or include personal details of anyone with a mental illness that could reasonably lead to their identification.

Clause 312 authorises the Minister to issue written directions about general policy to the Director in relation to his or her functions under the Act. The Minister must consult with the Director before issuing these directions and the Director must comply. The Director may also request that the Minister make changes to the Director’s functions. The directions issued would be intended to improve the role of the Complaints Office and would therefore not be based on one particular complaint, person or body. The Minister must table the direction before each House of Parliament within the time specified and the direction must be included in the Complaints Office’s annual report.

Clause 313 entitles the Minister to access information that is related to the functions of the Director under this Division. The Minister can retain or make copies of such documentation. The Director must comply with the Minister’s request for information and must make Complaints Office staff and facilities available so that the Minister may have that information. The Minister cannot, however, have personal information about an individual unless that person has provided consent.

Subdivision 3: Right to complain

Clause 314 sets out who may make a complaint to the Complaints Office. The complaint must be about a service provider in accordance with *clause 319* and can only allege that a service provider acted unreasonably or failed to act in a manner as set out in *clause 319*. The complaint can be made personally by the person who has or may have a mental illness, or on behalf of that person by their representative, a service provider or a registration board as prescribed in Subdivision 3. A person may make a complaint in their own right, or on behalf of themselves and another person or persons. Further, two or more people may make a complaint on their own behalf, or on behalf of themselves and another person or persons.

Clause 315 details who the Director may recognise as a representative of a person with a mental illness or a carer. This includes someone who has been chosen by the complainant. If the complainant is unable to choose a representative and is unable to complain themselves, or if the complainant has died, the Director may recognise a person as a representative if that person has sufficient interest in the subject matter of the complaint. A representative cannot be remunerated for representing a complainant and must not have a financial interest in the outcome of the complaint unless the representative has been prescribed by the Director.

Clause 316 defines a prescribed person as someone who is a mental health advocate, or someone who the Director prescribes to be a representative, or a person or class of persons prescribed by Regulations for this definition. If the representative is not prescribed, it is an offence to demand or receive remuneration.

Clause 317 authorises a service provider to make a complaint on behalf of a person with a mental illness or a carer if the Director is satisfied that the person or carer has died or because they are unable to make a complaint themselves because of their state of health or general situation.

Clause 318 states that a registration board may make a complaint about a service provider on behalf of a person with a mental illness or their carer if the registration board is responsible for that service provider's professional or occupational registration.

Clause 319 stipulates that a complaint can only be made about a service provider that was providing a mental health service at the time that the complaint arose. Further, *clause 319* describes the various grounds of complaint, including that the service provider acted unreasonably in the manner of providing a mental health service, failed to provide a mental health service, or failed to comply with the Charter of Mental Health Care Principles or the Carers Charter (in the *Carers Recognition Act 2004*), amongst other things.

Clause 320 sets out the timeframe for making a complaint as being within 24 months from the time of the incident complained about. However, the Director has discretion to accept a complaint out of time if there was good reason for the delay. This acceptance of a complaint out of time may be particularly relevant where a person with a mental illness has taken some time to get to the point of sufficient recovery or improvement to raise a complaint.

Subdivision 4: Initial procedures

Clause 321 provides that a complaint can be made orally or in writing. If a complaint is made verbally, it must usually be followed up by a written complaint. The intent here is to ensure that the requirement to put a complaint in writing does not hinder people from making a complaint, particularly those who may, for example, be illiterate or unable to write in English and unable to have someone assist them. As a minimum, the Director requires the complainant's name and may request other information. If the complainant does not provide the information required by the Director within the time specified, the complaint may be rejected.

Clause 322 stipulates that if a complaint is made about a free mental health service provided in a rescue or emergency situation, the Director may refer the complaint to an appropriate person or body. The Director must get the written consent of the complainant to do this.

Clause 323 addresses withdrawal of a complaint. A complainant can withdraw a complaint at any time by notifying the Director. The Director must then stop dealing with the complaint and notify the respondent or referral agency that it has been withdrawn.

Clause 324 states that the Director can reject a complaint if the person or body that made the complaint has not taken reasonable steps to resolve the matter with the respondent themselves. The aim here is to ensure the respondent is given an opportunity to respond prior to a complaint being made to the Complaints Office, and to encourage complaints to be resolved by the parties themselves when possible.

Clause 325 dictates that a complaint against a registered service provider may be dealt with by the Director if that complaint is not to be dealt with by a National Board under section 150 of the *Health Practitioner Regulation National Law (Western Australia)*, which requires the National Board and the Complaints Office to consult about which body should deal with the complaint, or whether to split the elements of the complaint between the Complaints Office and the National Board.

Clause 326 states that, if a complaint made to the Director is being dealt with by a National Board under section 150 of the *Health Practitioner Regulation National Law*

(Western Australia), the Director must notify the complainant within 28 days that their complaint is being dealt with by the National Board.

Clause 327 details the preliminary decision made by the Director about a complaint that is not being dealt with by a National Board under section 150 of the *Health Practitioner Regulation National Law (Western Australia).* Within 28 days of receiving a complaint, the Director must decide whether to accept, reject, defer or refer a complaint and may make appropriate inquiries to make this decision. If it is of benefit to the complainant, the Director may extend that 28 day period by a further period of up to 28 days in order to make an informed decision about the complaint. Further, the Director may determine that it is appropriate to accept, reject, defer or refer a part of the complaint rather than the entire complaint. If the Director accepts the complaint, the complainant must be informed, in writing, within 14 days of the decision. If the Director decides that the complaint will be dealt with by negotiated settlement or conciliation, then the Director must also write of the arrangements made for discussions between the complainant and respondent. The Director must also give the respondent information in writing within 14 days of making the decision to accept the complaint. This information includes the details of the complaint, the decision made and, if the decision is that the complaint will be dealt with by negotiated settlement or conciliation, then the Director must also write of the arrangements made for discussions between the complainant and respondent. In addition, the Director must advise the respondent that they may make a written submission to the Director. If the Director rejects the complaint, the Director must write to the complainant and provide details of that decision. If the Director defers or refers the complaint, the Director must inform the complainant in writing and must also write to the respondent and provide details of the complaint and the decision to defer or refer it. If the Director accepts the complaint, the Director may require the respondent to provide a written response to the complaint in accordance with *clause 329*. A complaint which has been accepted can be dealt with by negotiated settlement, conciliation or investigation, depending on which approach the Director determines is most suitable. When a respondent is informed in writing of the Directors decision to accept, defer or refer a complaint, the Director cannot provide personal information about the complainant if it is determined that disclosure of that information may result in the health, safety or welfare of the complainant being put at risk or disclosure would prejudice the proper investigation of the complaint. However, if after some period of time the Director determines that this disclosure no longer poses a concern, then the Director must disclose the personal identity of the complainant to the respondent. If the Director decides that a complaint is not suitable to negotiate a settlement, conciliate or investigate, then the Director must write to the complainant and advise them of that decision and that no further action

will be taken. The Director must complete the functions within this clause before trying to settle a complaint.

Clause 328 details the rejection, deferral and referral of complaints. The Director must reject complaints that are vexatious, trivial, or without substance, as well as those that do not warrant further action or do not comply with Division Three. The Director cannot deal with issues in a complaint that has already been dealt with under another provision of this Act, or another written law, or under a Commonwealth law, or by a court. If an issue in a complaint is being dealt with by another provision of this Act, or under another law, or under a Commonwealth law, or by a court, then the Director must defer dealing with that issue of the complaint. If a complaint raises issues that the Director determines would be better dealt with under another provision of this Act or by another law, then the Director may, with the written consent of the complainant, refer the complaint to the appropriate person or body. However, this referral cannot be made to a National Board under the *Health Practitioner Regulation National Law (Western Australia)* or a court.

Clause 329 states that when a respondent has been advised that a complaint about them has been accepted by the Director, they may provide a written response to the complaint within 28 days or by the end of any extension provided. If a respondent is given notice that they must provide a written response to a complaint, they must provide the written response to the Director within 28 days of that notice or by the end of any extension provided. If the respondent does not provide a written response, the Director may continue to deal with the complaint. If the respondent does not provide a written response and the Director feels that there is no reasonable excuse for this, then the Director must include details of this in the annual report.

Subdivision 5: Negotiated settlements and conciliation

Clause 330 indicates that after the Director accepts a complaint and has notified both the complainant and respondent of this, the Director may negotiate with the complainant and respondent to attempt to bring about settlement of the complaint that is acceptable to the parties. In doing so, the Director may make appropriate inquiries. The Director has 56 days to negotiate a settlement, or longer if the Director determines an extension of time is for the benefit of the complainant. If settlement of the complaint is not negotiated within this period, the Director must refer it for conciliation under *clause 331* or investigate it if it is not suitable for conciliation and the likely costs and benefits of an investigation have been considered. If the complaint is not suitable for conciliation and does not warrant investigating, then the Director must write to the complainant and advise them of the decision and that no further action will be taken.

Clause 331 states that when a complaint is referred for conciliation, it must be assigned by the Director to a staff member whose duties include conciliating complaints. The conciliator must encourage settlement of the complaint. To encourage parties to reach their own confidential and suitable resolution of complaints, the complainant and respondent can only represent themselves during the conciliation process. However, if the complaint has a recognised representative, then that person may represent the complainant. Further, the Director may allow the complainant and respondent to be represented if the Director feels that the process will not be effective otherwise. The conciliator may allow others to attend the conciliation if the conciliator feels it will be helpful. As conciliation meetings are confidential, information shared during the conciliation process is not admissible in proceedings before a court or tribunal. If the conciliation process results in the settlement of the complaint, the conciliator must make a final report to the Director detailing that result, including the agreement reached. If the conciliation process does not resolve the complaint, the Director may investigate it if the Director is of the opinion that an investigation is warranted, having considered the likely costs and benefits of an investigation.

Subdivision 6: Investigations

Clause 332 stipulates that the Director may encourage settlement of a complaint at any time during an investigation. As opposed to conciliation and negotiated settlement where the role of the Complaints Office is to assist parties to reach a mutually agreeable resolution to issues raised in a complaint, the purpose of an investigation is for the Director to determine whether or not a service provider has acted, or failed to act in a manner outlined in *clause 319*. To make this determination, the Director must consider the information in *clause 332* and must investigate as quickly and with as little formality and technicality as possible. The Director is not bound by the rules of evidence and must apply the rules of natural justice. The Director may have Complaints Office staff assist with the investigation.

Clause 333 states that, during an investigation, the Director can give a person written notice to provide relevant information. This statement must be signed by the person, or if the person is a body corporate, it must be signed by an officer of the body corporate. The Director may also write to a person and require them to produce a record of information relevant to the investigation. The Director can only give written notice to a person who the Director believes is capable of proving the information or records requested. The notice must give the time and place for providing the information or producing the records requested. In relation to a relevant record, the Director may retain it for as long as reasonably necessary and may inspect and take a copy of all or part of the record. During this time, the Director must allow a person who is entitled to do so, to inspect or take a copy of the whole or any part of the

record. If the information or record requested is covered by legal professional privilege, the person can refuse to provide it to the Director. A person can also refuse to produce medical records if this has not been consented to by the person to whom the medical record relates, or their representative. *Clause 333* sets out a number of offences which relate to the Director's power to require information and records, including the provision of false or misleading information. As with other clauses in the Act relating to the provision of false or misleading information, it is only an offence where the person knowingly provides false or misleading information.

Clause 334 authorises the Complaints Office to apply for a warrant to enter and inspect premises under the *Health and Disability Services (Complaints) Act 1995*. The offences relating to warrants prescribed in that Act also apply for the purposes of this Act.

Clause 335 provides that the Complaints Office staff member who conciliated or attempted to conciliate the complaint cannot investigate that complaint. This is consistent with the confidential nature of conciliation.

Subdivision 7: Consequences of investigation

Clause 336 states that at the end of an investigation, the Director must decide whether or not the service provider acted unreasonably or failed to act in a manner referred to in *clause 319*. The Director must also give written notice of this decision to both the complainant and respondent. If the investigation was conducted as a result of a direction by the Minister under *clause 340*, written notice of the decision must be given to the Minister and any person affected by the decision. Notices must be given within 14 days of the Director making the decision and must specify the reasons for the decision and any action that the Director recommends should be taken to remedy the matter. Before recommending action that should be taken to remedy the matter by the respondent or another person, the Director must consult with that respondent or other person, as well as anyone else that the remedial action is likely to affect.

Clause 337 articulates that if the respondent or other person receives written notice of the outcome of an investigation and remedial action has been recommended, that respondent or other person must give a written report about the remedial action taken within 45 days of receiving the notice. An extension to that period can be sought before the end of the 45 day period and if the Director considers it appropriate, the 45 day period can be extended by up to a further 15 days. Failure to report on remedial action is an offence.

Clause 338 declares that, if the respondent or other person does not provide a report of the remedial action taken, or does not take the remedial action recommended

within a reasonable time, the Director must give to the Minister a copy of the decision and a written report about this. In this report to the Minister, the Director cannot include personal information about a complainant except with the consent of the complainant. The Minister may lay a copy of the documentation provided by the Director before each House of Parliament. Clauses 337 and 338 are intended to ensure that recommendations made or advice given by the Complaints Office is implemented where appropriate.

Subdivision 8: Other matters relating to investigations

Clause 339 stipulates that the Director must stop investigating or dealing with a complaint to the extent that it relates to an issue that the Director becomes aware is being dealt with under another provision of this Act or under another written law or under a Commonwealth law or in a court. Within 14 days of this, the Director must write to the complainant and respondent and notify them that they have stopped dealing with the issue. The Director may resume dealing with an issue if they become aware that the issue is no longer being dealt with under another provision or law or by that court but has not been resolved.

Clause 340 states that the Minister may direct the Director to conduct an investigation under Subdivision 6 if the Minister is of the opinion that there are circumstances relating to a person who has or may have a mental illness that justify a complaint being made, or it is in the public interest on a matter of general importance relating to mental health services that an investigation be conducted. These types of investigations are intended to be broad in focus and may address systemic issues.

Clause 341 is a confidentiality provision aimed at protecting persons from disclosure of personal or sensitive information. It confirms that information derived from negotiated settlement, conciliation and investigation must not be disclosed to third parties by anyone, including Complaints Office staff, the complainant or the respondent. Unauthorised disclosure is a serious offence.

Division 4 - Miscellaneous matters

Clause 342 enables the Director to report to Parliament in the wide circumstances specified in the clause. This cannot include personal information without the consent of the person.

Clause 343 creates an offence for provision of false or misleading information or documents.

Clause 344 clarifies that a person must not be penalised for making a complaint either through their own service providers' complaints procedure or to the Complaints Office. Further, a person must not threaten or intimidate another person in an

attempt to persuade that person not to make or continue with a complaint, or withdraw a complaint, or provide information or assist the Complaints Office to perform their functions under this Part. Further, a person must not refuse to employ, dismiss from employment or subject the person to any detriment if that person intends to make or has made a complaint, or intends to take part in a complaint under Division 3. Breach of this provision is an offence.

Clause 345 states that the Director must establish and maintain a register of complaints made under *clause 307* and under Division 3 Subdivision 3. The Director must also establish and maintain a register of matters that the Minister has directed be investigated under *clause 340*. Each register must be established and maintained in a way determined by the Director. Further, the form and contents of each register must be determined by the Director.

Clause 346 discusses delegations by the Director and states that the Director may delegate any power or duty of the Director under another provision of this Part to a member of the Complaints Office staff. This delegation must be in writing and signed by the Director. The person to whom the delegation has been made cannot delegate that power or duty.

Part 20 Mental health advocacy services

Division 1 - Preliminary matters

Clause 347 details who an identified person is for the purposes of Part 20, and states that mental health service includes a private psychiatric hostel for the purposes of Part 20.

Division 2 - Mental health advocates: appointment or engagement, functions and powers

Subdivision 1: Appointment or engagement, functions and powers

Clause 348 creates the statutory office of the Chief Mental Health Advocate, appointed by the Minister.

Clause 349 enables the Chief Mental Health Advocate to engage or appoint mental health advocates. The clause requires the appointment of at least one mental health advocate who has qualifications, training or experience relevant to children and young people (a youth advocate). It is anticipated that the Chief Mental Health Advocate will also engage advocates with specialist expertise in working with a range of groups in our community, including indigenous people, and those with co-occurring issues such as intellectual disability.

Clause 350 describes the functions of the Chief Mental Health Advocate.

Clause 351 sets out the functions of mental health advocates. Included is the requirement to contact identified persons in accordance with *clause 356*, to inquire into or investigate the conditions of the mental health service, to ensure the person has been informed of their rights and that these are being observed, to assist with complaints and the enforcement of an individual's rights including access to legal services and other services, to refer any issues arising to the appropriate bodies to deal with the issues and any other function conferred by another law. It is intended that the reference to 'conditions' of the mental health service be interpreted broadly, to include environmental, therapeutic and recreational conditions, for example. *Clause 351* enables anyone with a sufficient interest, such as a carer, close family member or nominated person to make a complaint to a mental health advocate for investigation. Further, it enables a mental health advocate to make a complaint to a mental health service or pursuant to Part 19; and assist an identified person in relation to proceedings before the MHT or the State Administrative Tribunal. When performing a function under *clause 351*, a mental health advocate is subject to the general direction and control of the Chief Mental Health Advocate.

Clause 352 empowers a mental health advocate to do anything necessary or convenient for the performance of functions under the Act.

Clause 353 gives the Minister the power to issue directions of a general policy nature after consultation with the Chief Mental Health Advocate. For example, it allows the Minister to include additional classes of voluntary patients in the scope of the work of the service. The CEO of the Commission has the authority to issue directions about administrative policies and procedures after consultation with the Chief Mental Health Advocate. Examples include compliance with Public Sector policies and procedures, contracting requirements and budget management. Directions cannot be issued with respect to a particular person, mental health service or other person or body, but could be issued with respect to, for example, all children involuntarily detained in mental health services. The Chief Mental Health Advocate can also request the Minister or the CEO to issue a Direction.

Clause 354 gives the Minister the power to issue a written direction requiring the Chief Mental Health Advocate to report to the Minister about the provision of treatment or care by a particular mental health service to a particular person or to ensure that a particular mental health service is visited and a report given to the Minister. Where the Minister issues such a direction this must be laid before each House of Parliament and included in the Chief Mental Health Advocate's annual report. The publication of personal information about a person is not allowed in any report.

Subdivision 2: Contacting identified person or person with sufficient interest

Clause 355 enables specified persons to request a mental health advocate to contact an identified person. Those persons are the identified person, the identified person's psychiatrist, and a person who has a sufficient interest in the identified person such as a close family member, carer or nominated person. The request can be made directly to the Chief Mental Health Advocate or to the mental health service. If the request is made to the mental health service then the service must advise the Chief Mental Health Advocate within 24 hours of the request being made.

Clause 356 creates a duty for a mental health advocate to contact an identified person within specified time limits. In relation to a request (as opposed to automatic contact) time runs from when the request was made to the Chief Mental Health Advocate or when the mental health service advises the Chief Mental Health Advocate of the request.

Clause 357 allows a mental health advocate to contact an identified person on the mental health advocate's own initiative, or the initiative of another mental health

advocate (including the Chief Mental Health Advocate) unless there is a direction from the Chief Mental Health Advocate to the contrary.

Subdivision 3: Specific powers of mental health advocates

Clause 358 vests specific powers in mental health advocates, including the power to inspect any part of a mental health service that they visit and for as long as they deem necessary. This provision ensures that a mental health advocate is able to visit a mental health facility, including private psychiatric hostels, without a specific request from a resident. *Clause 358* also enables a mental health advocate to make inquiries about specified things, to require a staff member to respond to certain queries and to provide information and give reasonable assistance. *Clause 358* also deals with access to medical records by mental health advocates. In relation to an involuntary patient, *clause 358* creates a default position that a mental health advocate can inspect or take a copy of the involuntary patient's medical record. The exception is where the involuntary patient actively objects. In contrast, in relation to a voluntary patient, consent must be sought from the voluntary patient (if they have capacity) or the person authorised by law to consent on their behalf (if the voluntary patient does not have consent), and if consent is not provided then the mental health advocate cannot access the voluntary patient's medical record. *Clause 358* also stipulates that all the provisions within that clause are subject to the direction of the Chief Mental Health Advocate.

Clause 359 allows a mental health service to prevent a mental health advocate from disclosing information to a patient where access by the patient has been restricted for the reasons specified in *clause 248*. The mental health service must inform the mental health advocate that access to a document by a patient has been refused and that disclosure constitutes an offence.

Clause 360 creates an offence for a mental health advocate to disclose information obtained pursuant to *clause 358*.

Clause 361 sets out offences in relation to a person who interferes with a mental health advocate's exercise of powers.

Clause 362 allows a mental health advocate to attempt to resolve issues by dealing directly with staff members of a mental health service. If the issue is unable to be resolved or the mental health advocate deems it to be appropriate then the matter must be referred to the Chief Mental Health Advocate. The Chief Mental Health Advocate can provide a report to the mental health service and can also provide a copy of the report to the Minister, CEO, CEO of the Health Department, and the Chief Psychiatrist. If a report is issued then the person to whom the report was issued must advise the Chief Mental Health Advocate as to the status of any further investigations.

Division 3 - Terms and conditions of appointment or engagement

Subdivision 1: Chief Mental Health Advocate

Clause 363 provides for the term of appointment of the Chief Mental Health Advocate and states that the terms and conditions of appointment are determined by the Minister.

Clause 364 details the remuneration of the Chief Mental Health Advocate.

Clause 365 provides for resignation of the Chief Mental Health Advocate at any time.

Clause 366 provides for removal of the Chief Mental Health Advocate from office on grounds of mental or physical incapacity, incompetence, neglect of duty, or misconduct.

Clause 367 provides for an Acting Chief Mental Health Advocate in certain circumstances. It is essential given the oversight role that there is at all times a person in the position.

Subdivision 2: Other mental health advocates

Clause 368 provides for the terms and conditions of engagement or appointment of mental health advocates other than the Chief Mental Health Advocate. This clause allows for flexible arrangements to cater for the different requirements across the State and for advocates with different skills and experiences to meet the needs of consumers, such as people of Aboriginal or Torres Strait Islander descent, young people, people from culturally and linguistically diverse backgrounds or people with expertise in co-occurring conditions.

Clause 369 details the remuneration of mental health advocates.

Clause 370 sets out how a mental health advocate other than the Chief Mental Health Advocate may resign, being to the Chief Mental Health Advocate.

Clause 371 provides for removal of the mental health advocate from office on grounds of mental or physical incapacity, incompetence, neglect of duty, or misconduct.

Division 4 - Other matters relating to mental health advocates

Division 4 applies to all mental health advocates, which includes the Chief Mental Health Advocate.

Clause 372 sets out circumstances in which a mental health advocate will be considered to have a conflict of interest. The mental health advocate cannot

perform functions as a mental health advocate in relation to an identified person where the mental health advocate has a conflict of interest.

Clause 373 is a delegation clause in relation to the Chief Mental Health Advocate, providing flexibility and workability, but with the necessary safeguards set out in the clause. The delegate cannot sub delegate.

Division 5 - Staff and facilities

Clause 374 provides for appointment of public service officers to assist the Chief Mental Health Advocate in performing functions under the Act or another written law.

Clause 375 allows the Chief Mental Health Advocate to use government staff and facilities provided for in the clause.

Division 6 - Annual reports

Clause 376 requires the Chief Mental Health Advocate to publish an annual report, promoting accountability and community awareness. The report must include the general activities of the mental health advocates but this does not preclude the reporting of additional matters.

Clause 377 requires the Minister to table annual reports.

Part 21 Mental Health Tribunal

Division 1 - Preliminary matters

Clause 378 defines some of the terms used in Part 21.

Division 2 - Establishment, jurisdiction and constitution

Clause 379 establishes the Mental Health Tribunal (MHT). The MHT is intended to replace the Mental Health Review Board established under the 1996 Act. The change of name is intended to reflect the role of the MHT in relation to new functions, in addition to the role of the Mental Health Review Board under the 1996 Act.

Clause 380 states that the MHT has the jurisdiction conferred on it by the provisions in Part 21.

Clause 381 requires the MHT to be, subject to *clauses 383-383*, constituted by the members specified by the President of the MHT when exercising its jurisdiction.

Clause 382 relates to the constitution of the MHT for reviews, other than for psychosurgical matters. Reviews must always be constituted by a lawyer; psychiatrist; and a member who is not a lawyer, medical practitioner, nor a mental health practitioner who currently works at a mental health service. This member is informally referred to as a community member. It is intended that the third member specified will effectively ensure that community standards and expectations are upheld by the MHT. The requirements around who can be a community member are intended to avoid any bias and actual or perceived conflicts of interest. *Clause 382* also includes an expectation that, for reviews relating to children, a member of the MHT who is a child and adolescent psychiatrist will constitute the proceeding. There is an exception where a member who is a child and adolescent psychiatrist is not available, which is intended to ensure that proceedings can still be heard expeditiously. In such a situation, there must be a member who is a psychiatrist, but it is preferable if the views of a child and adolescent psychiatrist, or a person who is a medical practitioner or mental health practitioner who has experience relevant to children, are also sought.

Clause 383 sets out the constitution of the MHT for psychosurgical matters. In addition to the members in *clause 382*, a neurosurgeon and an additional psychiatrist are required. In the unlikely event that that the patient is a child, a child and adolescent psychiatrist is required.

Clause 384 enables two or more types of reviews, differently constituted in accordance with *clauses 381-383*, to be conducted at the same time.

Division 3 - Involuntary treatment orders: review

Clause 385 requires that, subject to some narrow exceptions, the MHT is to commence (to allow for adjournments, for example to obtain a further psychiatric opinion or more information) an initial review of an involuntary patient order as soon as practicable and, in any event, within the specified time limits. For an adult the timeframe is 35 days and for a child it is 10 days. The purpose is to decide whether the involuntary patient is still in need of the involuntary treatment order having regard to the criteria in *clause 25*.

Clause 386 provides for periodic reviews whilst an order is in force. Reviews must be commenced by the MHT within specified time limits, which vary depending on the circumstances. In general, this is 3 months for adults and 28 days for children. The MHT must consider whether or not the criteria for an involuntary treatment order are still met. It is noted that the periodic review period for a CTO is 3 months, being the same as the maximum period of a CTO (subject to a continuation order being made). This takes account of logistical problems in prescribing more frequent reviews, particularly in remote areas. However, reviews can always occur sooner than the maximum time limits.

Clause 387 relates to *clauses 385-386*. There is an exception where an involuntary patient has not been an involuntary patient for a continuous period. *Clause 387* details the requirement for an involuntary patient to be considered to have been an involuntary patient for a continuous period which is a gap of no more than seven days between two orders. This relates to inpatient treatment orders and CTOs.

Clause 388 enables the MHT to extend the review period in *clauses 385-386* outside the specified time limits but only in circumstances where the MHT has already reviewed the involuntary patient within the prescribed period.

Clause 389 allows an involuntary patient to request a review in relation to certain matters including involuntary status and transfer between hospitals. *Clause 389* gives express standing to the involuntary patient, their carer, close family member or other personal support person and a mental health advocate to apply for a review, in addition to any other person who, in the opinion of the MHT, has a sufficient interest in the matter. *Clause 283* refers to a situation where there is more than one close family member or carer, but this does not mean that a person can only have one close family member or carer for the purposes of the Act. That is, any close family member or carer can initiate proceedings before the MHT – it does not have to be the one close family member or carer who the mental health service generally informs and involves, for example. A review in relation to an application made in a prescribed period (following the MHT already having already conducted a

review) will not be conducted unless there has been a material change in the involuntary patient's circumstances since that day. An example includes where the patient's psychiatrist makes a transfer order shortly after review of the status of an involuntary inpatient. A review may be conducted within the prescribed period because of the change of circumstances. Further, there may be a change to the involuntary patient's circumstances such as the return of an involuntary inpatient's carer to the state offering a less restrictive option in the form of a CTO or revocation of the inpatient treatment order.

Clause 390 enables the MHT to conduct a review of certain matters on its own initiative.

Clause 391 allows the MHT to suspend an involuntary patient order, and make other specified orders, pending a review. This may be done on application of a party or on the MHT's own initiative.

Clause 392 identifies parties to a proceeding under Division 3. To clarify, the persons expressing their views are not considered to be parties to a proceeding. This is the case for all provisions relating to parties to proceedings in Part 21. *Clause 392* and other provisions in Part 21 identifying parties to proceedings do not necessarily require that all of these people attend a proceeding. Even a patient cannot be obliged to attend all or a part of a proceeding. For example, where the involuntary patient is unwilling or unable to attend, or where the MHT has forwarded a notice of hearing to an involuntary community patient's last known address and the patient has changed residences, the hearing may proceed.

Clause 393 sets out the matters to which the MHT must have regard when conducting a review. They include the patient's wishes, the views of the patient's personal support persons, and the patient's treatment, support and discharge plan, amongst other things.

Clause 394 allows the MHT to make orders and give directions upon completing a review under Division 3. The MHT cannot make orders or give directions in relation to a treatment, support and discharge plan, but may make recommendations for review and amendment by the patient's psychiatrist. That is, the MHT's role in relation to treatment, support and discharge plans is to ensure that the plans exist and that they meet the guidelines published by the Chief Psychiatrist under *clause 543*. There is no requirement in *clause 468* that the patient's psychiatrist give effect to a recommendation in relation to a treatment, support and discharge plan. A copy of the MHT recommendation in relation to a treatment, support and discharge plan may also be given to the Chief Psychiatrist.

Clause 395 applies where the MHT, during a review on an involuntary treatment order, changes the status of an involuntary inpatient to make them an involuntary community patient. The treating psychiatrist may apply to the MHT for a review of the direction. CTOs place a clinical responsibility on supervising psychiatrists and community mental health teams. When a decision to place a person on a CTO is made by a psychiatrist there has been careful analysis that the service can meet the legal requirements for visiting and community follow-up. If the decision is made by the MHT there may have been no proper analysis as to whether the requirements of the CTO can be delivered, therefore psychiatrists need to have the ability to contest the decision and request reconsideration. However that does not prevent the MHT making a CTO despite the service's position being that they are unable to supervise a CTO.

Division 4 - Involuntary treatment orders: validity

Clause 396 states that Division 4 applies to treatment orders, being involuntary treatment orders, continuation orders in relation to involuntary treatment orders, and orders varying CTOs.

Clause 397 enables the MHT to, on the application of a person specified in *clause 399* or on its own initiative, declare that a treatment order is valid or invalid, or make an order varying the terms of the treatment order in the manner the MHT considers most likely to give effect to the intention of the psychiatrist who made the treatment order. The MHT cannot make a declaration that a treatment order is valid if the treatment order is invalid because of a failure to comply with the Act.

Clause 398 stipulates the consequences of the MHT declaring a treatment order to be invalid. This will depend on the nature of the treatment order. In relation to a CTO if an order is declared invalid it ceases to be in force. In relation to an inpatient treatment order the inpatient treatment order ceases to be in force; however if the MHT reasonably suspects that the person is in need of an involuntary treatment order, the MHT may make an order for assessment to be conducted by a medical practitioner or AMHP and detained for that assessment to occur.

Clause 399 sets out who can make an application for a declaration under *clause 397*. *Clause 399* gives express standing to the involuntary patient, their carer, close family member or other personal support person and a mental health advocate to apply for a review, in addition to any other person who, in the opinion of the MHT, has a sufficient interest in the matter.

Clause 400 sets out some of the grounds upon which a treatment order may be declared to be invalid. These include where the relevant practitioner has failed to comply with the Act when making the order or conducting the assessment or examination, and because of that failure, the rights or interests of the involuntary

patient have been substantially prejudiced. There is nothing preventing a new order from being made following a declaration of invalidity.

Division 5 - Review of admission of long term voluntary inpatients

Clause 401 is the application provision for Division 5. A long term voluntary inpatient referred to in Division 5 is limited to inpatients in authorised hospitals who have been a voluntary inpatient at that authorised hospital for a continuous period of six months in relation to an adult and three months in relation to a child. Division 5 acknowledges that the increased vulnerability of voluntary inpatients in authorised hospitals who are so chronically unwell that they have been an inpatient for long periods of time. It also recognises that additional protections are required for patients without capacity who have been admitted by their guardian or enduring guardian or, in relation to a child, their parent or guardian.

Clause 402 sets out who can apply for a review. That is, the review is not automatic. *Clause 402* gives express standing to the long term voluntary inpatient, their carer, close family member or other personal support person and a mental health advocate to apply for a review, in addition to any other person who, in the opinion of the MHT, has a sufficient interest in the matter. The reference to a mental health advocate is included because a long term voluntary inpatient may in some situations be an identified person in accordance with *clause 347* and *clause 353*.

Clause 403 sets out who the parties to a proceeding under Division 5 will be.

Clause 404 sets out the matters to which the MHT must have regard when conducting a review. They are the same matters as listed in *clause 393*, but do not include the patient's treatment, support and discharge plan, given that such a plan is only required for involuntary patients and persons who are mentally impaired accused. Although the Act does not include a requirement for a treatment, support and discharge plan to be made with respect to a voluntary patient, best practice would support the creation of such a plan, and *clause 404* allows the MHT to have regard to 'any other things that the Tribunal considers relevant', which would generally include any treatment, support and discharge plan.

Clause 405 allows the MHT to make recommendations to the treating psychiatrist, including that the patient be discharged; that a treatment, support and discharge plan be prepared and reviewed regularly; and that the patient be discharged. There is no requirement in *clause 468* that the treating psychiatrist give effect to a recommendation of the MHT made under *clause 405*.

Division 6 - Electroconvulsive therapy approvals

Clause 406 is the application provision for Division 6 and is in accordance with the provisions in Part 14 Division 1 above stipulating where ECT can occur only with the approval of the MHT.

Clause 407 enables a patient's psychiatrist to apply to the MHT for approval to perform ECT on a patient, and sets out matters that must be set out in the application. These include the reasons why ECT is being recommended; and a treatment plan including the mental health service where the ECT would be performed, the maximum number of proposed treatments, the maximum period over which it is proposed to perform that number of treatments, and the minimum period that it is proposed will elapse between any two treatments if the MHT's approval was granted. It is considered that this treatment plan will assist the psychiatrist constituting the MHT, in addition to the legal member and community member, in deciding whether or not the requirements are met. It is considered appropriate that a legal member and a community member be involved to uphold legal requirements and raise community expectations.

Clause 408 identifies who the parties to a proceeding under Division 6 will be.

Clause 409 details what the MHT must be satisfied of to approve ECT. *Clause 409* also states that the MHT can only approve ECT where satisfied that the mental health service at which the ECT is proposed to be performed on the person is approved by the Chief Psychiatrist under *clause 540* for that purpose. It is important to note that *clause 439* allows the MHT to obtain assistance from persons with relevant knowledge or experience.

Clause 410 requires the MHT to have regard to the Chief Psychiatrist's guidelines in deciding whether or not to approve ECT being performed on a patient. These guidelines are required to be published pursuant to *clause 543*.

Clause 411 lists the matters that the MHT must have regard to, in addition to the Chief Psychiatrist's guidelines referred to in *clause 410*, if a person does not have capacity to provide informed consent. These include the views of the patient, whether they be an adult or a child; and despite the fact that they are considered not to have capacity (to the extent that it is practicable to ascertain those wishes). Also included are the views of the patient's personal support persons, reasons for the recommendation of ECT, and the alternatives and risks, amongst other matters. Where the patient is a child, the views of a medical practitioner or mental health practitioner with qualifications, training or experience relevant to children who is authorised by the Chief Psychiatrist for this purpose, must be sought and had regard to.

Clause 412 specifies the decisions that the MHT is authorised to make after hearing an application under Division 6. They can approve or refuse to approve the application; or approve the application subject to reducing the number of treatments to be performed on the person. If the application is not approved, there is nothing preventing the patient's psychiatrist from making a new application. To clarify, the MHT may also adjourn the matter to obtain a further opinion or additional information.

Division 7 - Psychosurgery approvals

Clause 413 is the application provision for Division 7 and is in accordance with *clause 208* stipulating that psychosurgery cannot occur without the approval of the MHT.

Clause 414 enables a patient's psychiatrist to apply to the MHT for approval to perform psychosurgery on a patient, and sets out matters that must be included in the application. These include why psychosurgery is being recommended; and a treatment plan including a detailed description of the proposed psychosurgery, who would perform the psychosurgery, and where it would be performed.

Clause 415 identifies who the parties to a proceeding under Division 7 will be.

Clause 416 sets out the things that the MHT must be satisfied of to approve the psychosurgery. The requirements include informed personal consent (consent from the patient himself or herself, not a substitute decision maker). *Clause 416* is drafted in a way that indicates that psychosurgery will be used only where earlier treatments and interventions have not resulted in sufficient and lasting benefit to the patient. As stated above in relation to *clause 409*, it is important to note that *clause 439* allows the MHT to obtain assistance from persons with relevant knowledge or experience.

Clause 417 sets out the matters to which the MHT must have regard when hearing an application for psychosurgery. They include the consequences for the treatment and care of the patient if the psychosurgery is not performed; and whether the psychosurgery is likely to promote and maintain the health and wellbeing of the patient. As with ECT, the MHT always has discretion even where the matters required to be considered indicate that psychosurgery should be provided.

Clause 418 specifies the decisions that the MHT is authorised to make after hearing an application under Division 7. They can approve or refuse to approve the application. If the application is not approved, there is nothing preventing the patient's psychiatrist from making a new application. To clarify, the MHT may also adjourn the matter to obtain a further opinion or additional information.

Division 8 - Compliance notices for non-clinical matters

Clause 419 defines some of the terms used in Division 8, being a prescribed requirement and a service provider. Prescribed requirements are in relation to giving a document or providing other information to a patient or another person, including a document or other information on a patient's medical record or complying with a request made by a patient or other person; or to ensure that one of these things is done. As the title of Division 8 and the definition of 'prescribed requirement' suggest, Division 8 does not confer jurisdiction on the MHT to direct clinical treatment. Prescribed requirements are in relation to mandatory and discretionary requirements in the Act. However, in the latter situation, the MHT may only order a person to consider doing something, rather than ordering them to do it. For example, where a clinician is required to provide information to a family member or carer, but the clinician is of the view that to do so would not be in the best interests of the patient, the MHT can require the clinician to consider providing the information, but cannot require the clinician to provide the information. A service provider for the purposes of Division 8 means the person in charge of a mental health service, the medical practitioner or the mental health practitioner required under the Act to comply with or ensure compliance with the prescribed requirement.

Clause 420 authorises the MHT to issue a compliance notice to a service provider. This can be on the application of a person specified in *clause 421*, or on the MHT's own initiative. The compliance notice may direct the service provider to take specified actions within the specified period, and to report to the MHT on remedial action taken or not taken. Before deciding whether to issue a compliance notice, the MHT can refer the matter to another person or body listed in *clause 420*. The consequence of failing to comply with a compliance notice relates to *clause 468* whereby a person who does not give effect to a compliance notice is committing an offence. If the MHT refers a matter to another person or body listed in *clause 420*, the MHT must advise the service provider in writing of the referral, given that the MHT is required to advise all parties of its decision (and provide reasons, if requested).

Clause 421 states who can make an application to the MHT for the service of a compliance notice. The patient or other person to whom the prescribed requirement relates; a carer, close family member or other personal support person; and a mental health advocate all have express standing; in addition to the ability of any other person who, in the opinion of the MHT, has a sufficient interest in the matter, to make an application.

Clause 422 identifies who the parties to the proceeding will be under Division 8.

Clause 423 requires the MHT to report on compliance notes in the annual report, to ensure that the practice and procedures of mental health services is made transparent, is regulated, and that there is additional oversight. The report must include the name of the service provider (named according to the relevant mental health service) and the number of compliance notices issued to each of the service providers during the year.

Division 9 - Review of orders restricting freedom of communication

Clause 424 allows persons specified in the clause to apply to the MHT for a review of restrictions on freedom of communication in force under *clause 462*. The patient; a carer, close family member or other personal support person; and a mental health advocate all have express standing; in addition to the ability of any other person who, in the opinion of the MHT, has a sufficient interest in the matter, to make an application.

Clause 425 identifies who the parties to a Division 9 proceeding will be.

Clause 426 specifies the decisions that the MHT can make after hearing an application under Division 9. The MHT can confirm the order as made or amended; amend or further amend the order; or revoke the order.

Division 10 - Jurisdiction in relation to nominated persons

Clause 427 stipulates who can make an application for a review pursuant under Division 10. The person who made the nomination; a carer, close family member or other personal support person (which includes the nominated person); and a mental health advocate all have express standing; in addition to the ability of any other person who, in the opinion of the MHT, has a sufficient interest in the matter, to make an application.

Clause 428 allows the MHT to make a declaration about the validity of a nomination. For example, the MHT may find that the person did not understand the effect of making the nomination at the time that it was made, as required under *clause 273*.

Clause 429 allows the MHT to revoke a nomination in specified circumstances, which is intended to cover situations such as where it is clear that the nominated person is not acting in the person’s best interests, or where the nominated person is incapable of, or unwilling or unable to perform his or her role as nominated person.

Clause 430 identifies who the parties to a Division 10 proceeding will be.

Division 11 - Review of decisions affecting rights

Clause 431 applies where a person's rights under the Act are affected in a way that is not dealt with in another Division in Part 21. The MHT has extensive powers pursuant to *clause 433*. The person whose right is affected; a carer, close family member or other personal support person; and a mental health advocate all have express standing; in addition to the ability of any other person who, in the opinion of the MHT, has a sufficient interest in the matter, to make an application.

Clause 432 identifies who the parties to a proceeding under Division 11 will be.

Clause 433 allows the MHT to, upon completing a review under *clause 431*, make any orders and give any directions that the MHT considers appropriate.

Division 12 - Procedural matters

Subdivision 1: Proceedings generally

Clause 434 requires an application or other document required to be made or given to the MHT to be lodged at the office of the MHT.

Clause 435 requires the President to determine where and when the MHT will sit.

Clause 436 provides that the MHT must exercise its jurisdiction with as little formality and technicality, and as speedily, as a proper consideration of the matter permits; within the bounds of the rules of natural justice. This provision reflects the fact that the MHT is a quasi-judicial body, where the purpose is to produce the correct and preferable decision at the time of the MHT's decision on the reviewable proceeding. In relation to the rules of natural justice, it is implied in the Act that there must not be any conflict between the MHT members hearing a proceeding, and any other interest. For example, a neurosurgeon hearing an application for neurosurgery to be performed on a patient must not be the neurosurgeon proposed to perform the neurosurgery.

Clause 437 states that the presiding member of the MHT for a proceeding must be a lawyer.

Clause 438 requires a question of fact in a proceeding before the MHT to be decided by majority; and a question of law to be decided by the presiding member hearing the matter. For the purposes of this clause, a question of law includes a question of mixed law and fact.

Clause 439 authorises the MHT to engage or appoint one or more persons with knowledge or experience that the MHT considers relevant to a proceeding to assist the MHT in the proceeding. For example, the MHT may draw on information or

expertise, clinical or otherwise, in relation to a particular review. This does not prevent the MHT from engaging or appointing a person to assist in a category of proceedings for example, such as all proceedings in relation to involuntary patients of Aboriginal or Torres Strait Islander descent.

Clause 440 stipulates, for the avoidance of doubt, that no fees are payable for any application or proceeding before the MHT under Part 21.

Clause 441 states that each party to a proceeding must bear their own costs. For example, any travel costs for a patient on a CTO, or the cost of obtaining a report from a private psychiatrist on the patient's own initiative.

Clause 442 restricts persons from bringing proceedings that are frivolous, vexatious, or for an improper purpose.

Subdivision 2: Notice of proceedings

Clause 443 requires the MHT to give a copy of an application for a MHT review to each of the persons specified in the clause, unless reasonable efforts have been undertaken and a particular person or persons cannot be given a copy of the application. In any case, where the person concerned is a child, the Chief Mental Health Advocate must always be given a copy of the application.

Clause 444 is in line with *clause 443*, but in relation to providing a notice of a hearing.

Clause 445 enables the MHT to request the name and contact details of an adult's guardian from the State Administrative Tribunal so as to comply with *clauses 443-444*. However, the State Administrative Tribunal is not required to comply with such a request from the MHT because there may be circumstances that would justify the information not being disclosed. However, it is envisaged that the information would be provided to the MHT if provision of the information were in the best interests of the person concerned.

Subdivision 3: Appearance and representation

Clause 446 applies to adults who are parties to a proceeding, whether or not they are the patient or another affected person. The person may appear in person or be represented by another person. This would include a personal support person, a mental health advocate, or a legal practitioner, for example. As referred to in relation to *clause 389*, the Act recognises that a person may have more than one close family member or carer, and the ability of a personal support person to represent a person is not limited to the close family member or carer who the mental health service generally informs and involves, for example. It is important

that patients have choice as to whether or not they are represented and who represents them. However, the MHT may make an order that the person be represented where it decides that it would not be in the best interests of the party to appear in person in the proceeding. The MHT may need to make arrangements for this representation and would be able to adjourn the hearing until such time as the hearing could be heard with a representative. *Clause 446* clarifies that, even where the person is represented, they are always entitled to express his or her views, which would include their wishes, about any matter arising in the course of the proceeding that may affect that party.

Clause 447 applies to children who have capacity to consent who are parties to a proceeding, whether or not they are the patient or another affected person. The child may appear in person or be represented by a person listed in *clause 447*. These persons include a legal practitioner; mental health advocate; the child's parent or guardian (unless the MHT orders that the parent or guardian be excluded from the hearing); or any other person who, in the opinion of the MHT, is willing and able to represent the child's interests. A mental health advocate may be a youth advocate referred to in *clause 349* or another mental health advocate. As with adults, being represented does not prevent the child from expressing his or her views about any matter arising in the course of the proceeding that may affect the child.

Clause 448 applies to children who do not have capacity to consent and are parties to a proceeding, whether or not they are the patient or another affected person. The child must be represented by a legal practitioner; a mental health advocate; their parent or guardian (unless the MHT orders that the parent or guardian be excluded from the hearing); or any other person who, in the opinion of the MHT, is willing and able to represent the child's interests. Again, being represented does not prevent the child from expressing his or her views about any matter arising in the course of the proceeding that may affect the child.

Clause 449 enables the MHT to make arrangements for a party to be represented at a hearing on that party's request. This does not require the MHT to do so. As referred to above, this clause applies not just to patients or other persons affected by a decision, but to all parties to a proceeding. *Clause 449* is in addition to the references in *clauses 446-448* in relation to the MHT being able to require representation. Where the MHT requires representation and the party requests that the MHT make arrangements, it is intended that the MHT will make such arrangements.

Clause 450 clarifies that the fact that a person has a mental illness or is being provided with treatment for a mental illness, is presumed not to be an impediment to the person being represented by, or giving instructions to, a legal practitioner for

the purpose of being represented at MHT proceedings. The intention is to provide legal practitioners with some certainty as to whether or not they can be engaged by a person to whom the Act applies for the purposes of representation at MHT proceedings, in addition to clarity for the MHT.

Clause 451 provides that a representative of a person at a MHT hearing must not be paid unless they are a legal practitioner, a mental health advocate or another person prescribed in Regulations for the purposes of *clause 451*. It is an offence for any other person to demand or receive remuneration for representing a party in a proceeding of the MHT.

Subdivision 4: Hearings and evidence

Clause 452 describes the purpose and nature of review proceedings before the MHT. The purpose of a review proceeding is to produce the correct and preferable decision at the time of the MHT's decision on the reviewable proceeding. A review proceeding is a hearing de novo, being from the beginning. The MHT is not confined to the matters that were before the decision maker under the Act at the time that a decision was made. New information can be considered.

Clause 453 states that a hearing in a proceeding is not open to the public, unless the MHT orders otherwise. This is due to the personal and confidential nature of information being disclosed. Further, the MHT may choose whether or not to allow a specified person to be present (including a witness). Where the MHT does not allow a specified person to be present, the MHT must give reasons.

Clause 454 allows the person concerned in a proceeding to choose another person (or persons) to be present. It is intended that that other persons give assistance and support to the patient and present the patient's views and wishes as appropriate. However, *clause 454* also recognises that it is not always in a person's best interests for a particular person to be present, so, in limited circumstances, the MHT may exclude that other person.

Clause 455 requires the MHT to give each party to a proceeding a reasonable opportunity to call evidence, give evidence, examine witnesses, cross-examine witnesses, and make submissions. However, as stated in relation to *clause 436*, the MHT must exercise its jurisdiction with as little formality and technicality, and as speedily, as a proper consideration of the matter permits; within the bounds of the rules of natural justice.

Clause 456 states that the MHT is not bound by the rules of evidence, but may inform itself of a matter relevant to a proceeding in any manner that the MHT considers to be appropriate.

Clause 457 aims to ensure that information that should not be accessed by a person (described in *clause 249*) is not revealed in oral evidence in proceedings before the MHT. The MHT may request a person to leave a part of a hearing. As a last resort, the MHT can order a person to leave a part of a hearing. Failure to comply with the order can be considered to be contempt of the MHT, and *clause 463* imposes a penalty in relation to this.

Clause 458 gives the MHT the power to compel a person to attend a proceeding to give information or produce evidence or both.

Clause 459 states that no privilege against self-incrimination applies in relation to proceedings before the MHT. That is, a person is not immune from an obligation to provide information on grounds that providing that information would incriminate the person or expose that person to conviction for an offence.

Clause 460 allows the MHT to inspect, retain for a reasonable time, and copy a whole or part of any document.

Clause 461 creates offences in relation to not giving evidence and giving false or misleading evidence.

Clause 462 allows the MHT to receive evidence from a transcript from judicial proceedings and to make findings, decisions or judgments in relation to judicial proceedings.

Clause 463 creates an offence for contempt of the MHT. This is intended to be a safeguard for all persons attending MHT proceedings. In relation to clinicians it supplements the *clause 461* offences outlined above. In relation to legal representatives and mental health advocates, it applies to discourage contemptuous behaviour that could jeopardise patient health and the therapeutic alliance between a patient and his or her treating team. *Clause 463* is in addition to rules about the conduct of clinicians and legal practitioners. The drafting of *clause 463*, including the use of the word ‘wilfully’ throughout, contemplates serious misconduct and necessitates intention (which a person experiencing mental illness may not have). *Clause 463* also applies to patients and personal support persons attending. A contempt provision is appropriate to recognise the importance of any judicial or quasi-judicial body and provide some course of action to the MHT where a person inexcusably acts contemptuously, particularly given that the circumstances may not constitute a course of action under any other written law. This provision is in addition to *clause 477* in relation to removal of MHT members from office for misconduct, for example.

Clause 464 requires hearings in proceedings before the MHT to be recorded, for the sake of accountability and transparency. To clarify, this does not extend to discussions held by the members of the MHT hearing the proceeding in making a decision in the absence of the parties to the proceeding, as is the case with other quasi-judicial bodies; that is – deliberations are undertaken in private. However reasons for decision may be obtained in accordance with *clause 466*.

Clause 465 reflects the sensitive nature of the MHT proceedings, creating an offence for publication of information, subject to narrow exceptions. This is in line with Schedule 1 clause 12 of the *Guardianship and Administration Act 1990*.

Subdivision 5: Decisions in proceedings

Clause 466 allows a party to a proceeding to obtain reasons for a decision of the MHT, providing a balance between confidentiality, accountability, and transparency. The request must be made within specified time limits. Reasons must be communicated in a way that the party is likely to understand.

Clause 467 enables the President of the MHT to grant an extension of time for a person to obtain reasons where it would be in the interests of justice to provide the reasons despite the delayed request.

Clause 468 governs the consequence of not giving effect to a decision of the MHT. It is an offence to not give effect to a decision of the MHT according to its terms. As noted above in relation to *clause 394* and *clause 405*, this does not apply in relation to recommendations of the MHT.

Division 13 - Rules

Clause 469 allows the President of the MHT to make rules for the MHT, in consultation with the members of the MHT.

Clause 470 provides a non-exhaustive list of examples of things that can be included in the rules of the MHT that are made pursuant to *clause 469*.

Clause 471 requires rules to be published, and tabled in Parliament.

Division 14 - Tribunal members

Clause 472 relates to the appointment of the President of the MHT.

Clause 473 relates to the appointment of other members of the MHT.

Clause 474 provides for the terms and conditions of appointment of the President and other members.

Clause 475 governs the remuneration of the President and other members. The term 'remuneration' is defined in *clause 4*.

Clause 476 stipulates how a member, including the President, may resign from their appointment.

Clause 477 gives the Governor the power to remove a person from the office of member (including President) in the circumstances set out in the clause.

Clause 478 gives the Minister the power to appoint an acting President and acting members of the MHT for up to 12 months. The clause also confirms the validity of anything done by an acting member (including the President) in circumstances specified in the clause, such as where there is a defect or regularity in the appointment.

Clause 479 is a delegation clause in relation to the President of the MHT, providing flexibility and workability to the MHT, but with necessary safeguards set out in the clause. A delegate cannot sub delegate.

Division 15 - Registrar and other staff

Clause 480 requires a registrar to be appointed.

Clause 481 sets out the functions of the registrar which will enable hearings to be scheduled and received, and documents to be managed appropriately, amongst other requirements.

Clause 482 allows the President to give directions to the registrar, and requires the registrar to comply.

Clause 483 requires other persons to be appointed as public service officers to assist the registrar.

Clause 484 allows the registrar to delegate powers or duties to a registry officer. The registry officer cannot sub delegate.

Division 16 - Annual reports

Clause 485 requires the MHT to provide an annual report to the Minister.

Clause 486 requires the Minister to table the annual report in Parliament.

Division 17 - Miscellaneous matters

Clause 487 requires the MHT to have a seal.

Clause 488 requires a court or other judicial person or body to take judicial notice and provide judicial authority of specified matters such as the signatures of Tribunal members and the registrar or use of the seal. Judicial notice is a rule of evidence that allows a fact to be introduced into evidence if the truth of that fact cannot reasonably be doubted.

Clause 489 enables members of the MHT to meet as often as necessary for the effective and efficient operation of the MHT.

Part 22 Review by State Administrative Tribunal

Division 1 - Preliminary matters

Clause 490 lists some of the terms used in Part 21.

Division 2 - Jurisdiction

Clause 491 gives the State Administrative Tribunal (SAT) the power to hear a review of a decision made by the MHT. Unlike hearings of the MHT, hearings before the SAT are in its review jurisdiction and the SAT does not have the jurisdiction to hear a matter from the beginning or hear an appeal. A person in respect of whom the MHT has made a decision can apply for a review. In recognition of more acutely unwell patients who may not be in a position to make an application, any other person who, in the opinion of the SAT, has a sufficient interest in the matter may also apply to the SAT for review of the decision of the MHT.

Clause 492 enables the MHT to apply to the SAT for determination of a question of law that arises in a proceeding before the MHT. The application must not relate to a determination of fact or mixed fact and law; only law. It is noted that this definition of 'question of law' in clause 472 varies from the corresponding definition in section 59 of the *State Administrative Tribunal Act 2004*. This is of no consequence because the power of the MHT does not depend on the power of the SAT.

Division 3 - Constitution

Clause 493 sets out the constitution of reviews by the SAT for matters other than psychosurgical matters, similar to the constitution of the MHT under *clause 382*.

Clause 494 sets out the constitution of reviews by the SAT for psychosurgical matters, similar to the constitution of the MHT under *clause 383*.

Clause 495 applies where the SAT is determining a question of law for the MHT pursuant to *clause 492*. In such a case, the SAT must be constituted by a judicial member.

Division 4 - Procedural matters

Clause 496 stipulates, for the avoidance of doubt, that no fees are payable for any application or proceeding before the SAT under Part 22.

Clause 497 allows a person to appear at a hearing in a proceeding before the SAT under Part 22 either in person or represented by another person. Section 39 of the *State Administrative Tribunal Act 2004* requires that, subject to some exceptions, representation at the SAT must be by a legal practitioner. The Act enables

representation of a person at the SAT by persons who are not legal practitioners. This more specific clause in the enabling Act is effective despite the variation from section 39(1) of the *State Administrative Tribunal Act 2004*. *Clause 497* permits the SAT to make an order that the person must be represented where representation would be in the person's best interests, and allows the SAT to make arrangements for representation at the request of the person. Further, *clause 497* has a provision in line with *clause 450* in relation to the MHT that a person with a mental illness or who is being treated for mental illness can be represented by a legal practitioner.

Clause 498 states that a hearing in a proceeding is not open to the public unless the SAT orders otherwise. The SAT may choose whether or not to allow a specified person to be present (including a witness).

Clause 499 is similar to *clause 465* in relation to the MHT. It recognises the sensitive nature of material presented at some SAT proceedings by prohibiting publication of information about proceedings, subject to narrow exceptions.

Division 5 - Appeals to Supreme Court

Clause 500 sets out the circumstances in which a person can appeal from the SAT to the Supreme Court in respect of a decision or order made by the SAT. The right to appeal in relation to a person in respect of whom a decision or order is made is automatic. Where another person seeks to appeal, the leave of the Supreme Court is required.

Clause 501 provides the grounds of appeal for an appeal under *clause 500*, being that the SAT made an error of law or of fact or of both law and fact; acted without jurisdiction or in excess of jurisdiction; or did both of those things. Further, there may be another sufficient reason for hearing an appeal against a decision or order, and this is a decision for the Supreme Court.

Clause 502 limits the time to appeal to 28 days from the date of the decision or order being made by the SAT. The SAT or Supreme Court can extend this in certain circumstances, being where satisfied that it is just and reasonable to do so.

Clause 503 enables the Supreme Court to make an order that a party to the proceeding under Part 22 be represented where it decides that it would not be in the best interests of the party for the party to appear in person in the proceeding.

Part 23 Administration

Division 1 - Preliminary matters

Clause 504 defines the term mental health service to include a private psychiatrist hospital, for the purposes of Part 23.

Division 2 - Chief Psychiatrist

Subdivision 1: Appointment, terms and conditions

Clause 505 establishes the role of the Chief Psychiatrist, who will be appointed by the Governor on the recommendation of the Minister.

Clause 506 provides for the term of appointment of the Chief Psychiatrist and states that the terms and conditions of appointment are determined by the Minister.

Clause 507 details the remuneration of the Chief Psychiatrist.

Clause 508 provides for resignation of the Chief Psychiatrist at any time.

Clause 509 provides for removal of the Chief Psychiatrist from office on grounds of mental or physical incapacity, incompetence, neglect of duty, or misconduct. This would be a serious step which would require a recommendation from the Minister to the Governor, but is necessary as the role is one of clinical leadership and needs to be of a high standard.

Clause 510 provides for an Acting Chief Psychiatrist in certain circumstances. It is essential given the oversight role that there is at all times a person in the position. It is important to note that the Chief Psychiatrist or any Acting Chief Psychiatrist must be a psychiatrist, as defined in *clause 4*.

Subdivision 2: Functions and powers generally

Clause 511 states that the functions of the Chief Psychiatrist are the functions conferred on the Chief Psychiatrist under the Act or under another written law.

Clause 512 describes the Chief Psychiatrist's responsibility for treatment and care, and lists the broad categories of persons who the Chief Psychiatrist is responsible for. The level of authority of the Chief Psychiatrist is significant ensuring responsiveness, consistency and compliance across the sector. The Chief Psychiatrist is also responsible for publishing standards for treatment and care in relation to the persons identified in the clause; and for overseeing compliance with those standards. This is a dual role for the Chief Psychiatrist which will help identify when a service is not meeting the proper standards which can then be reported on.

Clause 513 enables the Minister to issue directions about policy to be followed by the Chief Psychiatrist which cannot be in relation to a particular patient or service or clinician. This provides for the Minister to influence mental health policy in regard to the legislation which has raised public concern.

Clause 514 enables the Minister to request a report relating to the Chief Psychiatrist's functions. The Chief Psychiatrist must comply unless there are reasonable grounds for not doing so. This emphasises the important connection between the Minister and the Chief Psychiatrist but also ensures independence of the office.

Clause 515 is similar to *clause 514* but allows the CEO of the Health Department (both defined in *clause 4*) to request a report from the Chief Psychiatrist relating to treatment and care of patients where the matter or matters are within the remit of the CEO of the Health Department. The Chief Psychiatrist must comply unless there are reasonable grounds for not doing so. This indicates the clinical leadership role of the Chief Psychiatrist and the CEO of the Health Department within the mental health system.

Clause 516 confers the power on the Chief Psychiatrist to do anything necessary or convenient for the performance of the functions of the Chief Psychiatrist under the Act or another written law. This indicates the independent role of the Chief Psychiatrist and the ability to review complaints and look at other clinical matters not specifically addressed in the Act.

Subdivision 3: Specific powers relating to treatment and care

Clause 517 provides the Chief Psychiatrist with the power to review any decision of a psychiatrist about the provision of treatment to an involuntary patient or mentally impaired accused, and to require the psychiatrist to comply with directions about such matters. Whilst it is recognised that the psychiatrist involved in the day to day treatment, care and support of the person is likely to be in the best position to determine treatment and care; it is also an important clinical leadership role for the Chief Psychiatrist to have this power where required, and to discourage treatment being provided which is contrary to good practice.

Clause 518 allows the Chief Psychiatrist to visit an authorised hospital with or without notice whenever the Chief Psychiatrist considers it appropriate to do so, and a mental health service that is not an authorised hospital whenever the Chief Psychiatrist reasonably suspects that proper standards of treatment and care have not been, or are not being, maintained by the mental health service. *Clause 518* also sets out the powers of the Chief Psychiatrist upon visiting a mental health service. These powers are extensive and allow for a proper investigation of clinical practice and further powers such as inspection.

Clause 519 sets out details and penalties for interfering with a visit to a mental health service under *clause 518*. This provides an incentive for cooperation from mental health services.

Clause 520 requires that mental health services disclose information to the Chief Psychiatrist relevant to treatment and care. This emphasises the oversight role of the Chief Psychiatrist.

Subdivision 4: Notifiable events

Clause 521 is the application provision in relation to Subdivision 4, which is broad and includes voluntary patients being provided with treatment or care at mental health services, and residents of private psychiatric hostels, amongst other categories of persons.

Clause 522 defines a notifiable incident, which includes the death of a person, a medication error, an incident likely to have an adverse outcome, any unlawful sexual contact between a patient and staff, any use of unreasonable force and any other event the Chief Psychiatrist declares to be notifiable.

Clause 523 provides a mandatory reporting requirement in relation to notifiable incidents and sets out the procedure for such reporting.

Clause 524 sets out what the Chief Psychiatrist may do following notification which includes investigating the incident or referring it on to another authoritative body. It is anticipated that in most cases the Chief Psychiatrist will investigate the incident him or herself giving a direct role to accountability issues.

Clause 525 requires the Chief Psychiatrist to inform the person in charge of the relevant mental health service of the Chief Psychiatrist's decision to take action in accordance with c*lause 524*.

Clause 526 sets out the Chief Psychiatrist's powers of investigation.

Clause 527 provides for notification of the outcome of an investigation to the person in charge of the mental health service, and allows the Chief Psychiatrist to include recommendations in the report.

Subdivision 5: Chief Psychiatrist's staff

Clause 528 provides for appointment of public service officers to assist the Chief Psychiatrist in performing functions under the Act or another written law.

Clause 529 provides for the Chief Psychiatrist's use of government staff and facilities as agreed with the relevant department or agency.

Subdivision 6: Annual reports

Clause 530 requires the Chief Psychiatrist to publish an annual report. Publication of an Annual Report on a number of specific matters will inform the community of what is happening under the legislation and provide accountability for clinical interventions. The information specified in *clause 530* that must be included in the Chief Psychiatrist's annual reports does not preclude the Chief Psychiatrist from reporting on additional matters.

Clause 531 sets out the process with respect to tabling the annual report in Parliament.

Subdivision 7: Miscellaneous matters

Clause 532 enables the Chief Psychiatrist to provide information about a patient or person detained at a mental health service upon request of a person with a sufficient interest in the matter. The intention, in broad terms, is to allow persons such as relatives to find out where a person is (where, for some reason, they have not already been advised pursuant to Part 9 or Part 17 of the Act).

Clause 533 allows the Chief Psychiatrist to require a list of all mentally impaired accused from the Mentally Impaired Accused Review Board.

Clause 534 is a delegation clause in relation to the Chief Psychiatrist but only in relation to another psychiatrist. That other psychiatrist cannot sub delegate. This will enable psychiatrists who are clinical directors of mental health services to undertake some of the responsibilities of the Chief Psychiatrist at a local level.

Division 3 - Mental health practitioners and authorised mental health practitioners

Clause 535 details who will be considered to be a mental health practitioner.

Clause 536 details who will be considered to be an AMHP and provides for Regulations as to qualifications, training and experience and related matters. AMHPs can provide a more immediate mental health service when medical practitioners are not available to access treatment for people who may be in crisis.

Division 4 - Authorised hospitals

Clause 537 details the meaning of an authorised hospital.

Clause 538 sets out the authorisation process in relation to public hospitals. The authorisation process in relation to private hospitals is set out in the *Hospital and Health Services Act 1927*.

Clause 539 provides for a situation where a public or private hospital is no longer authorised hospital and requires patients to be transferred.

Division 5 - Mental health services approved for electroconvulsive therapy

Clause 540 governs where ECT can be performed, being places approved by the Chief Psychiatrist for the performance of ECT.

Division 6 - Approved forms

Clause 541 provides for approved forms for use under the Act, with the exception of forms used by police officers under Part 11 Division 2.

Clause 542 sets out the Chief Psychiatrist's responsibility to publish forms and related guidelines.

Division 7 - Guidelines and standards

Clause 543 requires the Chief Psychiatrist to publish guidelines in relation to specified matters. This will ensure quality practice which is flexible and responsive to improvements in contemporary best practice, and will provide consistency across mental health services.

Clause 544 allows the Chief Psychiatrist to apply, adopt or incorporate documents to be used as guidelines or standards (with or without changes). For example the National Standards for Mental Health Care can be used as a part of the Chief Psychiatrist's guidelines.

Clause 545 stipulates that it is sufficient for compliance if guidelines and standards are published on the Agency's website.

Division 8 - Miscellaneous matters

Clause 546 is a delegation clause allowing the Minister to delegate to the CEO of the Commission and the CEO to delegate to a public service officer in accordance with the clause. *Clause 546* does not limit the ability of the Minister or CEO to perform a function through an officer or agent.

Part 24 Interstate arrangements

Division 1 - Preliminary matters

Clause 547 defines some of the terms used in Part 24.

Division 2 - Intergovernmental agreements

Clause 548 permits the making of intergovernmental agreements. The overarching purpose of such agreements is to provide for the interstate treatment and care of people experiencing mental illness.

Clause 549 provides that a person cannot perform a function under Part 24 unless there is an intergovernmental agreement with a relevant State or Territory in place.

Clause 550 permits a person authorised to perform a function pursuant to Part 24 to perform any similar function under a corresponding law or intergovernmental agreement in another State or Territory.

Division 3 - Transfer to or from interstate mental health service

Clause 551 allows a person on an inpatient treatment order at an authorised hospital or a general hospital in Western Australia to be transferred from that hospital to an interstate mental health service. This extends to a person who is absent without leave. That is, arrangements may be made with respect to an involuntary patient who leaves the State without leave from hospital, for that patient to be admitted to a specified interstate mental health service. Various procedural requirements are in place to protect patients in this regard. The making of a transfer order under *clause 551* is a notifiable event.

Clause 552 enables a transport order to be made in respect of an involuntary inpatient in an authorised hospital or a general hospital in Western Australia, to transport the patient to an interstate mental health service. A transport order can only be made pursuant to this clause where there is no other safe means of transfer reasonably available. This is not a notifiable event because the patient's personal support person will already be aware that a transfer order has been made under *clause 551*.

Clause 553 allows the making of an order approving the transfer of a person who is under an interstate inpatient treatment order, and who is detained at or absent without leave from an interstate mental health service, to an authorised or general hospital in Western Australia. The making of a transfer approval order under *clause 553* is a notifiable event.

Clause 554 applies to an order made under *clause 553* and allows a person authorised to transport interstate patients under a corresponding law or an interstate agreement to exercise those powers in Western Australia.

Division 4 - Community treatment orders

Clause 555 provides involuntary community patients with a degree of freedom of movement or portability, stating that the terms of a CTO may include a requirement that a patient be provided with treatment by an interstate mental health service.

Clause 556 allows a transport order to be made in respect of an involuntary community patient in Western Australia where the patient does not comply with the requirement that he or she be provided with treatment by an interstate mental health service. This can only be made where no other safe means of transfer is reasonably available.

Clause 557 applies where a CTO is made interstate and requires an interstate community patient to be provided with treatment by a mental health service in Western Australia. The CTO is in force with the same terms, and for the same period, as the CTO made in the interstate jurisdiction.

Clause 558 enables a person authorised under a corresponding law of another State or Territory, to perform a function in relation to an interstate CTO in Western Australia.

Part 25 Ministerial inquiries

Clause 559 enables the Minister to appoint a person to conduct an inquiry and to report to the Minister in relation to specified matters.

Clause 560 sets out the powers of investigation of a person appointed under *clause 559*.

Clause 561 creates an offence for interfering with an inquiry conducted under Part 25.

Clause 562 provides that an inquiry under Part 25 must be conducted with as little formality and technicality, and as speedily, as a proper consideration of the subject matter of the inquiry permits. However, the person conducting the inquiry is bound by the rules of natural justice.

Clause 563 states that the rules of evidence do not apply in relation to an inquiry being conducted under Part 25.

Clause 564 allows a person to be summoned to give evidence and/or produce documents.

Clause 565 states that no privilege against self-incrimination applies in relation to a direction or summons given to a person in relation to an inquiry being conducted under Part 25.

Clause 566 gives a person appointed under *clause 559* powers in relation to documents produced in an inquiry.

Clause 567 creates offences in relation to evidence and documents, including not answering a question or giving false or misleading information.

Part 26 Information

Division 1 - Voluntary disclosure of information by public authorities and mental health services

Clause 568 authorises the CEO of the Commission (defined in clause 4 as the agency principally assisting the Minister in the administration of the Act) to request relevant information from and disclose relevant information to certain defined classes of entities, groups or individuals. These include those falling within the expanded definition of mental health service for this clause, which is intended to include public, private and non-government services funded wholly or partly by the Commission, where these are providing a service specifically for people who have or may have a mental illness or for the carers of such people. The expanded definition also specifically includes private psychiatric hostels. The expanded definition is in addition to the definition of mental health service in *clause 4*. The authority of the CEO of the Commission under *clause 568* to request and disclose relevant information also extends to State authorities, as defined in the clause. As well as state agencies and instrumentalities, government departments and the Minister, this includes a body or the holder of an office, post or position established or continued for a public purpose under a written law. Relevant examples of such entities or individuals would be the Chief Psychiatrist and the Chief Mental Health Advocate, both established under the Act, as well as other statutory appointments under this and other legislation and written laws. The definition of 'relevant information' in this clause includes personal information, which is defined in *clause 4* to have the meaning given in the glossary of the *Freedom of Information Act 1992*.

Clause 569 provides that CEOs of prescribed State authorities may disclose and request relevant information (including personal information) to and from one another. In order to be prescribed in the Regulations, it is expected that a State authority would be required to have adequate protocols in place to protect the confidentiality of personal information. The intent of this clause is that prescribed State authorities may request or disclose information that is relevant to the functions of the authorities or to the treatment and care or health and safety of a person who has or may have a mental illness, or the safety of another person. In many but not all cases, it is expected that the requesting and disclosing authorities will both be providing support or services to a particular individual. 'Relevant information' is defined more narrowly in *clause 569* than in *clause 568*.

Clause 570 has a similar purpose to *clause 569*, in that it seeks to make clear that mental health services, as defined within the clause, are explicitly authorised to request and disclose relevant information. This clause is intended to include private

service providers and non-government providers, as well as those services already included within the definition of mental health service in *clause 4*.

Clause 571 applies to the CEO of a prescribed State authority where the CEO does not have the power under another provision of the Act to delegate any power or duty of the CEO under clause 569. Clause 569 allows CEOs of prescribed State authorities to delegate their powers to disclose or request information under *clause 569*. The delegate cannot sub delegate.

Division 2 - Miscellaneous matters

Clause 572 provides for a penalty of $5,000 to any person who discloses or uses information obtained by virtue of their office, position, employment or engagement, or obtained under this Act or previous mental health legislation in Western Australia. The clause does not apply to the recording, disclosure or use of statistical or other information that is not 'personal information' (as defined in *clause 4*). The sole exception to what is intended to be a broad-reaching prohibition is those circumstances set out in *clause 573*.

Clause 573 describes those circumstances where recording, disclosure and use of information are permissible. The intention is to remove confusion about when information may be so dealt with, and to provide clarity about the consequences of doing so. The range of situations authorised specifically includes responses to requests under *clause 445* where the MHT requests information about a person's guardian from the SAT; *clause 568* in relation to requests for information from the CEO of the Commission for information from State authorities, interstate authorities, corresponding overseas authorities and mental health services; and *clauses 569-570* in relation to requests for information between prescribed State authorities and between mental health services. In many of these situations consent will not have been provided or have been able to be obtained from the individual to whom personal information relates. *Clause 573* also provides for the authorisation where such consent has been provided. *Clause 573* sets out some exceptions in relation to recording, disclosure and use of information, which relate to complaints, the MHT and Ministerial inquiries. Finally, *clause 573* is intended to remove any confusion about the effect of an authorised recording, disclosure or use under this clause. It is intended to ensure that a person acting pursuant to this clause will not incur civil or criminal liability, nor be regarded as having breached a duty of confidentiality or secrecy, or a professional, ethical or workplace standard of conduct, nor be considered to have acted unprofessionally.

Clause 574 provides for Regulations pertaining to the receipt, storage and access to information disclosed under various parts of this legislation. This provides safeguards to ensure that the confidentiality of personal and other information is protected.

Part 27 Miscellaneous matters

Clause 575 is designed to ensure that psychiatrists and other medical practitioners do not have the power to admit involuntary patients to a private hospital the licence for which is held by the practitioner or a related person. *Clause 575* also restricts medical practitioners (which include psychiatrists) and mental health practitioners from exercising powers under the Act in respect of certain persons, such as relatives.

Clause 576 creates an offence for, without reasonable excuse, obstructing or hindering a person from performing functions under the Act.

Clause 577 provides for circumstances where an order may have a formal defect such as a clerical error or an error because of an accidental omission, or an evident material error in the description of a person.

Clause 578 requires mental health services to keep medical records in the form set out in the clause.

Clause 579 protects persons performing functions or purporting to perform functions under the Act in good faith from liability in tort.

Clause 580 provides a defence against a charge of deprivation of liberty where, for example, an elderly person with dementia is prevented from wandering and putting themselves at risk, by the door of a psychogeriatric ward being locked (not all psychogeriatric wards are authorised hospitals), and the bodily restraint provisions in Part 14 only apply to authorised hospitals. The *clause 580* defence is limited and does not include restraining the person if the person attempts to leave. In those situations a common law duty of care may be relied upon in some circumstances.

Clause 581 provides that the Act has effect despite the *Freedom of Information Act 1992*. The *Freedom of Information Act 1992* will apply in some situations throughout the Act; for example, in relation to the Chief Mental Health Advocate and other mental health advocates being able to obtain records.

Clause 582 gives statutory force to Regulations made by the Governor pursuant to the Act.

Clause 583 provides for a review of the Act after five years. This important clause recognises the need for the legislation to be progressive and evolve with best practice, community expectations, interstate and international benchmarks, and to reflect future research.

Schedule 1 – Charter of Mental Health Care Principles

The Charter of Mental Health Care Principles is given statutory force in Part 4 of the Act. The Charter places the rights of people experiencing mental illness at the forefront of treatment and care. The establishment of a Charter as a Schedule to the Act will elevate the status and visibly of rights, and provide for common expectations and understandings. This approach mirrors that taken in the *Carers Recognition Act 2004* and the *Disability Services Act 1993*. Schedule 1 contains a preamble explaining the purpose of the Charter, and then lists 15 Principles. It establishes a collaborative and accountable approach to patient wellness, and promotes a recovery orientation. It also recognises the impact of mental illness on families and carers and the significant role that families and carers play in facilitating recovery of people experiencing mental illness. Compliance with the Charter is aspirational, given its subjective and immeasurable nature, and for consistency with the *Carers Recognition Act 2004* and the *Disability Services Act 1993*. However, a complaint may be made to HaDSCO under *clause 319* for any failure to comply with the Charter.

Schedule 2 – Notifiable events

Schedule 2 is referred to in *clause 138*. The table in Schedule 2 of the Act is intended to provide ease of reference and clarity for persons interpreting and applying the provisions in the body of the Act. It sets out the provision, description of the notifiable event, and the person responsible for the notification.