

MENTAL HEALTH BILL

Second Reading

Resumed from an earlier stage of the sitting.

HON HELEN MORTON (East Metropolitan — Minister for Mental Health) [10.21 pm]: It is acknowledged that “serious harm” is a subjective term that could be interpreted in different ways. This is one reason why the bill obliges the Chief Psychiatrist to publish guidelines regarding the application of the criteria. To return to a common and important theme, these guidelines will be developed in close consultation with consumers, families and carers, and clinicians.

The Legislative Assembly made an important amendment to the involuntary treatment criteria. Previous versions of the bill stated that a person could be made an involuntary patient if, in addition to meeting the other criteria, they either lacked a decision-making capacity or had unreasonably refused treatment. As a result of the change in the Legislative Assembly, the bill received here today does not make reference to unreasonable refusal of treatment. The implication of this change is that a person may be made subject to an involuntary treatment order only if they lack the capacity to make treatment decisions. The rationale behind this change is simple: a person’s wishes as to treatment should be respected unless they lack the capacity to make reasonable decisions. This is consistent with a global trend towards supporting people with mental illness to make their own decisions. Although most stakeholders expressed support for this change, some expressed concern that a person may be denied necessary treatment due to difficulties in determining whether they have a decision-making capacity. To address these concerns, a number of public mental health services will participate in a trial of the new criteria prior to the new legislation coming into force. This trial will help to illuminate any unforeseen consequences and, in doing so, contribute to the development of relevant guidelines and educational materials.

Other aspects of involuntary treatment: As with the assessment process, when examining an Aboriginal or Torres Strait Islander person, the psychiatrist must, to the extent that it is practicable and appropriate, involve an Aboriginal or Torres Strait Islander mental health worker and significant people from the person’s community such as elders and traditional healers. The bill allows for involuntary treatment either in an authorised hospital or general hospital, or in the community under a community treatment order. Examinations within the metropolitan area must be face to face. Audiovisual examination can be used only outside the metropolitan area. In these circumstances, a person may be made subject to a CTO or detained in a general hospital, however, they cannot be detained subsequently in an authorised hospital for more than 24 hours without being examined face to face by a psychiatrist unless that has already occurred in the meantime. All involuntary patients must be visited or otherwise contacted by an advocate from the advocacy service within seven days, or within 24 hours when the patient is a child. Involuntary patients may request a review of their involuntary status at any time. If no request is made, there is a mandatory review within 35 days for adults and 10 days for children.

Involuntary inpatients—detention in an authorised hospital: Adults who are made involuntary inpatients can be detained and treated for up to 21 days. For children, the time limit is 14 days. Before that time expires, the psychiatrist must examine the patient, and, if they continue to meet the criteria, may continue the detention for adults for up to three months and, for children, up to 28 days. Further continuation orders can be made. Patients may be treated either on “open” wards or more secure areas depending on the patient’s individual circumstances. Generally, children must be admitted to facilities specifically for children. However, it is recognised that sometimes children may have to be admitted to a ward where there are adults. For example, where a child in a rural or remote area is waiting to be transferred to a more appropriate mental health service in the metropolitan area, or where it is not practicable to transfer the child, the child may be cared for on a ward where adults are also being cared for. The person in charge of the mental health service must make sure that the care of the child in an adult facility is appropriate to the child’s needs. For example, the child may have his or her bedroom located directly outside the nursing station, or a chaperone may be provided. A written report must be provided to the child’s parent or guardian, in addition to the Chief Psychiatrist, stating what these special provisions for the child’s safety entail.

Involuntary inpatients may be granted leave. However, if they abscond or refuse to return in a situation in which leave is cancelled, an apprehension and return order may be issued. This authorises a police officer or person from the hospital to apprehend and return the person to the hospital. A patient when being admitted or returning from leave or in other circumstances—for example, following a visit—can be searched for illicit or dangerous items which can be seized and either returned to the patient or family member later, or dealt with by other lawful means. At any time a psychiatrist may make an involuntary inpatient no longer involuntary or subject to the less restrictive option of a CTO.

Involuntary inpatients—detention in a general hospital: At times a referred person or an involuntary patient may have such significant physical health issues that it would be detrimental for them to be transferred to, or remain

in, an authorised hospital. Under such circumstances, the person can be involuntarily detained in a general hospital. This can only happen with the approval of the Chief Psychiatrist, and the treating psychiatrist must report to the Chief Psychiatrist at least every seven days. If being transferred from a rural or remote general hospital as an involuntary detained patient and no face-to-face examination has occurred, the patient must be examined by a psychiatrist within 24 hours of being received at the authorised hospital. When a patient has recovered sufficiently from their physical illness, they must be transferred to an authorised hospital or discharged either as a voluntary patient or on a CTO. While a patient is in the general hospital, it is as though they are detained in an authorised hospital, and treatment can be provided without the requirement for informed consent.

Community treatment orders: A CTO is an involuntary order and a less restrictive way of ensuring that a patient who meets the criteria receives treatment and has their needs assessed regularly. A CTO can be made only when the person meets the criteria set out in the bill and when suitable arrangements can be made for the treatment and care of the person in the community. CTOs last for up to three months and can then be renewed for further periods of three months at a time. The patient's supervising psychiatrist must ensure the patient is advised of when and where treatment is to be provided. If an involuntary community patient refuses treatment, they can be subject to an order to attend a particular place, which may be a hospital or clinic, to receive treatment. A CTO can be revoked at any time, either to make the person an involuntary inpatient when they meet the criteria, or to make the person no longer an involuntary patient.

Treatment generally: The bill creates a default position that an adult has decision-making capacity and that a child does not have decision-making capacity, unless shown otherwise. To have decision-making capacity, the person needs to be able to understand information and advice about the decision. Decisions need to be made freely and voluntarily. The bill and the clinicians' guide give clinicians guidance on how treatment should be explained and what constitutes capacity. In making decisions, clinicians are required to take the person's wishes into account, to the extent that those wishes can be ascertained. A person may express their wishes at the time treatment is proposed to be provided. Wishes of a patient are sometimes in the form of an advance health directive or enduring power of guardianship. This is an important advance on the current legislation, which does not require the treating psychiatrist to pay attention to the wishes of an involuntary patient. Treatment decisions must always be made in the best interests of the patient. Voluntary patients, including people who have been referred for an examination by a psychiatrist, can be given treatment only with informed consent. This consent can be provided by the patient, or, if the patient does not have capacity, the person authorised at law to act on their behalf. If the person is an adult, the person authorised at law will be determined in accordance with the Guardianship and Administration Act. If the patient is a child, the person authorised at law will be the child's parent or guardian.

The requirements relating to informed consent set out in clause 19 should be read in conjunction with the professional standards and codes that guide the work of health professionals, such as the Medical Board of Australia's "Good Medical Practice: A Code of Conduct for Doctors in Australia". Failure to comply with the relevant professional standards and codes can have serious consequences, including loss of professional registration. An exception to the standard consent requirements applies to emergency psychiatric treatment. Emergency psychiatric treatment may be provided without consent if it is needed to save the person's life or prevent the person from behaving in a way that is likely to result in serious physical injury to the person or another person. A record of any emergency psychiatric treatment must be given to the patient and the Chief Psychiatrist. Emergency psychiatric treatment given to voluntary patients excludes providing ECT, which can be given only to adult involuntary patients in an emergency with the Chief Psychiatrist's approval. Involuntary patients can be given treatment without the requirement for informed consent. However, the proposed treatment needs to be discussed with the patient and their wishes need to be obtained, to the extent that this is possible.

Consistent with the recommendations of the 2012 Stokes review, the treatment, care and support of an involuntary patient will be governed by a treatment, support and discharge plan. The planning process will commence as soon as practicable after the person becomes an involuntary patient and will be undertaken in collaboration with the patient. The default position is that families and carers are also required to be involved, and that they will be provided with a copy of the plan. The plan must be reviewed regularly in line with guidelines that are required to be published by the Chief Psychiatrist. When conducting a review of involuntary status, the tribunal must consider the treatment, support and discharge plan and may make recommendations to the psychiatrist; however, because these are clinical issues, while the psychiatrist is obliged to consider the recommendation he or she is not obliged to specifically follow the recommendations. This enables a dialogue between the treatment services, the patient, their support person and the review services to best meet the patient's mental health needs.

The tribunal can also require clinicians to follow the requirements in the bill with respect to: making a person no longer involuntary; having freedom of communication; allowing a person to be a nominated person; and

changing detaining orders to community based orders, although there is scope here for further discussion between the treating team and the tribunal before an order is made.

Electroconvulsive therapy and psychosurgery: another aspect of the bill that has attracted significant attention is the special regulation of certain treatments, namely electroconvulsive therapy, known as ECT, and psychosurgery. ECT is a mainstream, evidence based treatment that can provide significant relief for some severe mental health conditions such as major depressive disorder. The rudimentary techniques of decades past have been steadily improved, to the point where current practice bears little more than a passing resemblance to the popular image associated with *One Flew Over the Cuckoo's Nest*. However, despite these very significant improvements, ECT remains a confronting procedure and a source of concern for many in the community. This bill has attempted to address these competing considerations by ensuring that ECT is available as a treatment option, but with additional safeguards around its use.

The most significant new safeguard for adult patients is the requirement that the approval of the Mental Health Tribunal be obtained prior to the administration of ECT to an involuntary patient. This is a marked departure from the current act, which permits the treatment to be provided with the approval of two psychiatrists. Rules relating to the administration of ECT to persons under the age of 18 have attracted particular attention. WA's existing legislation allows ECT to be provided to a child of any age. If the child is an involuntary patient, ECT may be provided under the authority of two psychiatrists. Even with these minimal safeguards, the administration of ECT to people under the age of 18 years has been rare.

The safeguards in the bill are far more stringent. ECT cannot be provided to a child without the prior consent of the Mental Health Tribunal, and the treatment is banned on children under the age of 14 years. The inclusion of these safeguards is in direct response to feedback received during consultation on earlier drafts of the bill.

The development of an evidence base relating to the provision of ECT to children has been complicated by the very small number of children who receive the treatment. Despite this, there is still ample clinical evidence suggesting that ECT can be a safe and effective treatment for a small number of people under the age of 18 years. I do not consider it appropriate for the government to totally preclude a treatment option that is capable of bringing significant relief to even a small number of young people in need.

To reiterate, the bill does not encourage the use of ECT on children. The safeguards proposed in the bill are far stronger than those currently in place and are arguably the most stringent of those of any Australian jurisdiction.

Psychosurgery: Psychosurgery has not been provided in Western Australia since the 1970s. Historically, psychosurgery has been associated with lobotomies and unregulated procedures. However, newer forms of treatment that fall within the definition of psychosurgery may provide safe and effective relief for some people with certain types of mental illness. Psychosurgery is included in the bill to ensure that there are appropriate safeguards around these emerging treatments.

The treatment contemplated at this time is known as deep-brain stimulation. DBS involves the surgical implantation of stimulating electrodes, such as a pacemaker, into the brain with a wire to an external device. The external device means that the variables and settings can be adjusted. DBS is fully reversible by removing the implant. DBS was first approved in the United States by the Food and Drug Administration in 2007 for Parkinson's disease. It was then approved in the USA for use for obsessive-compulsive disorder in 2009. DBS was introduced into Australia in 1994 and was first approved in 2009. Psychosurgery is subject to the most stringent regulation of any treatment or intervention in the bill. It cannot be performed without the consent of both the patient and the Mental Health Tribunal, and it cannot be performed on a patient who is under 16 years of age. Some have queried how a person who is so unwell that they require psychosurgery could possibly be capable of giving informed consent to the treatment. DBS is contemplated for use in relation conditions such as major depression and OCD that do not necessarily impact upon the decision-making capacity to the same extent as some other forms of mental illness.

Physical care and treatment: It is recognised that those who experience severe mental illness, on average, have poorer physical and dental health than other members of the community. It is also recognised that untreated physical conditions may hinder the path to recovery. As such, this bill makes it mandatory for a patient's physical health to be assessed. Patients must be offered a physical examination within 12 hours of admission. Involuntary patients and mentally impaired accused persons can be physically examined without a requirement for informed consent. If urgent non-psychiatric treatment, as defined in the Guardianship and Administration Act, is given to an involuntary patient by a medical practitioner, a report must be sent to the Chief Psychiatrist.

Seclusion: Seclusion involves confining a patient in an area in an authorised hospital from which free exit is prevented and is used when there is concern that a patient is at risk of harming themselves or others. A person can be confined in a room in an authorised hospital when an oral or written seclusion order is made. Oral or written authorisation can be given by a medical practitioner, a mental health practitioner or the person in charge

of the ward. If it is made by a mental health practitioner or person in charge of the ward, it must be confirmed as soon as practicable, and in any event within two hours, by a medical practitioner. The only circumstances in which a patient can be placed in seclusion are when the person is physically injuring himself or herself or another person or persistently damaging property and there is no less restrictive way of preventing the injury or damage. This is in line with the principle throughout the bill of using the least restrictive measures.

Seclusion is for a period of up to two hours. It can be extended by a medical practitioner and can also be revoked by a medical practitioner, a mental health practitioner or person in charge of the ward. If the seclusion order expires, the person must be released from seclusion. Whilst in seclusion, the person must be observed at least every 15 minutes by a mental health practitioner or enrolled nurse and reviewed at least every two hours by a medical practitioner. While in seclusion, the person's personal needs such as food, drink, toilet facilities, bedding and clothing must be met. Within six hours of being released from seclusion, if the person is still in the hospital, they must be given a physical examination by a medical practitioner and a note made if there is any deterioration in the person's mental or physical condition that is a result of the person having been in seclusion. Seclusion forms must be completed and a copy sent to the Chief Psychiatrist and a copy given to the person. Families and carers are generally entitled to information about any incidence of seclusion.

Bodily restraint: Bodily restraint is the physical or mechanical restraint of a person who is being provided with treatment or care in an authorised hospital and is used to provide the person with treatment, prevent the person from physically injuring himself or herself, or to prevent the person from persistently causing serious damage to property when there is no less restrictive way of preventing this. Oral or written authorisation can be from a medical practitioner, a mental health practitioner or the person in charge of the ward. If it is made by a mental health practitioner or person in charge of the ward, it must be confirmed as soon as practicable and, in any event, within 30 minutes by a medical practitioner. Restraint must be for the shortest time possible but can be extended or varied. Restraint can be ceased at any time by the medical practitioner, a mental health practitioner or person in charge of the ward. While in restraint, the person's personal needs such as food, drink, toilet facilities, bedding and clothing must be met. Within six hours of being released from restraint, if the person is still in the hospital, they must be given a physical examination by a medical practitioner and a note made if there is any deterioration to the person's mental or physical condition that is a result of the person having been restrained. Restraint forms must be completed and a copy sent to the Chief Psychiatrist and a copy given to the person. Families and carers are generally entitled to information about any incidence of bodily restraint.

Families, carers and nominated persons: The bill recognises the important role that family members, carers and other persons play in supporting people experiencing mental illness. This is reflected in the objects of the bill, and in specific obligations relating to family, carer and nominated person involvement. The bill enshrines a default position that one carer, one close family member, and the patient's nominated person are entitled to be provided with information and involved in decision-making, including treatment, support and discharge planning. A nominated person is a person who is formally nominated by the patient as a support person. The role of this nominated person is to ensure that the person's rights are respected and that their interests are taken into account. The role of the nominated person does not detract from the role of the patient's close family member or carer. There are safeguards around the nominated person provisions including an exception where informing or involving the nominated person would not be in the best interests of the patient, a decision that can be challenged in the tribunal. The tribunal also has jurisdiction to declare a nomination valid or invalid. If a voluntary patient unreasonably refuses to consent to their family member, carer or nominated person being informed or involved, or is unable to give informed consent, the patient's family member, carer and nominated person are to be provided with information and involved in decision-making unless the treating psychiatrist reasonably believes that this would not be in the best interests of the patient. A family member, carer or nominated person must also be notified by the mental health service or person who took the action of matters such as detaining a referred person, involving the police in transport, making an involuntary order, granting or cancelling leave, transferring a patient, revoking a CTO, making an order to attend or releasing a patient at any time.

Children: The bill recognises that children experiencing mental illness are particularly vulnerable and as such sets out additional safeguards for children and their parents or guardian. Clinicians performing a function under the act in relation to a child must have regard to the views of their parents and guardian, and to the wishes of the child. The best interests of the child must be a primary consideration. Children with decision-making capacity may decide to become a voluntary patient, discharge themselves or agree to accept treatment. Alternatively, these decisions may be made by the child's parent or guardian. I have already described the requirements in place to deal with situations in which a child is being detained on an adult ward. I stated earlier, electro-convulsive therapy is not a treatment option for a child under 14 years of age, whether voluntary or involuntary. I have also explained the processes and safeguards around ECT in relation to children aged 14–17 years.

Mental Health Advocacy Service: The Mental Health Advocacy Service replaces the Council of Official Visitors, with an increased focus on individual advocacy. Mental health advocates will be appointed by the Chief

Mental Health Advocate to perform a number of tasks in relation to “identified persons”. This is just one of the ways in which the bill ensures that the advocacy service will be sufficiently independent. An identified person is a person referred for an examination by a psychiatrist, is an involuntary patient, a mentally impaired accused person in an authorised hospital or released under a “release order”, a resident of a private psychiatric hostel or a voluntary patient who falls within a direction by the Minister for Mental Health for access to the advocacy service.

The Chief Mental Health Advocate will make sure the advocates complete their tasks, promote compliance with the Charter for Mental Health Care principles, prepare guidelines, standards and protocols for the work of the advocates and make sure training is provided. Advocates will visit identified persons, visit mental health facilities, help to resolve complaints and represent patients before the tribunal. In response to feedback, the bill clearly states that mental health advocates can, at any time and for any length of time, visit a mental health service at which one or more identified persons are being detained or being provided treatment or care; and that advocates can inspect the mental health service they are visiting. This is in addition to the power of a mental health advocate to visit an identified person on its own initiative at any time. This is the case whether that mental health service is a public or private authorised hospital; a private psychiatric hospital; a public psychiatric hospital; or a private psychiatric hostel. By virtue of increasing individual advocacy, there will necessarily be an increase in systemic advocacy. Advocates are required to visit or otherwise contact adult involuntary patients within seven days of the person becoming involuntary, and in relation to children, within 24 hours. Other persons are required to be visited upon request, within the time frames specified in the bill. Involuntary patients can also request additional contact with advocates at any time.

Mental Health Tribunal: The Mental Health Tribunal will replace the Mental Health Review Board from the current act. The tribunal is a quasi-judicial body, independent of mental health services. The tribunal will be constituted by a lawyer, an independent psychiatrist and a person who is neither a lawyer nor a psychiatrist, widely known as a “community member”. In special circumstances they may also be constituted by a child and adolescent psychiatrist, and in considering a psychosurgery application will have five people on the panel, including a neurosurgeon.

The tribunal’s functions are to conduct mandatory and requested reviews of involuntary patients with the power to make a person no longer involuntary; conduct mandatory reviews of long-term voluntary patients after six months for adults and three months for children; conduct reviews of the validity of involuntary treatment orders; consider applications for approval of ECT for adult involuntary patients, and child voluntary and involuntary patients; consider applications for approval of psychosurgery for all patients; issue compliance notices in the event of non-compliance with non-clinical matters; review orders restricting freedom of communication of involuntary patients; consider the validity of the nomination of a person as one of the patient’s support persons; and review other decisions affecting rights.

The role of the tribunal in conducting mandatory reviews of long-term voluntary patients is one of the important extensions of the right of vulnerable people that this legislation will bring about. To date long-term voluntary patients have not had the right of a review. While they are voluntary, the nature of their mental illness may preclude them from effectively exercising their rights as voluntary patients, such as to discharge themselves. A review by the tribunal will oblige a mental health service to review the patient’s treatment, support and discharge plan. The provisions in relation to the tribunal make it accessible, timely and responsive and able to be involved at many levels. Proceedings can be initiated by a patient’s psychiatrist, a patient’s carer or family member or other personal support person; and any other person who, in the tribunal’s opinion, has a sufficient interest in the matter. The bill unambiguously states that patients can be represented at hearings, including by a mental health advocate or legal practitioner. However, the patient remains at the centre of the hearing and is always welcome to express his or her own views, whether or not they have capacity at that point in time.

If a patient or their family member or carer is not satisfied with a decision by the tribunal they can have the decision reviewed by the State Administrative Tribunal, and from there they can appeal to the Supreme Court. There have been suggestions that the bill attempts to minimise the ability of patients to access legal support. This is incorrect. A patient is entitled to be represented by a lawyer if this is their preference. To the extent that the bill does not always single out lawyers for special mention, this is because the patient may legitimately prefer to obtain assistance from another person such as a mental health advocate.

The Chief Psychiatrist: The Chief Psychiatrist plays a pivotal role in the way this legislation impacts on people experiencing mental illness, families, carers and clinicians. The bill increases the level of authority of the Chief Psychiatrist over mental health services, ensuring consistency and quality. The Chief Psychiatrist will be responsible for overseeing the treatment and care of voluntary and involuntary patients, including those referred for an examination and in addition to mentally impaired accused in authorised hospitals. The Chief Psychiatrist will have the power to visit mental health services and review and, if necessary, direct a change in the treatment

of involuntary patients and mentally impaired accused. The Chief Psychiatrist will publish guidelines on a variety of issues about clinical practice under the act in addition to approving forms under the bill. The Chief Psychiatrist will receive information about notifiable incidents and collect other important data, such as the use of seclusion and restraint. The Chief Psychiatrist will play a role in authorising mental health practitioners to perform certain functions under the act and authorising hospitals to detain and treat involuntary patients.

Information: Importantly for patient safety, the bill clarifies that state authorities and mental health services are permitted to disclose some patient information to other state authorities. This ensures that the relevant authorities and services can be confident that, in situations in which the safety of a person is at serious risk, or to ensure that a person receives the best treatment, they are permitted to share relevant information. The bill also contains a range of strict confidentiality requirements, including offences with fines for inappropriate disclosure.

Review clause: Whilst the introduction of this bill is a milestone in the reform agenda, mental health legislation should not be viewed as an event, but as an ongoing process. This necessarily means that legislation is reviewed, revised and amended in light of advances in treatment and care and with improvements in service delivery. This bill incorporates a five-year review clause. After five years of operation this bill, its effectiveness and the provisions within it must be and will be subject to review. As this is a significant reform, this is an essential provision. It is hoped that whatever the government of the day, this review will be timely, comprehensive and genuinely engage all stakeholders.

Legislating around mental health will always be a challenging task as, at its core, is the inherent tension of addressing competing rights. There is the right of individuals who do not meet the criteria for involuntary status not to have their liberties curtailed by arbitrary detention or treatment; the right of carers and family members to be heard in their efforts to ensure their loved ones receive the best possible treatment they can, and as soon as they can; the right of some people with mental illness to treatment even when they lack capacity to consent; and the right of the community to feel safe, which cannot be ignored. I will not pretend that this legislation will get it right for every single scenario every single time. No legislator can give that undertaking, but it is certainly the hope that this bill goes some way to ensuring a greater level of accountability in the system, ensuring that consumers, families and carers have a greater say in the treatment that they and their loved ones receive and that their valuable lived experience is not only respected, but also incorporated into treatment and personal recovery.

This bill is only one step in the overall reform agenda, but it is a fundamental one. It is the hope of this government that the need for this reform is not only recognised, but also embraced, and that this bill goes some way to contributing to positive change in the delivery of mental health services.

Pursuant to Legislative Council standing order 126(1), I advise that this bill is not a uniform legislation bill. It does not ratify or give effect to an intergovernmental or multilateral agreement to which the government of the state is a party, nor does this bill by reason of its subject matter introduce a uniform scheme or uniform laws throughout the commonwealth. I commend the bill to the house and table the explanatory memorandum.

[See paper 1447.]

Debate adjourned, pursuant to standing orders.