Government of **Western Australia**
Mental Health Commission

Report on the Statutory Review of the Mental Health Act 2014 (WA)

February 2024

This document was prepared by:
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Acknowledgement of Country
The Mental Health Commission acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of this country and its waters. The Commission wishes to pay its respects to Elders past and present and extend this to all Aboriginal people seeing this message.

Recognition of Lived Experience
The Mental Health Commission recognises the individual and collective expertise of those with a living and lived experience of mental health, alcohol and other drug issues and or suicidal crisis. This also includes those who love and have loved and care for them. We value the vital contribution they make by sharing their unique experience to achieve better outcomes for all.

Accessibility
This document is available in alternative formats for people with a disability on request to the Mental Health Commission.

Disclaimer
The information in this document has been included in good faith and is based on sources believed to be reliable and accurate at the time the document was developed. While every effort has been made to ensure that the information contained within is accurate and up to date, the Mental Health Commission and the State of Western Australia do not accept liability or responsibility for the content of the document or for any consequences arising from its use.

All quotes from consumers and carers in this document are sourced from submissions and statements made during the consultation phase of the Review, unless otherwise cited. To ensure the consumers' and carers' voices are accurately reflected, quotes have not been altered; however, for privacy reasons, quotes have been anonymised and identifying details removed, where necessary.

This document does not constitute legal advice.

Suggested citation
Mental Health Commission, 2024. *Report on the Statutory Review of the Mental Health Act 2014 (WA).* Mental Health Commission, Government of Western Australia.

Mental health, alcohol and other drug support
For mental health, alcohol and other drug support and information call Here For You on 1800here4u (1800 437 348) from 7am to 10pm any day of the week.

For other helplines, visit: www.mhc.wa.gov.au/helplines.

In an emergency, call 000.

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Terminology

AAOD Act – *Alcohol and Other Drug Act 1974*

AMHP – Authorised Mental Health Practitioner

AOD – Alcohol and Other Drugs

Children – A person who is under 18 years of age

Commission – Mental Health Commission

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

ECT – Electroconvulsive Therapy

HaDSCO – Health and Disability Services Complaints Office

LGBTQAI+SB – Lesbian, gay, bisexual, transgender, queer, asexual, intersex and Sistergirl and Brotherboy

MHAS – Mental Health Advocacy Service

MIA Act – *Criminal Law (Mentally Impaired Accused) Act 1996*

Minister – Minister for Mental Health

PIR – Post-Implementation Review

RANZCP – Royal Australian and New Zealand College of Psychiatrists

Review – Statutory Review of the *Mental Health Act 2014*

The Act – *Mental Health Act 2014* (WA)

The Charter – The Charter of Mental Health Care Principles

Minister's Foreword

I am pleased to present this report on the Statutory Review of the *Mental Health Act 2014* (WA) (the Review). This marks a significant step towards ensuring the ongoing operation and effectiveness of contemporary mental health legislation in Western Australia.

The implementation of the *Mental Health Act 2014* (WA) (the Act) on 30 November 2015 signified a meaningful shift in the State's mental health legislation towards stronger human rights protections for consumers, carers and family members.

A continued focus on the Objects of the Act has been fundamental to the Review, both in the process itself and in the development of recommendations for legislative amendments.

Given the recency of the Act, and in line with the Review's Guiding Principles, the Government will prioritise legislative amendment in the areas of further enhancing consumer rights; enhancing access to culturally appropriate care for Aboriginal and Torres Strait Islander people; and refining existing processes. It is intended that these legislative amendments will strengthen the way the Act is operationalised to better meet its Objects.

This report also suggests considerations for system improvements in areas such as education, training and organisational processes and practices. Whilst not requiring legislative amendment, these areas play an essential role in supporting the implementation of Act and its proposed amendments.

Consultation for the Review was comprehensive and undertaken over many months. The recommendations in this report represent the perspectives of a diverse range of stakeholders who are passionate and committed to providing the best possible care and support for those who need it, and to their family and carers. Consultation was undertaken with mental health professionals, policy makers, administrators, and most importantly, those with lived experience. I would like to sincerely thank all those who have contributed and so generously shared their expertise, personal experiences and wisdom.

I would also like to recognise the assistance provided by the Review's Steering Group which was chaired by the former Chief Mental Health Advocate, Ms Deborah Colvin.

The Western Australian Government remains committed to prioritising the delivery of a recovery-orientated, community focused and integrated mental health system, and this has been a key focus for the recommendations in this report.

We look forward to working with the mental health services sector and community to ensure continued improvement for those receiving treatment and care under the Act.

Hon. Amber-Jade Sanderson MLA
Minister for Mental Health

Executive Summary

In accordance with section 587 of the *Mental Health Act 2014* (WA) (the Act), the Minister for Mental Health (Minister) has undertaken a Statutory Review (the Review) of the operation and effectiveness of the Act. As the agency principally responsible for assisting the Minister in administering the Act, the Mental Health Commission (the Commission) facilitated the Review on behalf of the Minister.

This report provides a summary of background information on the Act, as well as previous review and consultation processes that were used to inform this Review.

The Review was focused on legislative amendments that have the potential to improve the operation and effectiveness of the Act. Recommendations have been grouped into chapters relating to key themes: Objects of the Act; Charter of Mental Health Principles; Aboriginal and Torres Strait Islander people; Consumer Rights; Involuntary Treatment Orders; Electroconvulsive Therapy; Use of Seclusion, Restraint and Reasonable Force; Voluntary Consumers on Locked Wards; and Independent Bodies.

A total of 54 recommendations for legislative amendment are proposed.

Other suggestions for improvement identified throughout the consultation processes have been summarised in this report such as policies, procedures, guidelines and education and training. While not the primary focus of the Review, these findings provide valuable guidance for implementing the Act, as well as the proposed amendments.

Whilst the Terms of Reference and Guiding Principles for the Review developed in 2021 remain relevant today, the outcomes of the Review and proposed recommendations in this report have been considered alongside current government priorities and legislative environment.

Summary of Recommendations

Recommendation 1

Amend the Objects of the Act as follows:

- At section 10(1)(a) to include the following:
  a) to provide trauma-informed care which recognises and responds to the diverse needs of people;
  b) to provide holistic treatment which addresses other needs, such as physical health needs;
  c) to promote the recovery of people who have a mental illness and to support their full participation in community life;
  d) to deliver and evaluate mental health care in a way that ensures people living with mental illness or psychological distress, and the people receiving treatment, their carers, families and supporters are the centre of changes in practices and service delivery; and
  e) to ensure provision of culturally safe services and environments for Aboriginal and Torres Strait Islander people and others who are of culturally diverse backgrounds.
- At section 10(1)(d) by replacing the phrase "to help minimise the effect of mental illness on family life" with the phrase "to maximise opportunities and capabilities for people with mental illness to enable consumers to live a life that is meaningful for them."
- At section 10(2) of the Act to require a person or body performing a function under the Act to "make every effort to meet the Objects of the Act" replacing the words "have regard to."

Recommendation 2

Amend the Mental Health Charter as follows:

<u>Principle 3</u>

Amend Principle 3 at:

(3.1) To include a reference to "any experience of trauma" and provision of trauma informed care. Example of amended principle:

"A mental health service must uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including by recognising life experiences (including any experience of trauma), needs, preferences, aspirations, values and skills, while delivering goal-oriented treatment, care and support."

(3.2) To include a diversity principle to ensure access to a diverse mix of care and support services.

<u>Principle 5</u>

Amend Principle 5 to include a reference to supported decision making as follows:

"People receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. The views and preferences of the person receiving mental health and wellbeing services are to be given priority where appropriate to do so."

Principle 6

Amend Principle 6 to include: “gender identity,” “religion or religious conviction,” “race,” (replacing the phrase “cultural and spiritual beliefs and practices,” and “diverse ability and capability”). It is recommended that the terminology align with the findings of the Law Reform Commission WA Project 111 Final Report – Review of the *Equal Opportunity Act 1984* (WA).

Principle 7

Amend Principle 7 to strengthen the requirements for supported decision making for Aboriginal and Torres Strait Islander people, and remove the phrase “to the extent that it is practicable and appropriate to do so” as follows:

“A mental health service should provide treatment and care to people of Aboriginal and Torres Strait Islander descent that is appropriate to, and consistent with, their right of self-determination, their cultural and spiritual beliefs and practices and having regard to the views of their families and the views of significant members of their communities, including Aboriginal community controlled organisations, Elders and traditional healers, and Aboriginal and Torres Strait Islander mental health workers.”

Principle 8

Amend Principle 8 to include “family and domestic violence.”

Principle 9

Amend Principle 9 to include a reference to providing culturally appropriate services.

Example of amended principle:

“A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, [any experience of trauma], accommodation, recreation, education, financial circumstances and employment [and provide culturally appropriate services].”

Principle 14

Amend Principle 14 to add “peer workers, advocates, or any other support person of the consumer’s choice.”

New Principle

Amend the Charter to insert a new gender safety principle.

Recommendation 3

Amend the Act to remove the phrase “to the extent that it is practicable and appropriate to do so” in sections 50, 81 and 189 and Principle 7 of the Charter, replacing it with a phrase that puts a greater onus on the service provider to facilitate consultation and collaboration with Aboriginal and Torres Strait Islander people, and include safeguards that protect the consumer’s autonomy.

Recommendation 4

Amend the Act to require that the person in charge of a mental health service must contact the patient’s nominated person as soon as practicable upon the patient’s presentation at the service, if the patient has a nominated person.

Recommendation 5

Amend the Act to remove the option of making a complaint to the Chief Psychiatrist by a person refused voluntary admission to an authorised hospital while retaining the ability for a complaint to be made to either the person in charge of the authorised hospital or the Health and Disability Services Complaints Office.

Recommendation 6

In relation to further opinions, amend the Act to include the following requirements:

- If a further opinion is not provided within 14 days of the request, the inpatient treatment order lapses.
- A statement that a person has the right to seek a further opinion.
- A further opinion report is to be:
  (a) in a form approved by the Chief Psychiatrist; and
  (b) provided to the person who requested the further opinion no later than 14 days after the request is received. This timeframe is consistent with the timeframe in section 121(7)(a) of the Act which provides that a continuation for a community treatment order does not come into force or ceases if a further opinion is not obtained on or within 14 days of the request.

Recommendation 7

With regards to transport orders and appropriate training and authorisation, amend the Act at sections 129(2), 133(1), 152(2), 154(1) and 560(1) to replace “mental health practitioner” with “authorised mental health practitioner.”

Recommendation 8

Amend the Act to:

- Allow the destination specified in the transport order to be changed in certain specified/limited circumstances (and make any consequential amendments to Form 4A).
- Allow the person carrying out the transport order to stop at a hospital on the way to the specified destination in certain circumstances (and make any consequential amendments to Form 4A).
- Require notification of any transportation or changes in transportation to the patient’s family, carer and personal support person.

Recommendation 9

Amend the Act to provide for the transfer of an involuntary patient from one general hospital to another general hospital.

Recommendation 10

Amend the Act (and make any consequential amendments to Form 7D) to provide that the police or transport officer, in consultation with the person who signed the Form 7D (or, if they are not available, the person in charge of the hospital or other place from which the patient is absent without leave or a medical practitioner employed by that hospital or other place), may take the patient to a place other than the place specified in the apprehension and return order if:
(a) the change in destination is required to ensure the patient's health and safety;
(b) the patient is apprehended somewhere other than the metropolitan area; or
(c) prior to transportation, the police or transport officer who has apprehended the patient makes arrangements with another health service that has the capacity and expertise to assess the patient's fitness for travel.

Recommendation 11

Amend the Act to require that wherever there is a change to destination specified in Form 7D, it is added to the suite of notifiable events, in order to ensure that family members, carers or personal support persons be notified of the change where consent has been provided.

Recommendation 12

Amend the Act to provide that the psychiatrist completing an examination in a general hospital can make an order authorising the person's continued detention to enable further examination, subject to the same provisions and time limits that apply to the detention of a person at an authorised hospital (72 hours on a Form 3C).

Recommendation 13

Amend the Act at section 581(3) to limit the persons who can make a revocation order in consultation with relevant stakeholders to clearly identify whom the provision should be limited to.

Recommendation 14

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

Recommendation 15

Amend the Act to allow an amendment of the authorised hospital specified in the order authorising a person's reception and detention at an authorised hospital under section 61(1)(c) of the Act.

Recommendation 16

Amend the Act to provide that a person may be transferred from one authorised hospital to another while on a Form 3C, provided the Form 3C remains current, the transfer is required for clinical reasons, and those reasons are clearly documented and placed on the person's file.

Recommendation 17

Amend the Act to:

- Provide for the extension of communications technology to people in the metropolitan area for the purposes of assessment and examination, but only in limited circumstances where the use of communications technology is clinically necessary and only in accordance with the Chief Psychiatrist's guidelines.
- Require that when an assessment or examination has been undertaken by communications technology, the reasons why are stated on the resulting order.

Recommendation 18

In support of community treatment order examinations and consumer rights, amend section 77(f) to remove the word "authorised."

Recommendation 19

Amend the Act to require the Mental Health Tribunal to consider, at the time of an electroconvulsive therapy application, whether an involuntary patient is still in need of an involuntary order, with the conditions that:

a) this does not have the effect of extending the amount of time between the electroconvulsive therapy application and the hearing date; and
b) this review of the patient's involuntary status is different to and separate from the patient's initial and periodic reviews otherwise required by the Act and does not affect the timing of those reviews unless those reviews would have been due within 14 days or less of the electroconvulsive therapy hearing.

Recommendation 20

Amend section 410(b) of the Act to remove the requirement for an electroconvulsive therapy treatment plan to include:

a) the mental health service at which it is proposed to perform the electroconvulsive therapy; and
b) the minimum period that it is proposed will elapse between any two treatments.

Recommendation 21

Amend section 218 to include that an order extending a seclusion order must be in the form approved by the Chief Psychiatrist for that purpose.

Recommendation 22

Amend the Act to clarify current powers to:

- Expressly state that reasonable force and associated use of mechanical restraints may be used by relevant persons (such as ambulance providers and transport officers) when apprehending, transporting and detaining a person under the Act during transport, subject to the other requirements relating to restraint, detention and safeguards.

Recommendation 23

Amend the Act to:

- Allow services to notify an "on duty psychiatrist" of the use of seclusion and restraint, supported by an obligation to inform the treating psychiatrist, when the treating psychiatrist is unavailable.
- Provide for notification of the use of seclusion or restraint occurs "as soon as practicable" rather than "in due course."

Recommendation 24

Amend the Act to define chemical restraint and regulate its use.

Recommendation 25

Amend the Act to introduce a principle related to the use of restrictive practices to provide that a restrictive intervention can only be used to prevent imminent and serious harm to that person or another individual, or, in the case of bodily restraint, to administer treatment or medical treatment to the person.

Recommendation 26

The Mental Health Commission undertake further consultation and analysis to develop recommendations regarding potential amendments to address identified issues relating to the use of seclusion and restraint in certain settings. Consideration of appropriate safeguards and clear circumstances in which reasonable force can be authorised are to be thoroughly examined as are any staff resource implications.

Recommendation 27

Amend the Act to prescribe that when an identified person raises a complaint, the Chief Mental Health Advocate's powers and functions under the Act continue until that complaint is resolved or no further action can reasonably be taken even when the person is no longer an identified person and subject to the person's consent.

Recommendation 28

Amend the Act to require the Chief Mental Health Advocate to be notified of an involuntary treatment order within 48 hours for adults and two hours for children.

Recommendation 29

Amend the Act to require the Chief Mental Health Advocate to be notified when: a child is admitted as an inpatient to an adult mental health ward, regardless of whether the child is admitted as a voluntary or involuntary inpatient; a child is referred for examination under a Form 1A; a child is ordered to be detained for assessment while a voluntary patient under a Form 2; a child is ordered to be detained under a Form 3A or for continuing detention under a Form 3A. Consultation is to occur with relevant stakeholders to identify suitable timeframes for notification.

Recommendation 30

Amend the Act to provide that a mental health advocate has the power to make inquiries regarding the discharge of a person or withdrawal of care to a person by a mental health service or other place.

Recommendation 31

Amend the Act to require notification to the Chief Mental Health Advocate within 24 hours of the decision being made not to contact the personal support person (rather than "as soon as practicable").

Recommendation 32

Amend the Act to add a requirement to notify the Chief Mental Health Advocate (within a specified timeframe) regarding the admission into and detention of a mentally impaired accused person in an authorised hospital.

Recommendation 33

Amend the Act to provide that the Chief Psychiatrist can access information about former and deceased patients, when doing so is necessary for the discharge of the Chief Psychiatrist's obligations under the Act.

Recommendation 34

Amend section 577(1) of the Act to allow for persons, who carry out a function under the Act and who obtain information that relates to an individual who is deceased, to disclose that information in response to a written request from:

a) a coroner, a coroner's registrar, a coroner's investigator or a member of the staff of a coroner's court in connection with an investigation into the death of the individual; or
b) a medical practitioner who is performing a post-mortem on the body of the individual at the direction of a coroner.

Recommendation 35

Amend the Act to remove section 582(2) regarding the medical record having to be in an approved form; but retain section 582(1) regarding the requirement to keep a medical record.

Recommendation 36

Amend the Act to require general hospitals to provide copies of inpatient treatment orders and revocation orders to the Chief Psychiatrist.

Recommendation 37

Amend the Act to require a mental health service to report to the Chief Psychiatrist every seven days (following initial notification under section 303) when a patient aged under 18 years is an inpatient in a mental health service that does not ordinarily provide treatment or care to children. Consultation is to occur with relevant stakeholders to identify how this provision could apply to specialist youth inpatient units.

Recommendation 38

Amend the Act to require:

- The treating psychiatrist of an involuntary patient to prepare and submit a written report prior to a Mental Health Tribunal hearing. Such a report should contain information required by the Act.
- The report be submitted to the Mental Health Tribunal, the involuntary patient and the involuntary patient's representative at least 72 hours prior to the hearing.
- The mental health services provide an involuntary patient's representative with timely, free and full access to medical files and records relating to the patient (as enabled by sections 248-251) at least 72 hours prior to the Mental Health Tribunal hearing.

Recommendation 39

Amend the Act to allow for the Mental Health Tribunal to mandate clinician attendance at hearings by means other than summons, such as by formal direction.

Recommendation 40

Amend the Act to provide that where the Mental Health Tribunal conducts a review upon application that this is regarded as the “last review” date when calculating the next periodic review period.

Recommendation 41

Amend the Act to provide that, if a party requests reasons for a decision by the Mental Health Tribunal, a written transcript of the part of proceedings that contain the reasons for the decision given orally may suffice.

Recommendation 42

Amend the Act to allow the Mental Health Tribunal to correct minor mistakes, accidental errors or minor omissions in its reasons or decisions. The amendment should include an obligation on the part of the Mental Health Tribunal to:

a) make a note of the error and any correction in the relevant case file;
b) notify the person (and the person’s advocate or legal representative, if any) to whose matter the correction relates; and
c) distribute the correct version of the document to all parties, alerting them of the error and any correction.

Recommendation 43

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

Recommendation 44

Amend the Act to require mental health service providers to notify the Mental Health Tribunal, the Chief Mental Health Advocate and the Mentally Impaired Accused Review Board (as relevant) when a community treatment order has been made without referral and is since confirmed or is no longer in force within 24 hours.

Recommendation 45

Amend the Act to require a copy of transfer orders between hospitals to be provided to the Mental Health Tribunal, the Chief Mental Health Advocate, and the Chief Psychiatrist.

Recommendation 46

Amend the Act to require that a copy of a continuation order is provided to the Mental Health Tribunal, the Chief Mental Health Advocate and to the Chief Psychiatrist where a person is in a general hospital on an involuntary treatment order.

Recommendation 47

Amend the Act to prescribe that voluntary patients:

a) be informed on admission of their lawful right to leave a ward, whether locked or unlocked, both orally and in writing; however
b) be also made aware that should criteria under section 25 be met, a psychiatrist can make an inpatient treatment order.

Recommendation 48

Amend the Act so that voluntary older adult inpatients in authorised units be considered identified persons under the Act, so they can be assisted by the Chief Mental Health Advocate.

Recommendation 49

Amend the Act to prescribe the following categories of patients as "identified persons":

- Children up to the age of 18 years who are being treated, or who are seeking admission, or who are proposed to be provided treatment, by or in:
  - a public hospital as defined by the *Health Services Act 2016*; or
  - an authorised hospital.
- Children up to the age of 18 years who have been assisted by Mental Health Advocacy Service in the last six months, while either a voluntary patient or an involuntary inpatient, and who are being treated, or are proposed to be treated, by a community mental health service.

Recommendation 50

Amend the Act to allow the Chief Psychiatrist to designate, by order published in the Government Gazette, persons with the relevant training and experience as "psychiatrists" under the Act (and to revoke any such designation) following consultation with the Medical Board of Australia established under the *Health Practitioner Regulation National Law Act 2010* (WA) and the Royal Australian and New Zealand College of Psychiatrists.

Recommendation 51

Amend the Act to allow the Chief Psychiatrist to designate, by order published in the Government Gazette, a child and adolescent psychiatrist for the purposes of the relevant sections of the Act, provided the Chief Psychiatrist is satisfied that the psychiatrist to be designated has the relevant qualifications and clinical training in the treatment of mental illness in children.

Recommendation 52

Amend the Act throughout to ensure gender-neutral terminology is used.

Recommendation 53

Subject to further consultation with the Salaries and Allowances Tribunal, amend section 349 of the Act so that the Salaries and Allowances Tribunal determines the remuneration for the Chief Mental Health Advocate.

Recommendation 54

Amend the Act to enable the Mental Health Commission to deal with property for the purpose of supporting people with mental health services.

The Mental Health Act 2014

Development and implementation of the *Mental Health Act 2014* (WA)

In October 2014, the *Mental Health Act 2014* (WA) (the Act) was passed in Western Australia, commencing operation on 30 November 2015 and replacing the *Mental Health Act 1996* (WA) (the 1996 Act). It was informed by the statutory review findings of the 1996 Act which recommended that the protection of the human rights of consumers, their families and carers be encapsulated in the Act's Objects and a Charter of Mental Health Care Principles. This reflected a renewed intent or 'spirit' of the Act.[1]

The development and implementation of the Act was based on extensive consultation. After the statutory review was undertaken, significant consultation occurred on two draft Mental Health Bills (in 2007 and 2011), followed by the Green Bill in 2012. The Mental Health Commission (the Commission) then led an implementation planning process in collaboration with relevant stakeholders, with oversight and input from the Mental Health Bill Implementation Group, Chaired by Dr Judy Edwards and Mr Eric Ripper.

As part of the implementation planning process, a series of workshops were held with consumer and carer representatives, government agencies, clinicians and mental health staff. The workshops explored processes and documentation required to support the implementation of the Act.

Post-implementation review of the *Mental Health Act 2014* (WA)

In March 2018, in line with the Western Australian Government's regulatory requirements, the Commission completed a two-year Post-Implementation Review (PIR) of the Act. The PIR focused on the progress made in achieving its Objects, and while noting the positive changes since the Act was introduced, identified 45 recommendations for improvement and development.

The two key themes emerging from the PIR to better meet the Act's Objects were:

- Increased training and education for those working within mental health services (both around compliance with, and in relation to the 'spirit' or intent of, the Act); and
- Improved data collation and reporting.

The PIR highlighted a range of issues. Those that have the potential to result in a legislative amendment have been considered as part of this current Review. Recommendations that were operational in nature continue to be implemented by the relevant agencies and stakeholders where appropriate.

[1] CDJ Holman, The Way Forward. Recommendations of the Review of the Mental Health Act 1996 (Report, 2003) 4.

The Statutory Review: Requirements, Governance and Process

Statutory requirement to conduct a review

Under section 587 of the Act, the Minister for Mental Health (the Minister) is required to undertake a review of the operation and effectiveness of the Act as soon as is practicable five years after commencement (the Review). The operation of the Act commenced on 30 November 2015.

The Minister is also required to prepare a report about the outcomes of the Review and table that report in both Houses of Parliament. As the agency principally responsible for assisting the Minister in administering the Act, the Commission conducted the Review in accordance with the process and methodology outlined below.

It is noted that the commencement of the Review was delayed due to the COVID-19 pandemic emergency. The report's recommendations are proposed following almost three years of extensive consultation and research and considered alongside current government priorities and the legislative environment.

Terms of Reference

The Terms of Reference for the Review were approved by the then Minister for Mental Health, Hon Roger Cook MLA, in early 2021, at which point the Review formally commenced.

The Terms of Reference for the Review are as follows:

1. Review the operation and effectiveness of the Act, ensuring that there are multiple perspectives including from carers,[2] consumers and clinicians.
2. This Review will include consideration of the following:
    a) Recommendations and outcomes of the post-implementation review completed in 2017;
    b) the set of proposed amendments to the Act;
    c) the set of proposed deferred amendments to the Act (Deferred Amendments) identified in 2019;
    d) the register containing issues raised by stakeholders, studies, or review reports since 2015;

[2] The perspective of families will also be recognised.

e) translational issues[3] relating to the Act previously reported to the Office of the Chief Psychiatrist since 2015;
f) issues specifically encountered by clinicians in applying the provisions of the Act; and
g) any other relevant matters or issues raised by stakeholders during the process of consultation for the review.

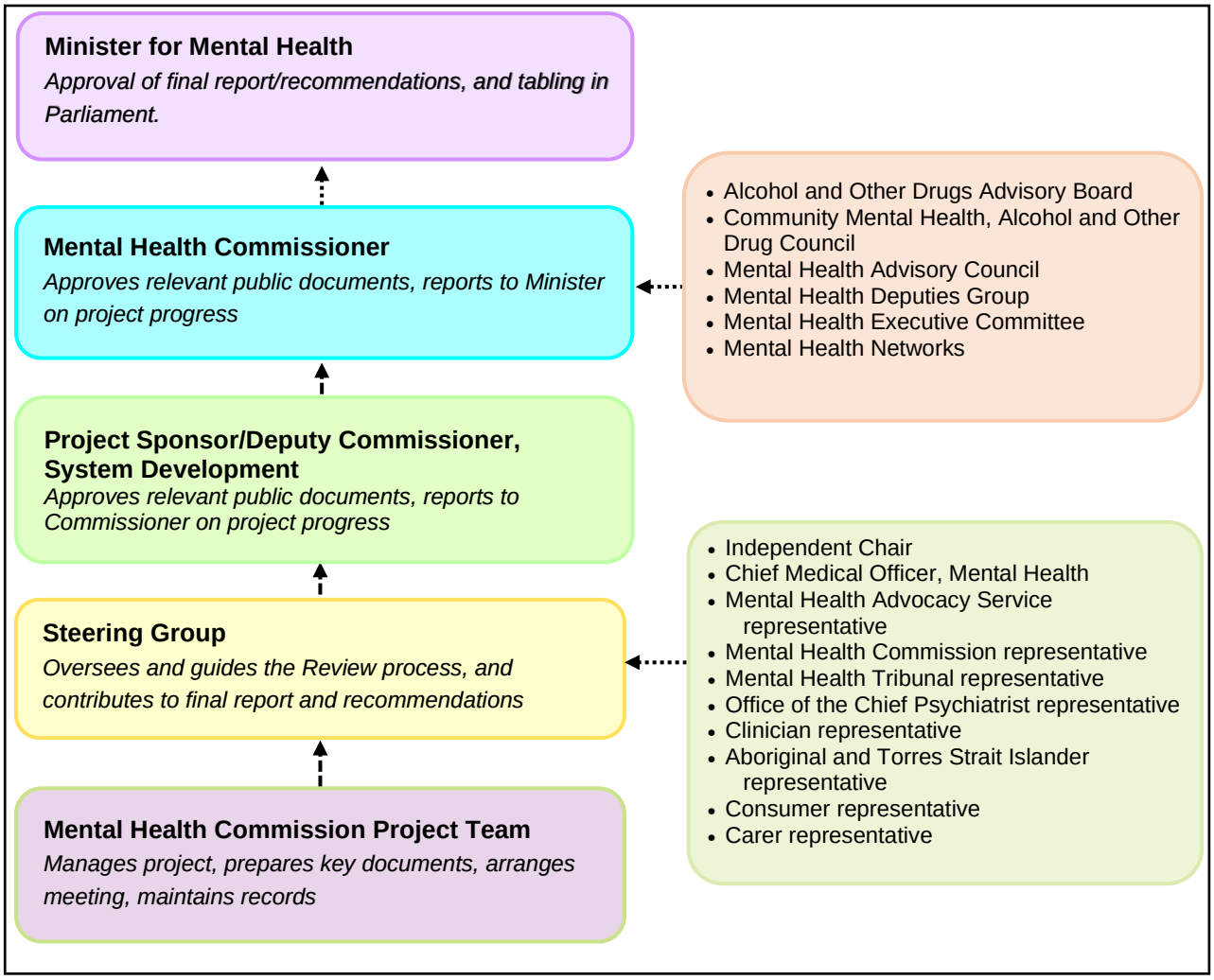
Guiding Principles

The Review was conducted in accordance with the Guidelines for the Review of Legislation published by the Public Sector Commission. The Commission also developed its own set of Guiding Principles, endorsed by the then Minister in early 2021 as follows:

1. Legislation should be developed or amended only when there is no other appropriate way of responding to an issue after taking all relevant circumstances into account, for example using policies, procedures, guidelines and/or education;
2. Legislative changes should seek to advance the human rights of persons with mental illness, their families and carers;
3. Due consideration be given to submissions from all stakeholders recognising their efforts, areas of expertise and lived experience;
4. Recommendations for significant legislative change should be evidence-based, with due consideration given to possible flow-on effects including unintended consequences;
5. Regard should be given to the principles of substantive equality in recognition of the differing impact legislation may have on certain groups in the community;
6. Overly prescriptive provisions which set out processes or requirements in detail can be counterproductive and should generally be avoided and addressed through policy and practice guidance where possible; and
7. Legislative changes should not seek to direct the specifics of clinical practice, nor create an interface which may lessen therapeutic engagement, nor create an excessive administrative burden which may significantly reduce the practical time in direct face-to-face clinical care.

[3] Clinicians contact the Office of the Chief Psychiatrist for assistance in understanding and applying the various provisions of the Act within a clinical setting, whilst upholding the objects of the Act and its principles.

Governance Arrangements



Steering Group

As part of the governance arrangements, in early 2021, a Steering Group was approved by the then Minister to guide the Review. Membership of the Steering Group was intentionally diverse to ensure that a broad range of perspectives, experience and expertise could inform the Review process. The Steering Group Terms of Reference and overview of membership is provided in Appendix 1.

The Steering Group guided an extensive body of work including literature reviews, a six-month public engagement period, targeted consultations and workshops on complex issues. Details of the Review process are provided in Appendix 2.

Chapter 1: Objects of the Act

The Act requires a person or body performing a function under the Act to have regard to the Act's Objects and Charter of Mental Health Care Principles (the Charter).[4] While neither the Objects nor the Charter create a direct right of action, the requirement to "have regard to" both is intended to ensure that the 'spirit of the Act' is upheld and that consumers are provided with the best possible treatment, care and support.[5]

From a consumer perspective, the spirit of the Act, as embodied in the Objects and the Charter, impact significantly on the type of care people receive and their experience of involuntary treatment under the Act, as highlighted by the following comment received through the consultation process:

> *"The [consumer] stated that she felt the most positive experience of her treatment under the Act was the care and empathy shown to her by the nursing staff, and by her psychiatrist. She states that her psychiatrist communicated with her well and was compassionate. The empathy shown by the clinical staff, the [consumer] stated, has impacted her journey positively in the sense that she states she is more receptive to treatment in the future."* Consumer

The Review received 32 submissions which commented on the 'spirit of the Act', either through comments specifically on the Objects, the Charter or both. Additional submissions referred more generally to the way in which the Act has been interpreted or implemented.

The Review considered how amendments to the Charter and Objects of the Act could support best practice, such as through supported decision making and trauma-informed care.

The Review suggested amendments to the Act's Objects to emphasise the importance of:

- minimising the impact of mental health on a person's life and their family;
- cultural safety in the provision of mental health care;
- utilising trauma-informed practices in mental health care; and
- concurrently treating a patient's physical health whilst they are receiving mental health care.

Stakeholders also raised the importance of strengthening compliance with the Objects of the Act through an amendment to section 10(2). It was suggested that "must have regard to" be amended to "must make every effort to comply with."

The Review found that there was broad support for improving and strengthening the Objects of the Act by adding references to:

- diverse needs and trauma-informed practices;
- a holistic approach to treatment;
- support for a meaningful life;
- culturally safe practices; and
- delivering and evaluating mental health care services in consultation with people who have lived experience.

[4] *Mental Health Act 2014* (WA) s 10(2).
[5] Ibid n2

To strengthen the Objects of the Act, the following recommendation is proposed:

Recommendation 1

Amend the Objects of the Act as follows:

- At section 10(1)(a) to include the following:
  a) to provide trauma-informed care which recognises and responds to the diverse needs of people;
  b) to provide holistic treatment which addresses other needs, such as physical health needs;
  c) to promote the recovery of people who have a mental illness and to support their full participation in community life;
  d) to deliver and evaluate mental health care in a way that ensures people living with mental illness or psychological distress, and the people receiving treatment, their carers, families and supporters are the centre of changes in practices and service delivery; and
  e) to ensure provision of culturally safe services and environments for Aboriginal and Torres Strait Islander people and others who are of culturally diverse backgrounds.
- At section 10(1)(d) by replacing the phrase “to help minimise the effect of mental illness on family life” with the phrase “to maximise opportunities and capabilities for people with mental illness to enable consumers to live a life that is meaningful for them.”
- At section 10(2) of the Act to require a person or body performing a function under the Act to “make every effort to meet the Objects of the Act” replacing the words “have regard to.”

Chapter 2: Charter of Mental Health Care Principles

The Charter, provided in Schedule 1 of the Act, contains 15 principles that mental health care service providers are expected to comply with when providing treatment, care and support to consumers, their families and carers. The Review considered strengthening the Charter as a way to improve the experience of specific groups of people receiving care in the mental health system or address specific issues such as the need for trauma-informed care.

Trauma-informed care

Trauma-informed care has been defined as "a strengths-based approach that is responsive to the impact of trauma", emphasising "physical, psychological and emotional safety for both survivors of trauma and service providers."[6] The need for trauma-informed care to be an integral part of mental health care was mentioned in many of the Review's submissions. An amendment to Principle 3 would reinforce the importance of trauma-informed care provided under the Act.

Supported decision making

Supported decision making "focuses not on the outcome of decision, but that the person most deeply involved in making the decision is the person who will be affected most by the impact of the choice."[7] Feedback received throughout the Review identified the need for supported decision making for mental health consumers regarding decisions about their assessment, treatment and recovery. To strengthen the focus of supported decision making, a legislative amendment to Principle 5 in the Charter is proposed.

To better support consumer decision making, a number of submissions highlighted examples where consumers experienced stigma when receiving care under the Act and proposed that access to peers and advocates would assist consumers in receiving care that responds to their needs. Amending Principle 14 would ensure consumers are supported to have access to peers to assist in supportive decision making regarding their care.

Aboriginal and Torres Strait Islander people

Review workshops held with Aboriginal and Torres Strait Islander people suggested that collaborative or shared decision making involves Aboriginal and Torres Strait Islander staff (including Aboriginal health workers and traditional healers) to overcome the effects of systemic racism, and to assist in ensuring rights are recognised and upheld. The involvement of families and communities were also recognised while at the same time acknowledging that supported decision

[6] State of New South Wales (Agency for Clinical Innovation), *Trauma-informed care and practice in mental health services across NSW – A framework for change* (Framework, 2022) 1.

[7] Consumers of Mental Health WA, 'Supported Decision Making in Mental Health: A Literature Review' (Literature Review, 2022) 11.

making needs to also consider individual consumer's needs (for example, a person may, or may not, want their family to be contacted).

Accordingly, it is proposed that legislative amendment to Principle 7 of the Charter would place greater onus on the service provider to facilitate consultation and collaboration with Aboriginal and Torres Strait Islander people.

Culturally and Linguistically Diverse communities

The Review heard that people from Culturally and Linguistically Diverse backgrounds may have additional requirements regarding how they receive mental health treatment and care due to their cultural or religious background or their proficiency in English.

While the Act does not contain provisions relating to Culturally and Linguistically Diverse communities, Principle 6 references "cultural and spiritual beliefs and practices." There is an opportunity to better address the needs of people from Culturally and Linguistically Diverse backgrounds by amending the principles within the Charter to reinforce the need for culturally appropriate services.

Family and domestic violence

Principle 8 requires mental health services to address co-occurring needs of consumers. Experiences of family and domestic violence impact on the mental health of patients and should be considered a co-occurring need in the same way as other issues. As a point of contact for many people experiencing family and domestic violence, clinicians need be aware of factors or signs which may make a person more vulnerable to family and domestic violence, as well as the complexities of the relationship between the person experiencing the violence and the perpetrator.[8] Psychiatrists may also work with perpetrators in assessing risk and providing treatment and referrals where appropriate.[9]

An amendment to Principle 8 to include "family and domestic violence" is therefore considered appropriate.

Gender safety

The Act recognises gender and sexuality through Principle 6, however it does not explicitly recognise gender safety. The *Mental Health and Wellbeing Act 2022* (Victoria) adopts gender safety as one of its 14 mental health and wellbeing principles. This aims to promote safe and responsive service delivery, having regard to any specific safety needs or other concerns that people might have based on their gender. The principle is intended to apply to people of all genders, including trans and non-binary people.[10]

It is recommended that a new gender specific safety principle be included in the Charter.

Gender identity

Principle 6 provides that mental health services must recognise, and be sensitive and responsive to, gender and sexuality, but it does not reference gender identity within the Act. The Review received several submissions on gender diversity and gender identity, suggesting that gender

[8] The Royal Australian and New Zealand College of Psychiatrists, *Family violence and mental health* (Position Statement No 102, 2021).
[9] Ibid
[10] Explanatory Memorandum, Mental Health and Wellbeing Act 2022 (Victoria).

diverse people may experience stigma and discrimination in their interactions with mental health services and the Act.

A lack of recognition of gender identity in the Act may have an impact on gender diverse consumers. This may be rectified by amending Principle 6 to include “gender identity” in the list of diverse individual circumstances which a mental health service must recognise and be sensitive and responsive to. A general amendment to replace gender specific terminology with gender-neutral terminology was also highlighted throughout the Review (refer to Recommendation 52).

People with disability and neurodivergence

The Act explicitly recognises people with disability through Principle 6 and in relation to communication in section 9(2). The Review identified challenges with the provision of services to people with co-occurring conditions, such as the need to explain rights in a way that meet the needs of people with disability (for example, via interpreters) and the lack of clear pathways for advocacy. There is a need for mental health services to be sensitive and responsive to people with diverse abilities and capabilities, in addition to people with disabilities.

Diversity and intersectionality

The principles contained within the Charter recognise the importance of diversity in providing mental health care. For example:

- Principle 1 of the Charter provides that “A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.”
- Principle 3 of the Charter focuses on the provision of person-centred care.
- Principle 6 of the Charter further requires mental health services to recognise and respond to consumers’ diverse needs, circumstances and subjectivities.

However, the Charter does not specifically acknowledge the importance of providing a diverse range of services which are responsive to the intersectionality of people’s needs.

The Royal Commission into Victoria’s Mental Health System concluded “an intersectional approach is an important perspective through which to consider and address the convergence of multiple determinants and/or identities in shaping an individual’s mental health outcomes.”[11] The Royal Commission’s findings with respect to diversity and intersectionality have been incorporated into the *Mental Health and Wellbeing Act 2022* (Victoria), which includes both a "diversity of care principle” and a "diversity principle."[12]

To ensure that mental health provision takes a holistic approach to the complex needs of people receiving treatment under the Act, the following recommendation is proposed:

[11] State of Victoria, Royal Commission into Victoria’s Mental Health System, *Final Report, Volume 1: A new approach to mental health and wellbeing in Victoria* (Report, 2021) 150.
[12] *Mental Health and Wellbeing Act 2022* (Vic) s 17.

Recommendation 2
Amend the Mental Health Charter as follows:

Principle 3

Amend Principle 3 at:

(3.1) To include a reference to "any experience of trauma" and provision of trauma informed care. Example of amended principle:

"A mental health service must uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including by recognising life experiences (including any experience of trauma), needs, preferences, aspirations, values and skills, while delivering goal-oriented treatment, care and support."

(3.2) To include a diversity principle to ensure access to a diverse mix of care and support services.

Principle 5

Amend Principle 5 to include a reference to supported decision making as follows:

"People receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. The views and preferences of the person receiving mental health and wellbeing services are to be given priority where reasonable to do so."

Principle 6

Amend Principle 6 to include: "gender identity," "religion or religious conviction," "race," (replacing the phrase "cultural and spiritual beliefs and practices," and "diverse ability and capability"). It is recommended that the terminology align with the findings of the Law Reform Commission WA Project 111 Final Report – Review of the *Equal Opportunity Act 1984* (WA).

Principle 7

Amend Principle 7 to strengthen the requirements for supported decision making for Aboriginal and Torres Strait Islander people, and remove the phrase "to the extent that it is practicable and appropriate to do so" as follows:

"A mental health service should provide treatment and care to people of Aboriginal and Torres Strait Islander descent that is appropriate to, and consistent with, their right of self-determination, their cultural and spiritual beliefs and practices and having regard to the views of their families and the views of significant members of their communities, including Aboriginal community controlled organisations, Elders and traditional healers, and Aboriginal and Torres Strait Islander mental health workers."

Principle 8

Amend Principle 8 to include "family and domestic violence."

Principle 9

Amend Principle 9 to include a reference to providing culturally appropriate services.

Example of amended principle:

"A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, [any experience of trauma],

accommodation, recreation, education, financial circumstances and employment [and provide culturally appropriate services]."

Principle 14

Amend Principle 14 to add "peer workers, advocates, or any other support person of the consumer's choice."

New Principle

Amend the Charter to insert a new gender safety principle.

Chapter 3: Aboriginal and Torres Strait Islander People

Right to culturally appropriate care

Aboriginal and Torres Strait Islander people have a statutory right to culturally appropriate care when being treated under the Act. Specifically, the Act states that the assessment,[13] examination[14] and treatment[15] of Aboriginal and Torres Strait Islander people is to be done (to the extent that it is practicable and appropriate) in collaboration with:

- Aboriginal and Torres Strait Islander mental health workers; and
- Significant members of the persons family, including elders and traditional healers.

This is reiterated in Principle 7 of the Charter, which states that a mental health service must provide treatment and care to Aboriginal and Torres Strait Islander people that is appropriate and consistent with their cultural and spiritual beliefs and practices. Furthermore, the views of their families and significant members of the community, including elders and traditional healers, should also be regarded to the extent that is practicable and appropriate to do so.

Receiving culturally appropriate and safe care can provide benefits for Aboriginal and Torres Strait Islander people treated under the Act, as illustrated by the following quote received from a consumer during the consultation:

> *"I think with any Aboriginal person, being able to be seen by an Aboriginal mental health or health professional, is really important because they just get you more than the Wadjellas…[t]hey want to go to people who they can trust people who understand them. And unfortunately, no matter how much cultural training you get, you're not going to be on the same path with a lot of people."*

The Review identified some positive changes following the implementation of the Act, such as health service providers anecdotally reporting an increase in the number of Aboriginal mental health workers and Aboriginal liaison officer positions which are qualified to meet the requirements of sections 50, 81 and 189 of the Act. However, several submissions identified the cultural safety provisions of the Act and the Charter were not being routinely implemented and that this impacts negatively on the experiences of Aboriginal and Torres Strait Islander people. This was highlighted in a report from a workshop consultation with Aboriginal people:

> *"The lack of opportunity for Aboriginal consumers to access traditional healing and/or Elders, was very clear. Just as clear was the consumers' strong desire for access. Many expressed surprise that this was something they could request as*

[13] Mental Act 2014 (n 5) s 50.
[14] Mental Act 2014 (n 5) s 81.
[15] Mental Act 2014 (n 5) s 189.

Aboriginal people. The traditional healers and cultural healers we spoke to as a part of this consultation were very open about their involvement, which often happens outside of the service, despite this being enabled under the Act."

The findings from the Review are consistent with those of an inquiry undertaken by the Mental Health Advocacy Service in 2020 that examined services for Aboriginal and Torres Strait Islander people and compliance with the Act[16]. The recommendations to improve compliance continue to be progressed under the oversight of the Department of Health and the Commission.

In accordance with the Review, to ensure the Act better facilitates access to culturally appropriate care, the following recommendation is proposed:

Recommendation 3

Amend the Act to remove the phrase "to the extent that it is practicable and appropriate to do so" in sections 50, 81 and 189 and Principle 7 of the Charter, replacing it with a phrase that puts a greater onus on the service provider to facilitate consultation and collaboration with Aboriginal and Torres Strait Islander people, and include safeguards that protect the consumer's autonomy.

[16] Mental Health Advocacy Service '*Inquiry into services for Aboriginal and Torres Strait Islander people and compliance with the Mental Health Act 2014 - Final report: July 2020* ' Weblink: https://www.wa.gov.au/system/files/2022-02/MHAS-Inquiry-into-Strait-Islander-People-and-Compliance-with-the-Mental-Health-Act-2014-July-2020.PDF.

Chapter 4: Consumer Rights

Supported decision making and nominated persons

Under the Act, a consumer may execute a Form 12A to nominate a person to assist them in the exercising of their rights. That person is referred to as a "nominated person". The nominated person is tasked with helping to ensure that all persons and bodies performing a function under the Act have respect to the patient's rights, take their interests and wishes into account, and are entitled to information regarding the patient's treatment and care.[17]

Supported decision making and the effective use of nominated persons is key to the protection of patients' rights. The Review identified some inconsistencies with how and when nominated persons are engaged. Examples were cited by consumers where nominated persons were not contacted until after discharge.

To support decision making and effective use of nominated person, the following recommendation is proposed:

Recommendation 4
Amend the Act to require that the person in charge of a mental health service must contact the patient's nominated person as soon as practicable upon the patient's presentation at the service, if the patient has a nominated person.

Complaints processes

Part 19 of the Act describes mechanisms for complaining about mental health services. For example, if a person wishes to complain about how they have been treated, they may use the internal complaints process of the mental health service or complain to Health and Disability Services Complaints Office (HaDSCO). To make a complaint to HaDSCO, the consumer should have raised the matter with the health service provider first, however under some circumstances, complaints can be made to HaDSCO directly.

Currently, a person who is refused voluntary admission to an authorised hospital may make a complaint to the person in charge of the hospital, HaDSCO or to the Chief Psychiatrist. However, the Office of the Chief Psychiatrist is not a complaints body, and this is the only circumstance in the Act where complaints may be made to the Chief Psychiatrist.

The following amendment, which is supported by HaDSCO, is recommended to provide consistency regarding the appropriate pathway for complaints by a person refused voluntary admission to an authorised hospital:

[17] *Mental Health Act 2014* (n 5) s 266(1)(a)(i).

Recommendation 5

Amend the Act to remove the option of making a complaint to the Chief Psychiatrist by a person refused voluntary admission to an authorised hospital while retaining the ability for a complaint to be made to either the person in charge of the authorised hospital or the Health and Disability Services Complaints Office.

Seeking further opinions

Under the Act, a consumer (or the consumer's support person) has the right to seek a further opinion if they are dissatisfied with the treatment being provided to them.[18] Further opinions may also be requested with respect to a continuation order (an order made to continue a community treatment order).[19]

As part of the Review concerns were raised regarding lengthy delays encountered by consumers in obtaining a further opinion. Furthermore, many questioned whether further opinions provided are truly independent. The Chief Psychiatrist's Annual Report 2021-2022 stated:

> *"The Chief Psychiatrist continues to be concerned that there is no formal tracking process for requests for further opinions that do not come through the Office of the Chief Psychiatrist. There is no consistent approach to providing timely further opinions across [health service providers]. There remains a systemic risk that patients may not always be able to access the further opinions they request in a reasonable timeframe."*[20]

Legislative amendment will assist in facilitating opinions in a timely manner, recognising they are essential to maintaining human rights given the loss of freedom experienced by consumers and their inability to choose the treating psychiatrist and treatment. The following recommendation is proposed:

Recommendation 6

In relation to further opinions, amend the Act to include the following requirements:

- If a further opinion is not provided within 14 days of the request, the inpatient treatment order lapses.
- A statement that a person has the right to seek a further opinion.
- A further opinion report is to be:
  (a) in a form approved by the Chief Psychiatrist; and
  (b) provided to the person who requested the further opinion no later than 14 days after the request is received. This timeframe is consistent with the timeframe in section 121(7)(a) of the Act which provides that a continuation for a community treatment order does not come into force or ceases if a further opinion is not obtained on or within 14 days of the request.

[18] *Mental Health Act 2014* (n 5) s 182(2).
[19] *Mental Health Act 2014* (n 5) s 121(5-8).
[20] Chief Psychiatrist of Western Australia, Annual Report 2021-2022 (Report, 2022) 67.

Chapter 5: Involuntary Treatment Orders

Section 21 of the Act specifies that an involuntary patient is a person who is under an involuntary treatment order. This includes being under an inpatient treatment order or a community treatment order. The Act provides a framework on how a person is cared for under an involuntary treatment order, including their detention and transport.

Transport under the Act

Transport orders

There are various reasons why a person may need to be transported under the Act, such as when they require examination or treatment. The Act prescribes who can make a transport order, including:

- section 29 provides that a transport order may be made by a medical practitioner or an authorised mental health practitioner (AMHP);
- sections 63, 67, 92 and 112 provide that only a psychiatrist may make a transport order under certain, related provisions;
- section 556 of the Act authorises the person in charge of the hospital to make a transport order.

In addition, sections 129(2), 133(1) and 560(1) of the Act allow a mental health practitioner to make a transport order. Sections 152(2) and 154(1) of the Act also allow a mental health practitioner to extend or revoke a transport order. Mental health practitioners do not receive the same training as AMHPs on the application of the relevant provisions of the Act. The Chief Psychiatrist can designate a mental health practitioner as an AMHP if they are satisfied that they have the qualifications, training and experience appropriate to the role.

With consideration to this, as part of the Review, the Office of the Chief Psychiatrist recommended amendments to sections 129(2), 133(1), 152(2), 154(1) and 560(1) of the Act to ensure that all persons who make, vary or revoke a transport order are appropriately trained to do so.

The following recommended legislative amendment will ensure that persons making a transport order under the Act are appropriately trained and authorised to do so and will address concerns raised through the Review process:

Recommendation 7

With regards to transport orders and appropriate training and authorisation, amend the Act at sections 129(2), 133(1), 152(2), 154(1) and 560(1) to replace “mental health practitioner” with “authorised mental health practitioner.”

Allow amendment of transport orders

The Review considered whether the Act should be amended to allow health service providers to make amendments to transport orders to reflect changes in patient risk levels and/or changes to the transport destination.

Under the Act, medical practitioners or AMHPs have the power to extend a transport order or to revoke it if it is no longer required. However, where there has been a change in the risk level (affecting the party responsible for the transport) or in the place where the patient being transported is to be examined (affecting the destination), medical practitioners or AMHPs are constrained in their ability to amend the transport order. This results in additional “red tape” and delays in transportation timeframes.

When a transport officer carries out a transport order pursuant to a Form 4A, they are required to transport the patient to the place specified in the order. There are currently no provisions in the Act to change the location or stop mid-transit. An ability to change destination would be beneficial, for example, where there are no available beds at the facility specified in the transport order, or there is a deterioration in the condition of the patient being transported requiring a diversion to a closer facility.

Furthermore, an ability to stop mid-transit may be desirable or necessary. For example, to take the person who is a risk to themselves or someone else to a place where they can be safely managed and detained while awaiting transport to the place specified on the Form 1A or Form 3D.

Overall, there was support for greater flexibility in amending transport orders under the Act, provided the orders are amended in limited circumstances only. Sufficient safeguards are required to protect consumers, and that the patient’s family, carers and personal support persons are notified of any changes to the transport order in a timely manner.

To support improved, appropriate flexibility in the transport orders, the following recommendation is proposed:

Recommendation 8

Amend the Act to:

- Allow the destination specified in the transport order to be changed in certain specified/limited circumstances (and make any consequential amendments to Form 4A).
- Allow the person carrying out the transport order to stop at a hospital on the way to the specified destination in certain circumstances (and make any consequential amendments to Form 4A).
- Require notification of any transportation or changes in transportation to the patient’s family, carer and personal support person.

Transfers between general hospitals

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

The Review considered an amendment to the Act which would enable the transfer of an involuntary patient from one general hospital to another where a clinical need is identified. All submissions received on this proposed amendment supported the change, with one submission noting that it should be used sparingly to reduce delays in the provision of treatment.

To facilitate the transfer of involuntary patients where required, the following recommendation is proposed:

Recommendation 9

Amend the Act to provide for the transfer of an involuntary patient from one general hospital to another general hospital.

Apprehension and return orders

A medical practitioner or person in charge of a hospital or other place (such as an emergency department, mental health clinic or a general hospital) may make an apprehension and return order in relation to a person who is absent without leave, provided they are satisfied there is no other safe means of ensuring that the person returns to the hospital or other place.[21]

Under the Act, the person must be returned to "the hospital or other place specified" in the apprehension and return order, and there is no flexibility to change the destination.[22] It was recognised that this lack of flexibility may jeopardise the health of the person. For example, this could occur where an apprehension is in a regional area and where the specified destination is a metropolitan mental health service. Risks identified included a lack of opportunity for mental or physical review prior to transportation and general physical health risks such as being transported in extreme heat.

It was also noted that apprehension and return orders, particularly in regional areas, are facilitated by police which may be necessary, but not always desirable. The Western Australia Police Force noted that their officers are not health professionals, and submissions highlighted that police attendance can result in conflict when apprehending a person experiencing a mental health episode/crisis. Others highlighted the importance of appropriate training and skill development of transport officers.

To provide more appropriate application of apprehension and return orders, the following recommendations are proposed:

[21] *Mental Health Act 2014* (n 5) s 98(1).
[22] *Mental Health Act 2014* (n 5) s 99(b).

Recommendation 10
Amend the Act (and make any consequential amendments to Form 7D) to provide that the police or transport officer, in consultation with the person who signed the Form 7D (or, if they are not available, the person in charge of the hospital or other place from which the patient is absent without leave or a medical practitioner employed by that hospital or other place), may take the patient to a place other than the place specified in the apprehension and return order if:
(a) the change in destination is required to ensure the patient's health and safety;
(b) the patient is apprehended somewhere other than the metropolitan area; or
(c) prior to transportation, the police or transport officer who has apprehended the patient makes arrangements with another health service that has the capacity and expertise to assess the patient's fitness for travel.

Recommendation 11
Amend the Act to require that wherever there is a change to destination specified in Form 7D, it is added to the suite of notifiable events, in order to ensure that family members, carers or personal support persons be notified of the change where consent has been provided.

Referral and Detention Orders

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

The Review considered concerns that the legislated 24-hour maximum period for examination at a general hospital (as distinct from an authorised hospital) was insufficient, and whether this period should align with provisions relating to an authorised hospital (i.e., 72 hours). This revised timeframe could allow for a more thorough assessment and examination which may prevent a person being placed on an involuntary treatment order prematurely. The following recommendation is proposed:

Recommendation 12
Amend the Act to provide that the psychiatrist completing an examination in a general hospital can make an order authorising the person's continued detention to enable further examination, subject to the same provisions and time limits that apply to the detention of a person at an authorised hospital (72 hours on a Form 3C).

Persons who may make revocation orders

Section 581 of the Act relates to amending orders or referrals that contain a formal defect (clerical error, accidental omission or material error).

Subsequent acts or omissions done in reliance on the defective order or referral are not invalid, however a person undertaking an act or omission in reliance on the order can request that the order or referral be rectified. Under section 581(3) of the Act, an involuntary treatment order made in reliance of the original order or referral can be revoked if the request to rectify the order is not complied with.

During the review, concern was raised about the ambiguity around who can request a revocation order, with a perception that a range of people can currently request a revocation order under the current legislation. To clarify who can make a revocation order under section 581(3), the following recommendation is proposed:

Recommendation 13
Amend the Act at section 581(3) to limit the persons who can make a revocation order in consultation with relevant stakeholders to clearly identify whom the provision should be limited to.

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

While the Act authorises the reception and detention of a person in an authorised hospital who has been referred for further examination, it does not outline the process for revoking the referral where the psychiatrist has determined that the referral is no longer required.[23] Instead, the order remains valid for 72 hours.[24]

The Office of the Chief Psychiatrist recommended that where a person is examined within the 72 hour time period (prior to being received at an authorised hospital) and the psychiatrist determines that the order is no longer required, in keeping with the Objects of the Act, legislative amendment should outline the process for revoking the order that made the referral. All submissions that addressed this issue supported such amendment.

The Office of the Chief Psychiatrist also raised concerns about the inability to vary the authorised hospital specified in the order (Form 3D) where the further examination is to take place:

> *"This causes problems where there are lengthy delays in a bed becoming available at the nominated authorised hospital, and a bed becomes available at a different authorised hospital. The inability to vary or change the place of further examination can lead to delays in the patient being examined."*

Accordingly, the Office of the Chief Psychiatrist suggested an amendment to allow the authorised hospital specified in the order authorising a person's reception and detention under section 61(1)(c) of the Act to be changed (see, for example, section 46(1)).

The following recommendations are proposed:

Recommendation 14
Amend the Act to provide that an order authorising reception and detention in an authorised hospital for further examination can be revoked when the person is examined by a psychiatrist prior to being received at the authorised hospital, and the psychiatrist determines that the order is no longer required.

[23] *Mental Health Act 2014* (n 5) p6, dv 3.
[24] *Mental Health Act 2014* (n 5) p6, dv 3.

Recommendation 15
Amend the Act to allow an amendment of the authorised hospital specified in the order authorising a person's reception and detention at an authorised hospital under section 61(1)(c) of the Act.

Transfer of person on a Form 3C continuation of detention order

A person who has been referred[25] for examination by a psychiatrist at an authorised hospital may be detained there for up to 24 hours from the time of reception, to enable the examination to take place.[26] On completing the examination, the psychiatrist may make an order authorising the continuation of the person's detention at the authorised hospital to enable a further examination to be conducted by a psychiatrist (Form 3C).[27]

The Act does not provide for the transfer of a person on a Form 3C from one authorised hospital to another, suggesting that this is not permitted. While this was not raised as a widespread issue across mental health services the following recommendation is proposed to provide clarity on this issue:

Recommendation 16
Amend the Act to provide that a person may be transferred from one authorised hospital to another while on a Form 3C, provided the Form 3C remains current, the transfer is required for clinical reasons, and those reasons are clearly documented and placed on the person's file.

Use of communications (audio-visual) technology during assessment and examination

Under the Act, a practitioner may use communications (audio-visual) technology to conduct an assessment or examination of a person located outside a metropolitan area.[28] While the term "communications technology" is not defined in the Act, the Chief Psychiatrist has guidelines around the use of this technology.

During the Review, a number of issues were raised in relation to the current use of technology for assessments and examinations. Benefits of extending the use of communications technology include greater flexibility, reduced wait times, reduced travel times for people in rural, remote and regional areas, and increased timeliness and responsiveness. Identified risks include technological difficulties, the possible overuse of digital technology and potential inaccuracy of assessments that may lead to unwarranted or prolonged detention under the Act. The Review also heard that some consumers find the use of communications technology distressing.

With consideration to risks and benefits raised through the consultation processes, legislative amendment may ensure communications technology is only used where clinically necessary and where face-to-face assessment is not practicable. Additional reporting on any orders made using communications technology for assessment or examination should be noted on the relevant forms

[25] *Mental Health Act 2014* (n 5) ss 26(2) or 36(2).
[26] *Mental Health Act 2014* (n 5) s 52(1)(b).
[27] *Mental Health Act 2014* (n 5) s 55(1)(b).
[28] *Mental Health Act 2014,* (n 5) ss 48(3), 79(3).

including for people in regional areas. Relevant forms will have to be amended and approved by the Chief Psychiatrist.

To provide for the extension of communications technology in certain circumstances, the following recommendation is proposed:

Recommendation 17

Amend the Act to:

- Provide for the extension of communications technology to people in the metropolitan area for the purposes of assessment and examination, but only in limited circumstances where the use of communications technology is clinically necessary and only in accordance with the Chief Psychiatrist's guidelines.
- Require that when an assessment or examination has been undertaken by communications technology, the reasons why are stated on the resulting order.

Community treatment order examinations

Section 77 of the Act provides the various provisions required for an examination to be carried out in the case of a community treatment order and specifies whether the examination is to be carried out by a psychiatrist or another practitioner. Subsection 77(f) applies to an examination conducted "by a medical practitioner or AMHP before the review period for a community treatment order ends, as required by section 118(2)(b)."

However, the reference to an "authorised mental health practitioner" in section 77(f) is inconsistent with section 118(2)(b) of the Act that does not require the mental health practitioner to be "authorised". Section 118(2)(b) in fact provides for the examination to be conducted by another "medical practitioner or a mental health practitioner" if the supervising psychiatrist is unavailable.

The Review explored this matter and identified several issues, including that mental health practitioners may often have a more direct relationship with people under a community treatment order. There is also a limited number of AMHPs available across Western Australia, especially within regional areas, and there is no minimum required number of AMHPs at a service.

In response to the concern that a practitioner with sufficient experience to treat a patient on a community order is not deemed sufficiently experienced to conduct the monthly community treatment order review, the Office of the Chief Psychiatrist told the Review that:

> *"There may be a lack of understanding regarding what a "mental health practitioner" is… Section 538 defines "mental health practitioner" as someone who is either a psychologist, Division 1 Registered Nurse, occupational therapist or social worker, and who has at least 3 years' experience in the management of people who have a mental illness. Hence, they have respected professional qualifications and are experienced in the management of people with a mental illness."*

Legislative amendments to remove the word authorised from section 77(f) will support consumer rights by providing for the practitioner who knows the patient best the ability to examine the patient and provide the written report. Subsequently, the following recommendation is proposed:

Recommendation 18

In support of community treatment order examinations and consumer rights, amend section 77(f) to remove the word “authorised.”

Chapter 6: Electroconvulsive Therapy

The Act defines electroconvulsive therapy (ECT) as a treatment involving the application of an electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent.[29]

Consideration of involuntary status at the time of application for electroconvulsive therapy

Throughout the Review process, consideration was given to whether the Mental Health Tribunal should be required to consider if an involuntary treatment order remains appropriate at the time of an ECT application. Various stakeholders explicitly supported a legislative amendment to this effect.

While the Mental Health Tribunal may consider this issue, it is not a requirement. This raised concerns, particularly when an ECT application is made at a point in time where the consumer's involuntary status has not been reviewed for some time.

If an amendment of this nature is supported, conditions to guard against unintended consequences of the change should also be considered when drafting any amendments.

To ensure appropriate consideration of involuntary status is included at the time of the ECT application, the following recommendation is proposed:

Recommendation 19
Amend the Act to require the Mental Health Tribunal to consider, at the time of an electroconvulsive therapy application, whether an involuntary patient is still in need of an involuntary order, with the conditions that:

a) this does not have the effect of extending the amount of time between the electroconvulsive therapy application and the hearing date; and
b) this review of the patient's involuntary status is different to and separate from the patient's initial and periodic reviews otherwise required by the Act and does not affect the timing of those reviews unless those reviews would have been due within 14 days or less of the electroconvulsive therapy hearing.

[29] *Mental Health Act 2014* (n 5) s 192.

Information required for application to the Mental Health Tribunal to use electroconvulsive therapy

Under section 410 of the Act, an application to use ECT must include a treatment plan containing information such as the place where the ECT will be provided and the minimum number of days that must elapse between any two treatments.

These requirements may create practical issues if the location of ECT needs to change or the minimum period between sessions is not fully complied with. The latter may happen, for example, when a treatment plan refers to sessions occurring “no less than two days apart” but ECT is provided 46 hours later.

Clinical stakeholders had previously advised the Commission that provisions relating to Mental Health Tribunal approval of ECT are too prescriptive, particularly when compared with other Australian jurisdictions and New Zealand. Concerns were expressed that delays in the provision of treatment, may result in negative outcomes for consumers.[30] It was further suggested that the Mental Health Tribunal’s role should focus on the oversight of ECT and not the determination of clinical issues.

To ensure more appropriate information as part of the treatment plan for the use of ECT, the following recommendation is proposed:

Recommendation 20

Amend section 410(b) of the Act to remove the requirement for an electroconvulsive therapy treatment plan to include:

a) the mental health service at which it is proposed to perform the electroconvulsive therapy; and
b) the minimum period that it is proposed will elapse between any two treatments.

[30] Mental Health Commission (n 2) 43.

Chapter 7: The use of Seclusion, Restraint and Reasonable Force

Seclusion, restraint and force are part of a suite of "interventions and practices" which "have the effect of restricting the rights or freedom of movement of a person".[31] Methods of restraint may be chemical, mechanical, social or physical.[32]

Sections 211 to 240 of the Act authorise the use of seclusion and restraint at authorised hospitals where specific criteria are met.

Seclusion is defined by section 212 of the Act as the confinement of a person who is being provided with treatment or care at an authorised hospital. It involves leaving the person alone in a room or area and preventing them from exiting. The sections also outline the associated safeguards including authorisation required for use of seclusion and restraint, and mandatory recording and reporting requirements.

The Act provides for the use of reasonable force while people are being detained under the Act (section 170),[33] as well as limited powers for the use of reasonable force for those requested to assist in exercising a power under prescribed provisions (section 172).[34]

Extending a seclusion order

Section 218 of the Act allows a medical practitioner to extend a seclusion order in respect of a person. In practice, this order is captured within a 'Form 11E - Record of Examination of Secluded Person and Possible Extension of Seclusion,' however there is no express requirement that the order be in an approved form.

Legislative amendments to include this requirement will ensure that there is a consistent approach when an order is made to extend a seclusion order by clearly outlining what criteria must be met. This will also support transparency in decision making for medical practitioners and people who are subject to seclusion. With consideration to these issues the following recommendation is proposed:

Recommendation 21
Amend section 218 to include that an order extending a seclusion order must be in the form approved by the Chief Psychiatrist for that purpose.

[31] Australian Law Reform Commission, *Restrictive Practices in Australia* (Web Page, 2014) <https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-dp-81/8-restrictive-practices/restrictive-practices-in-australia/>.

[32] Ibid.

[33] *Mental Health Act 2014* (n 5) s 170(b)
[34] *Mental Health Act 2014* (n 5) s 172.

Use of mechanical restraints by transport officers

Sections 172(2) and 149(1) of the Act authorise transport officers to use reasonable force when performing their functions.

Section 227(4) of the Act defines mechanical restraint as a type of bodily restraint of a person by the application of a device (e.g., a seatbelt, harness, manacle, sheet or strap) to restrict the person's movement. The Act includes principles that must be applied when bodily restraint is required to ensure minimum force and restriction is used and a person is treated with dignity and respect.

The use of a mechanical restraint can be essential to prevent injury or harm to the patient, transport officers and other people in the vicinity. Some ambulance providers and other transport officers expressed that the Act is not clear about mechanical restraints, resulting in reluctance to carry out certain patient transports. This can mean greater demand for police transport services that may be stigmatising or traumatising for the consumer and their family.[35]

To provide greater clarity to transport officers, it is proposed that the Act is amended to make clear that the power to use reasonable force by relevant persons when apprehending, transporting and detaining a person may include the power to use mechanical restraints, subject to requirements that force is proportionate to the risk and individual circumstances (similar to principles in the Act that exist about the use of detention).[36] In this regard, any amendments should be aligned with existing safeguards and criteria for authorising seclusion. For example, the criteria for authorising seclusion as per section 216 of the Act.

To clarify the use of mechanical restraint by transport officers in line with the current status, the following recommendation is proposed:

Recommendation 22

Amend the Act to clarify current powers to:

- Expressly state that reasonable force and associated use of mechanical restraints may be used by relevant persons (such as ambulance providers and transport officers) when apprehending, transporting and detaining a person under the Act during transport, subject to the other requirements relating to restraint, detention and safeguards.

Informing treating psychiatrist of seclusion or restraint

Sections 217 and 233 of the Act require that a patient's treating psychiatrist must be informed of the use of seclusion or restraint within specified timeframes by the person who gave the authorisation. However, in practice this can be challenging as the treating psychiatrist may not be always on duty or on call.

Through the Review process it was identified that from an operational perspective it may be more practical to require services to notify the "on duty psychiatrist" rather than the patient's treating

[35] Ibid.
[36] Ibid.

psychiatrist, supported by obligations to inform the treating psychiatrist in due course.[37] The following recommendation is proposed:

Recommendation 23
Amend the Act to:

- Allow services to notify an "on duty psychiatrist" of the use of seclusion and restraint, supported by an obligation to inform the treating psychiatrist, when the treating psychiatrist is unavailable.
- Provide for notification of the use of seclusion or restraint occurs "as soon as practicable" rather than "in due course."

Definition of 'chemical restraint'

The Act is silent on the authorisation and application of chemical restraints.

The Victorian *Mental Health and Wellbeing Act 2022* defines chemical restraint as "the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment."[38] The use of chemical restraint is governed by various provisions[39], including a separate provision for the use of chemical restraint during transport[40].

As chemical restraint is occurring in practice in Western Australia, the Review found that this should be regulated through legislation by defining its meaning, specifying when it can be authorised, increasing safeguards around its use and providing explicit protections for people when it is applied to them. The following recommendation is proposed:

Recommendation 24
Amend the Act to define chemical restraint and regulate its use.

Principle of less restrictive practices

Seclusion, restraint and force are part of a suite of "interventions and practices" which "have the effect of restricting the rights or freedom of movement of a person."[41]

The Review considered that restrictive practices should generally be discouraged but acknowledged there are circumstances where they are unavoidable. It noted there should always be a sound legal basis for the use of restraint. Therefore, it is recommended that the Act is amended to introduce a principle on the use of restrictive practices which would apply to all persons and bodies performing a function under the Act as follows:

[37] Mental Health Commission (n 2) 41.
[38] *Mental Health and Wellbeing Act 2022* (Vic) s 3.
[39] *Mental Health and Wellbeing Act 2022* (Vic) ss 126(2), 132(2), 137(2)(b).
[40] *Mental Health and Wellbeing Act 2022* (Vic) s 139.
[41] Australian Law Reform Commission, *Restrictive Practices in Australia* (Web Page, 2014) <https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-dp-81/8-restrictive-practices/restrictive-practices-in-australia/>.

Recommendation 25
Amend the Act to introduce a principle related to the use of restrictive practices to provide that a restrictive intervention can only be used to prevent imminent and serious harm to that person or another individual, or, in the case of bodily restraint, to administer treatment or medical treatment to the person.

Use of reasonable force when detained for examination and when detained under other circumstances under the Act

A medical practitioner or AMHP may refer a person for examination by a psychiatrist to be conducted at an authorised hospital or other place.[42] This may occur where the medical practitioner or AMHP reasonably suspects the person needs an involuntary treatment order (or an inpatient treatment order if the person is already under a community treatment order).[43]

The medical practitioner or AMHP may make an order authorising the person's detention if they are satisfied that the person needs to be detained in order to be taken to an authorised hospital or other place by virtue of section 28.

The Act authorises the use of reasonable force in certain limited circumstances, which includes when a person, on a referral for examination by a psychiatrist, is:

- being transported to a place of examination; or
- apprehended and transported under a transport order; or
- under an apprehension and return order.[44]

However, this authorisation does not extend to the situation where a person has been referred and detained but is waiting for a transport order to be acted on. That is, before or during transportation. The Review identified this as a gap which creates uncertainty for clinicians and other staff, including concerns about increased risk to the person and staff.[45] This scenario may have been deliberately omitted because under the Act, a person could be detained in settings where training and experience in using restraint and reasonable force may be limited, which may give rise to safety issues for consumers and staff (for instance, a community mental health service or general practitioner's office).[46]

The Review also identified that an inability to use reasonable force and restraint when detaining people in certain circumstances under the Act can impact on the provision of appropriate care and treatment and can also create uncertainty and concern for health services staff. This includes situations where a person is subject to detention and staff have serious safety concerns, however there is no provision in the Act to allow the use of reasonable force to maintain that detention

[42] *Mental Health Act 2014* (n 5) s 26(2) or 26(3)(a).
[43] *Mental Health Act 2014* (n 5) s 25 for the criteria for an involuntary treatment order.
[44] *Mental Health Act 2014* (n 5) sections 171 and 172.
[45] Mental Health Commission (n 2) 37.
[46] Mental Health Commission (n 2) 37.

should the person try to leave. This could include a person who is at high foreseeable risk of suicide or violence towards others.

Given the potential impacts of legislative amendments, further consultation and analysis is required before specific amendments regarding the use of reasonable force in certain circumstances is required. The following recommendation is proposed:

Recommendation 26

The Mental Health Commission undertake further consultation and analysis to develop recommendations regarding potential amendments to address identified issues relating to the use of seclusion and restraint in certain settings. Consideration of appropriate safeguards and clear circumstances in which reasonable force can be authorised are to be thoroughly examined as are any staff resource implications.

Chapter 8: Independent Bodies

Mental Health Advocacy Service

The Mental Health Advocacy Service (MHAS) is a statutory office of the Chief Mental Health Advocate which was created under part 20 of the Act. It provides mental health advocacy services, and rights protection functions, to “identified persons”. Identified persons are:

- an involuntary patient in hospital;
- someone on a community treatment order;
- someone who has been referred for examination by a psychiatrist;
- a voluntary patient in a hospital being detained for assessment and unable to leave;
- a mentally impaired accused person who is detained in an authorised hospital or living in the community. For example, on a Hospital or Custody Order (under the Criminal Law (Mentally Impaired Accused) Act 1996); and
- a resident of a private psychiatric hostel.

The Act requires that MHAS to:

- contact or visit adults within seven days of being made an involuntary patient; and
- contact or visit children (under 18) within 24 hours of being made an involuntary patient.

Amongst other responsibilities, mental health advocates working for the MHAS help identified persons to understand their rights, investigate the extent to which those rights have been observed, advocate for those consumers who have concerns and complaints, assist consumers in Mental Health Tribunal hearings and advocate for, and facilitate access, to other services.

Providing support until complaints are finalised

The MHAS regularly supports people who have raised a complaint whilst an identified person under the Act. Once these people cease to be an identified person, the MHAS is no longer able to assist them with complaints or issues that are underway. This can be problematic where an identified person under the Act makes a complaint to the MHAS but ceases to meet the criteria for an identified person before the complaint is resolved.

Legislative amendment which expands advocacy services for people in the above circumstances would provide further human rights protections for consumers under the Act as proposed in the following recommendation:

Recommendation 27

Amend the Act to prescribe that when an identified person raises a complaint, the Chief Mental Health Advocate’s powers and functions under the Act continue until that complaint is resolved or no further action can reasonably be taken even when the person is no longer an identified person and subject to the person’s consent.

Notifications to Mental Health Advocacy Service

Under the Act, the MHAS is required to contact an involuntary patient within a prescribed timeframe following the making of an involuntary treatment order (seven days for adults, 24 hours for children).[47] This requires the person in charge of a mental health service informing the MHAS that an involuntary treatment order has been made. Where a mental health service provider does not provide timely notification that an involuntary treatment order has been made, the MHAS may not be able to comply with its statutory responsibilities.

The MHAS has an operational agreement with mental health service providers regarding notification timeframes that are reported as working well in practice.[48] Nevertheless, there is benefit in amending the Act to require services to notify the MHAS within prescribed timeframes.[49]

Similarly, the Review process identified that the MHAS should be notified in a timely manner when children are referred or detained under the Act. This includes examination under a Form 1A; detention for assessment while a voluntary patient under a Form 2; detention under a Form 3A; or continuing detention under a Form 3B. It also considered situations where children might be admitted to an adult inpatient setting (refer to the Office of the Chief Psychiatrist section "Ongoing reporting for children under 18 years of age admitted to adult wards" and Recommendation 37 for context).

To ensure more appropriate timing of notifications to MHAS, the following recommendations are proposed:

Recommendation 28

Amend the Act to require the Chief Mental Health Advocate to be notified of an involuntary treatment order within 48 hours for adults and two hours for children.

Recommendation 29

Amend the Act to require the Chief Mental Health Advocate to be notified when: a child is admitted as an inpatient to an adult mental health ward, regardless of whether the child is admitted as a voluntary or involuntary inpatient; a child is referred for examination under a Form 1A; a child is ordered to be detained for assessment while a voluntary patient under a Form 2; a child is ordered to be detained under a Form 3A or for continuing detention under a Form 3A. Consultation is to occur with relevant stakeholders to identify suitable timeframes for notification.

Inquiry power regarding discharge or withdrawal of care

Mental health advocates reported that they are often tasked with investigating complaints by a person discharged from a mental health service where that discharge also involved being evicted from a psychiatric hostel.[50] Although the investigation of such a complaint arguably falls within the remit of the MHAS, the Act does not specifically provide that advocates have the power to make inquiries about the discharge or withdrawal of care that results in an eviction.[51]

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[47] *Mental Health Act 2014* (n 5) s 357(2).
[48] Mental Health Commission (n 2) 43.
[49] Mental Health Commission (n 2) 43.
[50] Mental Health Commission (n 2) 43.
[51] Mental Health Commission (n 2) 43.

Six submissions were received on this issue, all of which supported the proposed amendment to expressly provide that a mental health advocate can make inquiries regarding the discharge of, or withdrawal of care to, a person by a mental health service or other place.

Legislative amendment is necessary to remove doubt regarding the remit of the MHAS in this regard. The following recommendation is proposed:

Recommendation 30
Amend the Act to provide that a mental health advocate has the power to make inquiries regarding the discharge of a person or withdrawal of care to a person by a mental health service or other place.

Advising the Chief Mental Health Advocate when clinicians do not notify or involve certain people

Under the Act, the person responsible for notifying a patient's carer, close family member or other personal support person of a "notifiable event" (provided in Schedule 2 of the Act) must ensure that, as soon as practicable after the event occurs, the relevant person is notified. The Review consultations identified that the phrase "as soon as practicable" can lead to significant delays which may impact on consumers being able to exercise their statutory rights.

Notification is not required if the relevant clinician (for example, the treating psychiatrist) determines that notification is not in the best interests of the patient. In such cases, the person responsible for notification must, as soon as practicable, file a record of the decision, the reasons for it, and provide a copy to the Chief Mental Health Advocate.

Legislative amendment that prescribes notification timeframes for the above will assist in ensuring all consumers in mental health facilities are provided with their rights through the oversight of the MHAS. To facilitate this, the following recommendation is proposed:

Recommendation 31
Amend the Act to require notification to the Chief Mental Health Advocate within 24 hours of the decision being made not to contact the personal support person (rather than "as soon as practicable").

Notifying admission and detention of mentally impaired accused

The Review considered a proposed amendment to add a requirement that an authorised hospital notify the MHAS (within a specified timeframe) regarding the admission and detention of a mentally impaired accused person. The Act requires that an advocate visit or contact the person within seven days of the detention for an adult, or 24 hours for a child. While it is implied that this would require the authorised hospital to notify the MHAS, this is not specified within the Act.

Legislative amendment is required to prescribe the notification of MHAS to ensure that the admission and detention of a mentally impaired accused people are provided within their rights through the oversight of the MHAS. The following recommendation is proposed:

Recommendation 32
Amend the Act to add a requirement to notify the Chief Mental Health Advocate (within a specified timeframe) regarding the admission into and detention of a mentally impaired accused person in an authorised hospital.

Office of the Chief Psychiatrist

Under section 508 of the Act, the Chief Psychiatrist is responsible for the treatment and care of all involuntary patients, mentally impaired accused persons detained in an authorised hospital, persons referred under section 26(2) or (3)(a) or 36(2) and those under an order made under section 55(1)(c) or 61(1)(c), as well as all patients of the Act's designated mental health services. The Chief Psychiatrist publishes standards for treatment and care to be provided by mental health services and oversees compliance with those standards.

Access to information regarding former patients

As part of the Review if was identified that the Chief Psychiatrist's ability to access information regarding former patients may be limited, impacting on the Chief Psychiatrist's efforts to oversee the treatment and care of patients and to monitor the standards of care being delivered by mental health services throughout the State.[52]

It was identified that the Act should be amended to allow the Chief Psychiatrist to obtain information regarding former patients (including deceased patients and those who have been discharged). The following recommendation is proposed to enable the Chief Psychiatrist to use previous consumer experiences to inform continuous improvement of standards for treatment and care provided by mental health services and to strengthen compliance with these:

Recommendation 33
Amend the Act to provide that the Chief Psychiatrist can access information about former and deceased patients, when doing so is necessary for the discharge of the Chief Psychiatrist's obligations under the Act.

Provision of personal information to coroner

Section 577(1) of the Act lists the circumstances in which the recording, disclosure or use of information obtained by a person under the Act is authorised. The Review considered that the Act does not allow for the disclosure of information to a coroner or a person assisting a coroner under the *Coroners Act 1996* (WA). It was further noted that section 220 of the *Health Services Act 2016* (WA) sets out the circumstances in which the collection, use or disclosure of information obtained under that Act is authorised, and in any circumstances prescribed for the purposes of section 220 (see section 220(1)(i)). Regulation 5(2) of the *Health Services (Information) Regulations 2017* (WA) specifies when the disclosure of information is authorised.

It is proposed that legislative amendment is required to align the Act with provisions equivalent to regulation 5(2) of the *Health Services (Information) Regulations 2017* as outlined in the

[52] Mental Health Commission (n 2) 46-47.

recommendation below. Consideration will be given to whether the amendment should apply to the Chief Psychiatrist only or more broadly to other persons who carry out a function under the Act.

Recommendation 34

Amend section 577(1) of the Act to allow for persons, who carry out a function under the Act and who obtain information that relates to an individual who is deceased, to disclose that information in response to a written request from:

a) a coroner, a coroner's registrar, a coroner's investigator or a member of the staff of a coroner's court in connection with an investigation into the death of the individual; or
b) a medical practitioner who is performing a post-mortem on the body of the individual at the direction of a coroner.

Approved form of medical records

Under the Act, the person in charge of a mental health service is required to ensure that all medical records are kept in an approved form.[53] The Chief Psychiatrist has the power to approve forms for this purpose,[54] which must be published once approved.[55] The Chief Psychiatrist also produces guidelines about how the forms are to be completed.[56]

The Review found that the requirement for the medical records to be in an approved form does not serve any useful purpose and is unworkable. Further, the "approved forms" requirement is not necessarily compatible with the national standards that mental health services are expected to comply with, including Australian Standard 2828 (AS 2828) and the National Safety and Quality Health Service (NSQHS) Standards (developed by the Australian Commission on Safety and Quality in Healthcare).[57] There was support for the requirement to be removed from the Act.

It is proposed that legislative amendment to remove the requirement under section 582 to keep a medical record in the approved form be considered, as outlined in the proposed recommendation below. However, the requirement to keep a medical record must be retained as this refers to essential recording keeping.

Recommendation 35

Amend the Act to remove section 582(2) regarding the medical record having to be in an approved form; but retain section 582(1) regarding the requirement to keep a medical record.

Making or revoking inpatient treatment orders in a general hospital

A psychiatrist cannot detain a person for involuntary treatment in a general hospital without the consent of the Chief Psychiatrist.[58] Where consent is provided, the order must be made in an approved form, filed and a copy provided to the person whom the order applies to. However, there is no requirement for the general hospital to provide a copy of the order or a revocation of the order to the Chief Psychiatrist.

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[53] *Mental Health Act 2014* (n 5) s 582.
[54] *Mental Health Act 2014* (n 5) s 545.
[55] *Mental Health Act 2014* (n 5) s 546(1)(a).
[56] *Mental Health Act 2014* (n 5) s 546(1)(b).
[57] Australian Commission of Safety and Quality in Healthcare, National Safety and Quality Health Service Standards (second edition) (Standards, 2021).
[58] *Mental Health Act 2014* (n 5) s 61(2)(b).

Legislative amendment is required to ensure a general hospital provides a copy of an involuntary treatment order to the Chief Psychiatrist to enable the Chief Psychiatrist to perform functions, as outlined in the proposed recommendation:

Recommendation 36
Amend the Act to require general hospitals to provide copies of inpatient treatment orders and revocation orders to the Chief Psychiatrist.

Ongoing reporting for children under 18 years of age admitted to adult wards

Section 303 of the Act considers situations where a child (a person who is under 18 years of age) is admitted to a mental health service that does not ordinarily provide treatment or care to children who have a mental illness, in settings commonly referred to as adult wards. The overwhelming majority of children in these circumstances are 16 to 17 years of age.

As per section 303(2), a child cannot be admitted as an inpatient unless the person in charge of the mental health service is satisfied that the service can provide the child with treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual beliefs. If deemed appropriate, the person in charge of the mental health service must also be satisfied that the treatment, care and support provided to that child is separate from any part of the mental health service in which adults are provided with treatment and care.

As per section 303(3), when a child is admitted as an inpatient by a mental health service, the person in charge of the service must provide a report to the child's parent or guardian that outlines why they are satisfied that the child can be admitted, as per the criteria outlined in section 303(2). The report must also outline how the service will ensure that the child is protected and how their individual treatment and care needs will be met. A copy of the report must be filed, and a copy provided to the Chief Psychiatrist. Currently, no further reporting is required.

The Office of the Chief Psychiatrist proposed an amendment to strengthen reporting obligations by requiring mental health services to report to the Chief Psychiatrist every seven days during a child's admission. These regular reporting intervals would provide additional oversight to support the protection of a child's ongoing treatment, care and safety. This approach would be similar to existing reporting requirements under section 65 of the Act which apply to involuntary patients in general hospitals.

The Review also considered the application of section 303 to people receiving treatment and care in Western Australia's specialist youth inpatient units, established after the Act came into effect. As these units cater specifically for young people aged 16 to 24 years of age, some submissions proposed the exclusion of specialist youth inpatient units from additional reporting requirements. Further consultation is required to identify how this provision may apply in these circumstances.

Noting that additional consultation is required in regard to youth inpatient units, a legislative amendment is suggested to increase appropriate oversight by the Chief Psychiatrist if a person under the age of 18 years is admitted to authorised mental health services that also admit adults, as outlined in the following proposed recommendation:

Recommendation 37
Amend the Act to require a mental health service to report to the Chief Psychiatrist every seven days (following initial notification under section 303) when a patient aged under 18 years is an inpatient in a mental health service that does not ordinarily provide treatment or care to children. Consultation is to occur with relevant stakeholders to identify how this provision could apply to specialist youth inpatient units.

Mental Health Tribunal

The Mental Health Tribunal (the Tribunal) is a WA Government statutory body established by section 380 the Act to safeguard the rights of involuntary patients in Western Australia. The Tribunal assesses applications for ECT and psychosurgery, reviews other orders and decisions, issues compliance notices to safeguard consumers' rights and promotes compliance with, and accountability under, the Act. This includes a review of all new involuntary treatment orders, as well as a periodic review to determine if involuntary treatment orders should remain in place. It makes these decisions based on information provided at a hearing where the Tribunal listens to participants' views. All decisions are reviewable by the State Administrative Tribunal.

Procedural fairness issues: mandatory written medical reports for review hearings

The Review considered a proposed amendment to expand the Mental Health Tribunal's authority to require a written report from the psychiatrist prior to the hearing.[59] As a matter of practice, the Tribunal requests a written report from the treating psychiatrist at least 72 hours before the hearing. This report sets out the reasons why the psychiatrist believes the criteria for the making of an involuntary treatment order has been met (as outlined in section 25 of the Act).

However, there is no requirement in the Act for the treating psychiatrist to provide a report prior to a Tribunal hearing. Reports are often filed late, and occasionally, not filed at all, although a clinician may appear in person. An amendment to the Act requiring a written report by the treating psychiatrist will better facilitate appropriate access to information for both the Tribunal and the consumer to inform decision making.

In addition, given its statutory roles and responsibilities, the Tribunal is bound by the rules of natural justice which require, at a minimum, that an involuntary patient be given access to all information necessary to enable them to respond to the treatment order. A legislative amendment to provide an involuntary patient's representative with timely, free and full access to medical files and records relating to the person would be consistent with other Australian jurisdictions.

The ability for the Tribunal to compel attendance at hearings by clinicians was also raised as an important issue for consumers. Tribunal hearings can be adjourned when clinical questions cannot be adequately answered, resulting in extended stays in hospital for consumers. While the Tribunal can summons a person to give evidence or produce documents (section 462); an ability to require the attendance of a specific clinician through less formal means is more desirable for procedural fairness and efficient management. It is noted that the clinical commitments and availability of clinicians should be considered prior to mandating clinician attendance at a hearing.

[59] Mental Health Commission (n 2) 29.

Legislative amendment is suggested to improve procedural fairness within the Tribunal for consumers, as proposed in the following recommendations:

Recommendation 38

Amend the Act to require:

- The treating psychiatrist of an involuntary patient to prepare and submit a written report prior to a Mental Health Tribunal hearing. Such a report should contain information required by the Act.
- The report be submitted to the Mental Health Tribunal, the involuntary patient and the involuntary patient's representative at least 72 hours prior to the hearing.
- The mental health services provide an involuntary patient's representative with timely, free and full access to medical files and records relating to the patient (as enabled by sections 248-251) at least 72 hours prior to the Mental Health Tribunal hearing.

Recommendation 39

Amend the Act to allow for the Mental Health Tribunal to mandate clinician attendance at hearings by means other than summons, such as by formal direction.

Calculating the timing of periodic reviews by the Mental Health Tribunal

The Act provides that the Tribunal must hold an initial review every time a new involuntary treatment order is made by a psychiatrist in Western Australia within 35 days (or 10 days for a child) of the order being made.[60] The Act also requires that the Tribunal review each order again every three months (or every 28 days for a child) while the order remains in place.[61] This is known as a 'periodic review'.

The Review heard concerns that parties can, through the strategic use of certain provisions, require the Tribunal to conduct monthly reviews rather than three-monthly periodic reviews (as per the definition of 'periodic review period' in the Act).[62]

The Tribunal has conveyed that this is contrary to the intention of the Act, and that allowing this fails to balance patient rights with administrative requirements. As part of the Review, an amendment to the Act was proposed to provide that where the Tribunal conducts a review upon application by a person it is included as a 'last review' in the calculation of the 'periodic review period'.

Legislative amendment is necessary to rectify this procedural matter, and provide clarity around review periods The following recommendation is proposed:

Recommendation 40

Amend the Act to provide that where the Mental Health Tribunal conducts a review upon application that this is regarded as the "last review" date when calculating the next periodic review period.

[60] *Mental Health Act 2014* (n 5) s 386
[61] *Mental Health Act 2014* (n 5) s 387
[62] Mental Health Commission (n 2) 44

Provide for a transcript of oral reasons

The Act provides that a "party may request the [Mental Health] Tribunal to provide the party with reasons for the Tribunal's decision in the proceeding."[63] Tribunal members usually give the parties oral reasons for the decision at the conclusion of the hearing, complemented by the informal practice of providing reasons for decision in the transcript. A transcript is a written or printed version of material originally presented in another medium.[64] This facilitates the applicant's understanding of the Tribunal's decision by providing clarity at the time of the hearing.

Legislative amendment to provide for written transcripts is necessary for administrative efficiency. It also benefits consumers by ensuring faster dispensing of the Tribunal's decision or reasons. All Review submissions commenting on this amendment were in support.

The proposed amendment mirrors the language in section 79 of the *State Administrative Tribunal Act 2004* (WA), which provides that "a written transcript of the part of the proceeding in which a decision is given orally or reasons are given orally is sufficient for a provision of this Act that requires the decision or reasons to be in writing." Allowing the transcript of the decision to suffice as reasons for the decision means that Tribunal members are not required to write a formal decision, saving time and cost, and ensuring more swift dispensing of the Tribunal's decision or reasons. The following recommendation is proposed:

Recommendation 41

Amend the Act to provide that, if a party requests reasons for a decision by the Mental Health Tribunal, a written transcript of the part of proceedings that contain the reasons for the decision given orally may suffice.

Correcting mistakes

Occasionally, judgments, reasons, orders and certificates issued by the Tribunal contain minor errors. However, once a statutory right has been exercised by a Tribunal member, it lacks the power to re-examine the decision and thus to correct the error by virtue of the doctrine of *functus officio*. The error could be remedied on appeal, but it is both impractical and inefficient from a time and cost perspective to require formal appeals purely for minor and technical amendments.

Judicial or quasi-judicial bodies, similar to the Tribunal, are often empowered to correct errors, whether on its own motion or on the application of a party (this is colloquially referred to as the "slip rule"). Most courts and tribunals have a slip rule, and these are generally considered non-contentious.[65] For example, the slip rule applicable to the State Administrative Tribunal is in section 83 of the *State Administrative Tribunal Act 2004* (WA).

As part of the Review process, an amendment to the Act was considered which would empower the Tribunal to correct a clerical mistake, accidental error, omission, miscalculation or defect of form in its reasons or decisions at any time.[66] Submissions were received from a range of stakeholders, and the majority were supportive of the proposed amendment. It was noted that any correction should be officially recorded, and relevant parties notified.

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[63] *Mental Health Act 2014* (n6) s 469(1).
[64] Mental Health Commission (n 2) 45.
[65] See for example *State Administrative Tribunal Act 2004* s 83.
[66] Mental Health Commission (n 2) 45.

While the law already provides for the correction of administrative errors in section 55 of the *Interpretation Act 1984* (WA) which may address some of the issues raised by the absence of a slip rule, it does not completely overcome the principle of *functus officio* and therefore, legislative amendments may provide for better clarity. The following recommendation is proposed:

Recommendation 42

Amend the Act to allow the Mental Health Tribunal to correct minor mistakes, accidental errors or minor omissions in its reasons or decisions. The amendment should include an obligation on the part of the Mental Health Tribunal to:

a) make a note of the error and any correction in the relevant case file;
b) notify the person (and the person's advocate or legal representative, if any) to whose matter the correction relates; and
c) distribute the correct version of the document to all parties, alerting them of the error and any correction.

Clarify when a decision of the Mental Health Tribunal takes effect

The Tribunal provides all decisions in writing, usually on the day of hearing, via a Notice of Decision sent to the health service provider and participants. Health service providers always have at least one representative present at hearings.

On occasion a mental health service may be unclear as to when a Tribunal decision takes effect.[67] For example, confusion may exist as to whether a patient is free to leave immediately following the conclusion of the hearing whereby the Tribunal has decided to revoke involuntary status.[68] In some circumstances, staff have been reluctant to let the patient leave until receipt of the Tribunal's written notice of decision, which may not always occur on the day of the hearing.[69] A provision that the Tribunal's decision takes immediate effect, subject to any stated exceptions, would minimise confusion, save resources and ensure that patients can access their rights expeditiously (which includes, importantly, not being detained without authority).

All submissions commenting on this matter were supportive of legislative amendments to clarify when a decision of the Tribunal takes effect as outlined in the proposed recommendation:

Recommendation 43

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

Additional notification provisions

There is a range of information that the Chief Psychiatrist, the Tribunal, the Chief Mental Health Advocate and the Mentally Impaired Accused Review Board may require to enable these bodies to properly perform their functions. The Review consultation identified several opportunities to support these bodies by enabling the notification of certain decisions and the provision of information.

[67] Mental Health Commission (n 2) 45
[68] Mental Health Commission (n 2) 45
[69] Mental Health Commission (n 2) 45

Notifying certain decisions regarding community treatment orders

A community treatment order can be made in the following circumstances:

- A psychiatrist examines a person on a Form 1A – Referral for Examination by Psychiatrist at either an authorised hospital or another place and makes a Form 5A – Community treatment order; and
- A psychiatrist examines a person without a referral at either an authorised hospital or another place and makes a Form 5A – Community treatment order.

A community treatment order made following an examination by a psychiatrist without a referral must be confirmed within 72 hours by another psychiatrist. Where another psychiatrist is not reasonably available, confirmation can be undertaken by another medical practitioner or an AMHP. If the order is not confirmed, then it ceases to be in force.

Review consultations identified that the Tribunal, the Chief Mental Health Advocate and the Mentally Impaired Accused Review Board are not notified when a community treatment order is *not* confirmed. This is different to when an order is revoked or expires, in which case parties such as the Chief Mental Health Advocate are notified. As the Chief Mental Health Advocate does not receive continuation orders, it is possible that the advocate continues to exercise powers and functions when the consumer is no longer an identified person. This can be particularly problematic when the consumer does not want the advocate to access their medical records.

Legislative amendment is required to ensure mental health service providers notify the Tribunal, Chief Mental Health Advocate and the Mentally Impaired Accused Review Board (if the person is a mentally impaired accused) in cases where a community treatment order has been made without referral and is since confirmed or is no longer in force. The following recommendation is proposed:

Recommendation 44

Amend the Act to require mental health service providers to notify the Mental Health Tribunal, the Chief Mental Health Advocate and the Mentally Impaired Accused Review Board (as relevant) when a community treatment order has been made without referral and is since confirmed or is no longer in force within 24 hours.

Transfer orders

The Review considered a potential legislative amendment requiring a copy of transfer orders between hospitals being provided to the Tribunal, the Chief Mental Health Advocate, and the Chief Psychiatrist.[70] It was found this would enable these bodies to perform their functions under the Act and therefore the following recommendation is proposed:

Recommendation 45

Amend the Act to require a copy of transfer orders between hospitals to be provided to the Mental Health Tribunal, the Chief Mental Health Advocate, and the Chief Psychiatrist.

[70] See *Mental Health Act 2014* (n 5) s 145(4)(c)

Continuation orders

Section 89 of the Act provides for a treating psychiatrist to examine an involuntary patient to make a continuation order to extend the inpatient treatment "from the end of the detention period for the further detention period that is specified."[71]

The Review considered a proposal requiring a copy of continuation orders being provided to the Tribunal, the Chief Mental Health Advocate, and Chief Psychiatrist.[72] It was found this would enable these bodies to perform their functions more effectively under the Act and therefore the following recommendation is proposed:

Recommendation 46

Amend the Act to require that a copy of a continuation order is provided to the Mental Health Tribunal, the Chief Mental Health Advocate and to the Chief Psychiatrist where a person is in a general hospital on an involuntary treatment order.

[71] *Mental Health Act 2014* (n 5) s 89(2)(a).
[72] Mental Health Commission (n 2) 48.

Chapter 9: Voluntary Consumers on Locked Wards

A "voluntary inpatient" is defined in the Act as 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* (MIA Act) to be detained at an authorised hospital.[73]

A "mental health service" includes a hospital, a community mental health service and any service prescribed by the regulations but does not include a private psychiatric hostel or a place defined for the purposes of section 23 of the MIA Act.[74]

Freedom of movement

> *"I was placed in a locked ward, as a voluntary patient, as a means of preserving my safety. Although the facility was pleasant, I was unable to freely leave the ward. I felt confined and disempowered. Seeking permission to exit the ward was disadvantageous, as it required considerable time and effort to locate available staff to unlock the door."* Consumer

A voluntary inpatient must provide informed consent before being provided with treatment (except for emergency psychiatric treatment) and is free to leave the ward at any time. However, if the voluntary inpatient wishes to leave a non-authorised hospital against medical advice (i.e., if it is believed the person needs an involuntary treatment order), a doctor or an AMHP may refer the person for an examination by a psychiatrist on a Form 1A.[75] If the person is on an authorised hospital ward, they can be stopped from leaving for up to six hours to allow for examination by a clinician who will decide whether a referral to a psychiatrist is warranted.[76]

Patients detained under the Act at some point, but whose status has changed from involuntary to voluntary, must also be allowed to leave the hospital, however, remain subject to six hours' detention under section 34 of the Act if they tried to leave against medical advice.[77]

[73] *Mental Health Act 2014* (n 5) s 4.
[74] *Mental Health Act 2014* (n 5) s 4.
[75] *Mental Health Act 2014* (n 5) s 34(1).
[76] *Mental Health Act 2014* (n 5) s 34(2) and (3).
[77] *Mental Health Act 2014* (n 5) s 95.

Legislative amendment is required to ensure that voluntary patients are clearly informed about their right to freedom of movement, regardless of whether the ward is locked or unlocked throughout their admission to the ward. In addition, voluntary patients should also be clearly informed that they may be detained for the purposes of examination by a psychiatrist on a Form 1A. With consideration of these issues the following recommendation is proposed:

Recommendation 47
Amend the Act to prescribe that voluntary patients:
a) be informed on admission of their lawful right to leave a ward, whether locked or unlocked, both orally and in writing; however
b) be also made aware that should criteria under section 25 be met, a psychiatrist can make an inpatient treatment order.

Inpatient voluntary older adults

The Review raised concerns that older adults are primarily admitted as "voluntary" patients to locked wards. For example, a person on a guardianship order under the *Guardianship and Administration Act 1990* may be admitted as a voluntary patient by consent of their guardian but be treated in a locked ward. As a result, their freedom of movement is restricted.

There is also concern that some older adults are being held on locked wards with the approval of next of kin and without a guardianship order. On the basis of "the principle of least restriction", the person is held on the ward in this manner to the extent that they are compliant, but they may not know or fully understand their rights, and do not have access to MHAS or review by the Tribunal.

Increasing access to advocacy is an important aspect of protecting the human rights of consumers under the Act. All submissions commenting on this matter recognised the additional needs and vulnerabilities of voluntary older adults on locked wards and supported their inclusion as "identified persons" for the purposes of accessing advocacy services. The following recommendation is proposed:

Recommendation 48
Amend the Act so that voluntary older adult inpatients in authorised units be considered identified persons under the Act, so they can be assisted by the Chief Mental Health Advocate.

Inpatient voluntary children

Under the section 348 of Act, the Mental Health Advocacy Service is empowered to provide advocacy services to specific classes of voluntary patients as "identified persons."[78]

In 2016, as per section 354 of the Act, the Minister issued a written direction[79], expanding the term "identified person" to include the following classes of voluntary patients:

[78] Mental Health Act 2014, s 348(j).
[79] Mental Health Advocacy Service, Voluntary Mental Health Patients Able to be Assisted by Mental Health Advocates (Directions, 2017).

- a child who is being treated, or who is seeking admission, or is proposed to be provided treatment, by or in:
  - a public hospital as defined by the *Health Services Act 2016* (WA); or
  - an authorised hospital;
- a child who has been assisted in the previous six months by a mental health advocate while:
  - a voluntary patient in accordance with this direction; or
  - an involuntary inpatient and is being treated, or is proposed to be provided treatment, by or in a community mental health service.

Under Section 4 of the Act a "child means a person who is under 18 years of age." There is an opportunity to amend the Act to confirm the written direction and current practice in legislation. The following recommendation is proposed:

Recommendation 49

Amend the Act to prescribe the following categories of patients as "identified persons":

- Children up to the age of 18 years who are being treated, or who are seeking admission, or who are proposed to be provided treatment, by or in:
  - a public hospital as defined by the *Health Services Act 2016*; or
  - an authorised hospital.
- Children up to the age of 18 years who have been assisted by Mental Health Advocacy Service in the last six months, while either a voluntary patient or an involuntary inpatient, and who are being treated, or are proposed to be treated, by a community mental health service.

Chapter 10: Terms and Concepts

Definition of “psychiatrist”

Section 4 of the Act defines the term “psychiatrist” as a medical practitioner who is:

a) a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP); or
b) a person, or a person in a class of person, prescribed by the regulations for this definition.

Pursuant to paragraph (b) of the definition, provided the Chief Psychiatrist is satisfied a person is sufficiently qualified to practise as a psychiatrist, the *Mental Health Regulations 2015* (the regulations) are then amended to prescribe the person as a psychiatrist for the purposes of the Act. Amending the regulations each time is inefficient, results in delays as psychiatrists wait for the regulations to be amended and potentially affects the provision of timely treatment and care.

An alternate option may be to designate or revoke a medical practitioner as a psychiatrist under the Act by way of an Order and publish in the Government Gazette. This is consistent with the Chief Psychiatrist’s existing powers under section 539 to designate a person as an AMHP.

Under this circumstance, the Chief Psychiatrist would be required to consult with the Medical Board of Australia established under the *Health Practitioner Regulation National Law Act 2010* (WA) and RANZCP prior to making the Order, and to maintain a register of designated psychiatrists in a manner similar to the existing requirement to maintain a register of AMHPs.

As part of the Review’s consultation processes, a health service provider informed the Review the “delays in having to amend the regulations to add these people [psychiatrists] by name cause significant problems for services, where a person in a consultant role cannot yet carry out functions under the Act,” and supported an amendment provided there was no inappropriate expansion of the definition of “psychiatrist” beyond the current parameters.

It is therefore proposed that the legislation be amended to facilitate a more timely and efficient way for the Chief Psychiatrist to designate persons with the relevant training and experience as psychiatrists under the Act, as follows:

Recommendation 50
Amend the Act to allow the Chief Psychiatrist to designate, by order published in the Government Gazette, persons with the relevant training and experience as “psychiatrists” under the Act (and to revoke any such designation) following consultation with the Medical Board of Australia established under the *Health Practitioner Regulation National Law Act 2010* (WA) and the Royal Australian and New Zealand College of Psychiatrists.

Definition of “child and adolescent psychiatrist”

Section 4 of the Act defines a “child and adolescent psychiatrist” as “a psychiatrist who has qualifications and clinical training in the treatment of mental illness in children.” However, the precise qualifications and clinical training required to meet this definition are not prescribed in the Act or the Regulations.

The Act also requires the Tribunal to include a child and adolescent psychiatrist whenever the Tribunal reviews the case of a child patient.[80] If there is no child and adolescent psychiatrist available, the Tribunal must have regard to the views of a medical or mental health practitioner who has the qualifications, training or experience relevant to children with a mental illness, or is authorised by the Chief Psychiatrist for this purpose.[81] To date, no practitioner has been so authorised.

As the Act does not define the required qualifications and clinical training, it is difficult to determine which psychiatrists meet the necessary criteria. Consequently, the opportunity to provide a definition of a “child and adolescent psychiatrist” in the Act was canvassed as part of the Review process. Consideration of the following criteria was provided:

- practitioners who have completed RANZCP’s Certificate of Advanced Training in Child and Adolescent Psychiatry; or
- practitioners who have completed an approved training program in child and adolescent psychiatry and current employment in child and adolescent psychiatry or a related field (e.g., perinatal or youth mental health).

A legislative amendment to enable the Chief Psychiatrist to determine the appropriate expertise required for the role of the Tribunal member is proposed through the following recommendation:

Recommendation 51
Amend the Act to allow the Chief Psychiatrist to designate, by order published in the Government Gazette, a child and adolescent psychiatrist for the purposes of the relevant sections of the Act, provided the Chief Psychiatrist is satisfied that the psychiatrist to be designated has the relevant qualifications and clinical training in the treatment of mental illness in children.

[80] *Mental Health Act 2014* (n 5) s 383(c)(i).
[81] *Mental Health Act 2014* (n 5) s 394(2).

Chapter 11: Administrative Improvements

Gender-neutral terminology

The Review identified the need for gender-neutral terminology throughout the Act and finds that replacing gendered terminology with gender-neutral terms is appropriate, as outlined in the proposed recommendation:

Recommendation 52
Amend the Act throughout to ensure gender-neutral terminology is used.

Remuneration of the Chief Mental Health Advocate

The Chief Mental Health Advocate's remuneration is currently determined by the Minister upon the recommendation of the Public Sector Commissioner.

In 2019, the Public Sector Commissioner recommended that an independent review be conducted which found the remuneration of the Chief Mental Health Advocate was inadequate, and revised salary and entitlements were proposed. The review found that the Salaries and Allowances Tribunal (SAT) would be the most appropriate organisation to determine the remuneration of the Chief Mental Health Advocate, however noted that legislative amendment would be required to enable this. The SAT assesses senior roles and ensures that remuneration levels are aligned to other senior roles in Western Australia.

The following recommendation is proposed to ensure consistent remuneration arrangements of comparable offices:

Recommendation 53
Subject to further consultation with the Salaries and Allowances Tribunal, amend section 349 of the Act so that the Salaries and Allowances Tribunal determines the remuneration for the Chief Mental Health Advocate.

Mental Health Commission's functions

The Commission works to establish mental health, alcohol and other drug systems that meet the needs of Western Australia's population and deliver quality outcomes for individuals and their families. It delivers programs and commissions services in the areas of:

- prevention, promotion and early intervention programs
- treatment, services and supports

- research, policy and system improvements.

The *Alcohol and Other Drug Act 1974* (WA) (AAOD Act) grants the Commission statutory authority to acquire, hold, manage, improve, develop, dispose of land and otherwise deal with real and personal property (this will be referred to as “deal with property”) for the purposes of assessment, treatment, management, care and rehabilitation of persons experiencing alcohol and other drug use problems or co-occurring health issues. This includes people who may have a mental illness. The AAOD Act cannot be used by the Commission to deal with property for the purpose of supporting persons experiencing mental illness in the absence of alcohol or other drug use.

This has caused administrative issues for the Commission when commissioning mental health related services and programs requiring land or property. An amendment to the Act to enable the Commission to deal with property for mental health related services or programs will create efficiencies and better support the Commission to deliver the Government’s priorities, as outlined in the proposed recommendation:

Recommendation 54
Amend the Act to enable the Mental Health Commission to deal with property for the purpose of supporting people with mental health services.

Chapter 12: Other Findings

While this report has focused on the legislative amendments identified to improve the operation and effectiveness of the Act, the Review also provided opportunities for feedback on a broader range of issues relating to the Act and the mental health system. These findings provide valuable insights into ongoing opportunities to support the Act's implementation.

The Review involved extensive consultation with a wide range of stakeholders. This took many forms including surveys, written submissions, transcribed voicemail messages and workshops. The Commission also coordinated a community grants process, where organisations received grants to conduct engagement sessions with consumers, carers and families across Western Australia.

Rich insights were received from the experiences of consumers and carers under the Act, as well as those involved in mental health policy, programs or services. Stakeholders put forward many suggestions on how to improve people's experiences of the mental health system. These included system improvements, changes to policies, procedures, training and education and practices, as well as where additional resources may be directed. These findings have been grouped into the following broad themes and are summarised at a high level in this chapter:

- Amending regulations to support the effective operation of the Act.
- Culturally secure approaches to improve outcomes for Aboriginal and Torres Strait Islander people under the Act.
- Enhancing education and training to improve practice and compliance with the Act.
- Organisational reviews, processes and practices to provide clear and structured ways to consistently apply the Act.
- Improving accessibility issues such communication and language services.
- Opportunities for further investigation which may enhance the operation and effectiveness of the Act.

The Commission will work with other government agencies and relevant stakeholders to consider these findings. This will include the development and implementation of initiatives to support the effective functioning of the Act, where appropriate.

Amending the Mental Health Regulations 2015

Several proposals were made to amend the subsidiary legislation, specifically the regulations, to support the operation and effectiveness of the Act. While amendments to the regulations should be considered following any amendments to the Act, some examples included:

- Amending the definition of "metropolitan area" to include areas more than a certain distance from the Perth Central Business District, or other appropriate method, to ensure that all persons living in remote and regional Western Australia not serviced by the WA Country Health Service are provided for under the Act.

- Following consultation with people with lived experience (consumers and carers), stipulating the minimum details on rights to be explained under the Act.
- Including additional mental health services to come under the remit of the Chief Psychiatrist.
- Amending the definition of “transport officer” to enable a broader range of providers or employees of health services to undertake these functions.

Culturally secure approaches and care

The Act provides access to elders, traditional healers and mental health workers for Aboriginal and Torres Strait Islander people. The importance of culturally secure and appropriate care was highlighted as being essential for improving the mental health outcomes Aboriginal and Torres Strait Islander consumers.

> *“I believe that we’ve just got to have more of those discussions of sitting down and really listening. Sometimes these fellows are real, but they are listening with your ears, listen with your heart and have empathy and understanding for what had happened to us as the First Australians. And then hopefully one day, you will encourage them other non-Indigenous people who don’t want to tell the truth to tell the truth. So, it starts that healing for us and for our old people, or what had happened through Stolen Generation and all of that sort of stuff.”* Cultural Healer

Despite being legislated, several barriers continue to be identified to Aboriginal and Torres Strait Islander people receiving appropriate levels of culturally secure care under the Act. Noting that actions are currently being progressed by relevant agencies to implement recommendations from the 2020 MHAS Inquiry into Services for Aboriginal and Torres Strait Islander People and Compliance with the Mental Health Act report, recommendations identified through this Review included:

- Ensuring appropriate level of resourcing to engage elders, traditional healers and mental health workers to improve access, particularly in regional and remote areas;
- Ensuring an appropriate level of remuneration of Aboriginal elders and traditional healers to support access to services;
- Reviewing policies and procedures to improve the ability of mental health care providers to identify, engage and renumerate Aboriginal elders and traditional healers. This could include reviewing the role and training provided to Aboriginal liaison officers within mental health wards to ensure they are skilled to facilitate these services for patients;
- Improving awareness of staff that Aboriginal and Torres Strait Islander people have a right to culturally appropriate services under the Act;
- Increasing awareness of Aboriginal and Torres Strait Islanders consumers of their right to access culturally secure services, where practicable, and also their right to deny this option if they so wish;
- Providing ongoing culturally secure training for non-Aboriginal staff in mental health services to build their understanding of the experiences that may contribute to poor mental health for Aboriginal people;

- Mental health care providers being required to record Aboriginal and Torres Strait Islander status on approved forms.

Enhancing education and training

A consistent theme was the need to improve the education and training of mental health professionals to facilitate ongoing compliance with the Act and to uphold the rights of consumers. This was also identified as a key issue within the PIR. Enhanced training and education of professionals was identified as important to:

- improve the knowledge of Act;
- improve compliance in the application of the provisions of the Act; and
- build the capacity of professionals to provide clear information about the Act and their rights under it to consumers, their carers, families and support people.

Stakeholders uniformly agreed that opportunities to review and enhance training, education and resources should be collaboratively designed with people with lived experience. Some of the specific opportunities for improvement included:

- Training for mental health professionals, including psychiatrists, on the importance of including consumers, nominated persons and personal support persons in the care received under the Act. For example, in the development of a treatment support and discharge planning;
- Mandatory and regular de-escalation training for staff to minimise instances where restraint and force are used;
- Where services are contracted, these contracts should include clauses regarding standards of safety and service provision including training and education. For example, in de-escalation and trauma-informed care;
- Education of professionals in the rights of children and young people to participate in decision making and the application of the principles of Gillick competency, in relation to the Act;
- Promotion and awareness of current available policies and guidelines on the provisions and requirements under the Act held by the Office of the Chief Psychiatrist and the Department of Health;
- Ongoing review and development of pamphlets and other written documents to be utilised by professionals in communicating rights to consumers. For example, the rights of consumers to appoint a nominated person and the right to freedom of movement of voluntary patients;
- Development of resources in plain English for consumers, personal support persons and community stakeholders to educate them on their rights under the Act;
- Provision of more focused training in relation to specific topics/areas such as co-occurring mental illness and alcohol and other drug issues, trauma-informed care, and cross-cultural models of illness and health.

Organisational reviews, processes and practices

Opportunities were identified to improve the operation and effectiveness of the Act through the review and updating of policies, procedures and practices. These operational frameworks are

crucial tools for people working within the mental health system to provide a clear and structured way to consistently apply the Act.

A summary of the main opportunities identified, include the review of:

- Client management systems and forms to ensure that they remain fit for purpose;
- Communication processes which apply to carers, family members and personal support persons to ensure that they are fit for purpose and meet the needs of these parties;
- Processes relating to involuntary inpatient leave to provide greater certainty to clinicians by clarifying what criteria must be met, and to clearly distinguish how a formal “leave of absence” differs from allowing involuntary inpatients with access to short breaks outside of a hospital;
- Current processes for the review of a further opinion and the conditions for which an additional further opinion can be obtained (e.g., where there is a difference in the opinions of two individuals), noting this should be developed by the Chief Psychiatrist and in consultation with people with lived experience; and
- Current complaints resolution process used by mental health services and HaDSCO to ensure that complainants are regularly advised of the progress of their complaints, and that lived experience representatives are included in the complaint resolution process.

Similarly, opportunities were also identified for the Chief Psychiatrist to undertake the following actions to improve the operation and effectiveness of the Act:

- Develop guidelines for consumers and carers on how to complete treatment, support and discharge plans; and
- Amendments to strengthen the Chief Psychiatrist’s Standards for Clinical Care and Guidelines.

Improving accessibility

Improvements in communication and access to information were highlighted, particularly for people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander people. This included the provision of information in accessible languages and ensuring access to translators during assessment, examination and treatment. Whilst this is a legislative requirement under section 9(2) of the Act, there are policy and procedural changes that could be made to support this legislative requirement in operation. For example, ensuring that staff in mental health services are aware of their obligation to offer an interpreter to consumers and the production of communication material in languages other than English.

Other opportunities identified included ensuring that people, regardless of their hearing, literacy or neurocognitive ability, have access to appropriate mental health and wellbeing information and means of communication in a range of formats.

Opportunities for further investigation

The Review process identified opportunities which may improve the operation and effectiveness of the Act that require further consideration and consultation. These include:

- Investigating whether there is merit in introducing new reporting requirements on the use of off-label medication in children; and
- Investigating other avenues for strengthening compliance with the Act across all health services by addressing challenges such as governance, resourcing, and physical facilities.

Summary

The proposals within this chapter will be explored in the context of supporting effective operation of the Act. The continuous improvement processes currently within mental health services are acknowledged as being integral for the effective implementation the Act. The Commission is committed to working with key stakeholders and utilising the extensive feedback and learnings of the Review to enhance these processes to improve the quality and consistency of the experiences of consumers, carers and stakeholders within the mental health system. This includes improvement in education, resources, policies and procedures to support the professionals who are dedicated to providing excellence in care, support and treatment for others on a daily basis.

Appendix 1: Steering Group

Background

The role of the Steering Group was to lead and guide the review process and participate in the development of the final report and recommendations.

Membership

Acknowledging personnel changes, Steering Group members involved during the most pivotal stages of the Review process are identified below.

- Independent Chair, Ms Debora Colvin.
- Carer representative, Mr Ron Deng.
- Chairperson, Aboriginal Health Council of Western Australia, Ms Vicki O'Donnell.
- Executive Manager Mental Health, Kimberley Aboriginal Medical Services, Ms Kristen Orazi (proxy for Ms Vicki O'Donnell).
- Chief Advocate, Mental Health Advocacy Service, Dr Sarah Pollock.
- Chief Medical Officer, Mental Health, Mental Health Commission, Dr Sophie Davison.
- Chief Psychiatrist, Office of the Chief Psychiatrist, Dr Nathan Gibson.
- Consumer representative, Ms Carli Sheers.
- Deputy Commissioner System Development, Mental Health Commission, Ms Kim Lazenby until 23 February 2023.
- Executive Director Patient Safety and Clinical Quality Directorate, Department of Health, Ms Audrey Koay until 31 July 2023.
- President, Mental Health Tribunal, Ms Karen Whitney until 31 December 2022; Dr Andrew Lu after 1 January 2023.
- Psychiatrist, Head of Clinical Service, Dr Mark McAndrew.

Roles and responsibilities

The members of the Steering Group were required to:

- review evidence and background information relevant to the review;
- review and provide advice to the Commission on the Discussion Paper used to support the public consultation process;
- contribute to the public consultation process through advising on the preferred consultation approach, and where appropriate participating in or facilitating consultations;
- consider key issues that have been raised during the consultation process, and through other consultation processes such as the Post Implementation Review and Issues Register; and
- contribute to the development of the recommendations.

Reporting

The final decision in relation to the recommendations in this report resides with the Minister.

Appendix 2: Review process overview

Methodology

The Review took a mixed-methods approach which included:

- inviting submissions from the public during a six-month engagement period;
- providing community grants to support consultation and submissions;
- a desktop review;
- literature reviews;
- targeted steering group consultations;
- analysis of submissions and contributions though other sources; and
- workshops on complex issues.

Each of these steps is discussed briefly below.

Public submissions

From 13 August 2021 to 31 January 2022, the Commission undertook a six-month public comment period, supported by a Discussion Paper. The Discussion Paper outlined key issues and proposed amendments that have been identified since the Act came into effect through processes such as the Post Implementation Review and feedback received over time by various stakeholders since the current Act came into operation.

The public consultation period was advertised and promoted on the Commission's website, via social media, newspaper advertising, mental health networks (clinician and consumer), and health service providers. In addition, the Chair of the Steering Group and the Review project team presented to various interest groups to promote the public consultation opportunities.

Submissions were invited in various formats including written submissions, short and long surveys, emails and voicemail messages.

Community grants process

Thirteen organisations received grants from the Commission to conduct engagement sessions with consumers, carers and families to inform the Review. The list of grant recipients is available in **Appendix 3**.

Engagement sessions comprised of both individual and group sessions involving consumers, personal support persons, carers, and family members. Grant recipients produced reports to the Commission detailing the feedback provided in the engagement sessions, along with demographic data of participants.

Desktop review

A desktop review of a range of publicly available information and documents relevant to the operation and effectiveness of the Act was undertaken, including a review of mental health legislation in comparable jurisdictions, along with any recently published statutory reviews or Royal Commission reports. These documents were analysed to provide insights into how other jurisdictions address the same (or similar) policy issues.

Literature reviews

Guided by the Steering Group, the Commission engaged researchers to undertake literature reviews on the following topics:

- Advance Health Directives;
- Legislation governing seclusion and restraint;
- Protection of human rights; and
- Shared and supported decision making.

The literature reviews informed the qualitative analysis of the submissions, as well as the workshop discussion papers prepared by the project team for the purposes of supporting the complex issue workshops (described below).

Targeted consultations

The Steering Group considered the Report of the Royal Commission into Victoria's Mental Health System (Royal Commission) and met with those responsible for drafting the *Mental Health and Wellbeing Act 2022* and the newly appointed Executive Director of Lived Experience, a position which arose from the Royal Commission recommendations.

Various other consultations were held as requested by the Steering Group, including with people with lived experience of specific issues relevant to the Review.

Analysis of submissions and other information

Between August 2021 and January 2022, the Commission received more than 290 submissions through a variety of forms from agencies, health service providers, advocacy organisations, groups and individuals, including individual clinicians, carers and consumers.

A list of entities that provided submissions is in **Appendix 4**.

Submissions were considered and analysed using a coding framework developed by the Commission and informed by a lived experience analyst. The results of this analysis were considered together with the findings of the desktop review, the literature reviews, and the targeted Steering Group consultations.

Complex issues workshops

Workshops were undertaken between August 2022 and September 2022 to investigate nine complex issues identified through the initial consultation (refer to **Table 1** for workshop topics and focus).

The workshops involved a range of government and non-government stakeholders, including people with lived experience and those who administer and work within the Act's legislative framework. Consumers and carers were also invited to attend pre-workshop sessions to prepare for the workshops in a safe space.

Table 1: Complex Issues Workshops

Workshop Topic	Focus
Aboriginal People and the Mental Health Act 2014	To identify the most significant issues and opportunities for improvement in the experiences of Aboriginal and Torres Strait Islander people with and under the Act
Advance Health Directives (AHDs)	To identify the most significant issues, opportunities for improvement and the best approach to addressing AHDs under the Act
Alcohol and Other Drugs (AOD)	To identify the most significant issues and opportunities for improvement on provisions around AOD under the Act, with a focus on compulsory AOD treatment, drug-induced psychosis, and co-occurring mental health/AOD issues
Children and the Mental Health Act 2014	To identify the most significant issues and opportunities for improvement in the experiences of children (0-18 years old) and families under the Act
Consumer Rights	To identify the most significant issues and opportunities for improvement on the topic of consumer rights within the Act. Topics discussed include: • Charter of Mental Health Care Principles • Voluntary Inpatient Rights • Explanation of Rights • Audio-visual Communication
Regulation of Treatment and Other Interventions	To identify the most significant issues and opportunities for improvement in the regulation of treatment and other interventions, with a focus on electroconvulsive therapy
Seclusion and Restraint	To identify the most significant issues and opportunities for improvement of the provisions dealing with seclusion and restraint under the Act
Transport, Apprehension, Search and Seizure	To identify the most significant issues and opportunities for improvement of the provisions dealing with transport, apprehension, search and seizure under the Act
Treatment, Support and Discharge Plans	To identify the most significant issues and opportunities for improvement of the provisions dealing with treatment, support and discharge plans

Appendix 3: List of grant recipients

Recipient Organisation	Target Stakeholder/s	Target Age Group/s	Target Region/s
Carers WA	Carers and Family Members with specific focus on Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse and LGBTQAI+ communities	All	Great Southern, Peel, Metropolitan
City of Gosnells	Culturally and Linguistically Diverse Consumers, Carers and Family Members	Ages 16-65+	Metropolitan
The Dash – Health Hub	Transgender (LGBTQAI+)	Ages 16 - 64	Metropolitan
Facilitatrix	Involuntary Consumers	Ages 25-64	Metropolitan
Health Consumers Council - 1	Voluntary Consumers	Ages 18-65+	Metropolitan
Health Consumers Council - 2	Aboriginal and Torres Strait Islander Consumers, Carers and Family Members	All	Metropolitan
Helping Minds	Carers	All	Kimberley, Midwest/Gascoyne, Peel, South West, Metropolitan
Housing Choices WA	Social and Community Housing Tenants Consumers and Carers	Ages 18-65+	Peel and Metropolitan

Recipient Organisation	Target Stakeholder/s	Target Age Group/s	Target Region/s
Kimberley Aboriginal Health Research Alliance	Aboriginal and Torres Strait Islander Consumers, Carers and Family Members	Ages 18-64	Kimberley
Living Proud (in partnership with Rainbow Futures WA, Pride WA, Youth Pride Network, GRAI Inc, WAAC and TransFolk of WA)	LGBTQAI+	All	Metropolitan
Mental Health Matters 2	Carers, Family Members and Personal Support Persons	Ages 25-65+	Metropolitan (with option for regional attendees via online attendance)
Roots TV	African and Middle Eastern Migrant Community, including those experiencing Alcohol and Other Drug issues and/or Custodial/Forensic experience	Ages 18 - 64	Metropolitan
Youth Focus	Young People	Ages 16 - 24	Wheatbelt and Metropolitan

Appendix 4: Public Submissions

Provided below is a list of entities who provided submissions as part of the public submissions process. To protect privacy, this list excludes submissions provided by individuals.

1. Aboriginal Health Council of WA
2. AOD Consumer & Consumer Coalition
3. Aus. College of Emergency Medicine
4. Aus. College of Mental Health Nurses
5. Aus. Council on Smoking and Health
6. Australian Medical Association WA
7. Australian Psychological Society
8. Cancer Council Info/Support Centre
9. Cancer Council Prevention/Research
10. Carers WA
11. Chief Health Officer
12. Citizens Commission on Human Rights
13. City of Gosnells
14. Commissioner for Children and Young People
15. Council for The National Interest
16. Department of Communities
17. Department of Education
18. Department of Health
19. Department of Justice
20. East Metropolitan Health Services
21. Facilitatrix
22. Health Consumers Council
23. Health/Disability Services Complaints Office
24. Helping Minds
25. Housing Choices WA
26. Kimberley Aboriginal Health Research
27. Law Society of WA
28. Lived Experience Australia
29. Living Proud
30. Mental Health Advocacy Service
31. Mental Health Matters 2
32. Multicultural MH Sub Network Steering Committee
33. National Drug Research Institute
34. Nunkuwarrin Yunti of South Australia
35. Office of the Chief Psychiatrist
36. Orygen
37. Public Sector Commission
38. Roots TV
39. Royal Aus./NZ College of Psychiatrists
40. RUAH Legal Services
41. Telethon Kids
42. The Dash Health Hub
43. WA Country Health Service
44. WA Police
45. Youth Focus

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