MENTAL HEALTH BILL 2012: A GREEN BILL FOR PUBLIC COMMENT

DRAFT EXPLANATORY MEMORANDUM

Introduction

The Mental Health Bill 2012 (the Bill) establishes a legislative framework for the treatment, care, support and protection of people who have a mental illness, for the recognition of the role of carers and families in providing care and support to people who have a mental illness and for related purposes.

The Bill is intended to repeal the *Mental Health Act 1996* (WA) (the current Act) and the consequential provisions relevant to that Act, and to make consequential amendments to various connected legislative provisions.

The overall purpose of the Bill is to bring mental health legislation into line with current community expectations; to codify good practice from an Australian and worldwide perspective; and to further emphasise the importance of human rights, particularly given that Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities (2006).

The Bill broadly reflects the recommendations arising from a statutory review of the operation and effectiveness the current Act conducted by Professor D'Arcy Holman from the University of Western Australia 2002-2003 (the Holman Review).

In 2003, following an extensive review and consultation process (which involved convening a number of working groups, consideration of numerous public submissions and direct consultations with community groups in rural and remote areas of WA), a synthesis of the Holman Review was published. This synthesis foreshadowed a series of proposals for legislative reform for the purpose of subjecting the proposals to public scrutiny for further comment.

A second round of public submissions was received, numbering over 300, which led to changes to various proposals.

In December 2003, a document outlining the final recommendations, entitled '*The Way Forward*', was presented to the then Minister for Health. The majority of the recommendations were accepted by the previous government.

The Way Forward recommends that the current Act be repealed and replaced with a new legislative framework. The recommendations advance the rights of persons with a mental illness; and support the responsibilities of clinicians in balancing quality of care for persons with a mental illness with important issues of community welfare.

Following a change of Government in 2008; the appointment of a Minister for Mental Health; and the establishment of the Mental Health Commission (the Commission), the Bill, as drafted in 2007, was further scrutinised. Advice was sought from key stakeholders and experts in the field from within Australia and overseas, which resulted in further redrafting of the Bill.

On 16 December 2011, the Mental Health Bill 2011: Draft Bill for Public Comment (the Draft Bill), was launched by the Minister for Mental Health (the Minister), the Hon Helen Morton MLC.

Public submissions were sought between December 2011 and March 2012. To facilitate discussion on the Draft Bill, the Commission published a 90 page explanatory guide to the Draft Bill, and convened over 40 forums in Perth and regional Western Australia. These sessions were attended by nearly 600 participants, including consumers, clinicians and members of government and non-government organisations, as people who simply had a common interest in the future of mental health in Western Australia.

The Commission received approximately 1,200 written submissions responding to the Draft Bill. Oral submissions arising from comment at public forums were noted. All suggestions were welcomed and have made a significant contribution to the tabled Bill.

Please note that this draft Mental Health Bill 2012 has been prepared for public comment but it does not necessarily represent the Government's settled position.

All submissions on this Bill should be forwarded to:

legislation@mentalhealth.wa.gov.au

or Mental Health Commission
Level 5, 81 St Georges Tce, Perth

GPO Box X2299, Perth Business Centre, WA 6847.

If possible, please send submissions in Word format or in email and indicate in your response:

- Whether or not you give permission for the response to be published on the Mental Health Commission website

- If so what name, if any, you want on the submission.

Submissions are due by 28 February 2013.

(This document is current at 7 November 2012)

Long title

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

Part 1 Preliminary matters

Clause 1 states the short title of the Bill.

Clause 2 sets the dates for commencement of sections 1 and 2 the Bill being the day the Bill receives Royal Assent. The rest of the Bill will commence on a day fixed by proclamation. This will allow time for the implementation process, which includes establishment of the Mental Health Tribunal (MHT); the Mental Health Advocacy Service; preparation of guides, pamphlets and forms; and education, training and information for clinicians, consumers and the community.

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

Part 2 Terms and concepts

Division 1 - Definitions and notes

Clause 4 explains some of the key terms that are central to understanding the Bill. The terms must be read in conjunction with those defined in various other provisions throughout the Bill.

Clause 5 clarifies that a note located in the text is provided to assist understanding and is *not* a part of the Bill.

Division 2 - Mental illness

Clause 6 sets out broad circumstances in which a person is said to have a mental illness for the purposes of the Bill, which is not dissimilar to the current Act. However, a person must not be considered to have a mental illness merely by reason of one or more circumstances listed in sub clause (2) being present. Rather, the presence of one or more of the listed circumstances does not prevent a person from being considered to have a mental illness.

The purpose of the listed circumstances is to ensure that persons falling within one or more of the exclusions are not inadvertently diagnosed with a mental illness, when exhibiting behaviours which may in fact be due to life choices for example, while still ensuring that people who require treatment, care and support are not overlooked. For example, a person may have a mental illness where they have been provided with treatment or care for mental illness in the past (being one of the listed circumstances), but this alone, or in combination with other circumstances listed in sub clause (2), is not enough to find that the person has a mental illness now. To that end, the inclusion of intellectual disability and use of alcohol or other drugs on the list of exclusions is not intended to imply that a person who has an intellectual disability or is using alcohol or other drugs cannot also be considered to have a co-occurring mental illness, or that they are ineligible to access mental health services.

The Bill emphasises the need for effective treatment, care and support where a person has co-occurring needs. *Clause 6* also states that a decision as to whether or not a person has a mental illness must be made in accordance with the internationally accepted standards prescribed in the regulations. These will include American Psychiatric Association's Diagnostic and Statistical Manual IV and the World Health Organisation's International Classification of Diseases 10. It is noted that internationally accepted standards are currently undergoing revision and accordingly the title of the publications may change prior to the Bill coming into operation. To clarify, dementia can constitute mental illness if the requirements of *clause 6* are met.

Division 3 – Best interests of a person

Clause 7 relates to situations throughout the Bill where a person or body must determine what is or is not in the best interests of a person. The Bill leaves 'best interests' as a matter for clinical judgment, but the person or body must consider the views and wishes of the patient and the views of the specified persons, that is a guardian, a child's parents, nominated persons, carers and a close family member.

Division 4 – Wishes of a person

Clause 8 relates to situations throughout the Bill where a person or body must ascertain the wishes of a person. Wishes may be expressed at the time of a treatment decision being anticipated; in an advance health directive made by the person; in the terms of any enduring power of guardianship made by the person; or pursuant to any other things that the person or body making a treatment decision considers relevant to ascertaining the person's wishes.

An advance health directive may be in any of the forms described in the definition in *clause 4*. To clarify, a directive made under the common law may be written or verbal. The wishes of a person are not binding, reflecting the fact that treatment and care needs to be responsive to a patient's needs at the time of a treatment decision being made.

Part 3 Objects

The Holman Review identified the need to strengthen and streamline the administration of the current Act. One of the key areas of reform proposed was improved clarity of the purpose and values of the legislation through a comprehensive statement of objects and fundamental principles.

Clause 9 sets out six objects to which a person or body performing a function under the Bill must have regard. The clause expands the objects of the current Act and works in conjunction with Part 4 of the Bill in relation to the Charter of Mental Health Care Principles.

Part 4 Charter of Mental Health Care Principles

The insertion of a Charter of Mental Health Care Principles (the Charter) was a key recommendation arising from advice sought from international mental health advisor Gregor Henderson. However the Charter itself was devised in conjunction with a group of consumers in 2011. The Charter is an aspirational document.

Clause 10 provides a statutory basis for Schedule 1, the Charter of Mental Health Care Principles. The clause requires a person or body performing a function under the Bill to have regard to the principles set out in the Charter.

Clause 11 requires mental health services to make every effort to comply with the Charter.

The Charter appears in Schedule 1 rather than in the body of the Bill. This is consistent with other legislation such as the *Disability Services Act 1993* and the *Carers Recognition Act 2004*.

Part 5 Decision making capacity and informed consent

Division 1 relates to decision making capacity generally. For example, a voluntary patient's decision regarding admission or discharge from hospital or, in relation to voluntary and involuntary patients, the patient's decision to inform and involve a nominated person, a close family member or carer in relation to their treatment and care.

Division 2 is more specific, relating to informed consent to the provision of treatment. For example, a voluntary patient's decision whether to accept or refuse a particular medication or intervention.

Division 1 - Decision making capacity generally

Clause 12 relates to adults making a decision about a matter relating to himself or herself under the Bill. The clause creates a rebuttable presumption that an adult has capacity to make decisions under the Bill. That is, an adult is deemed to have the requisite capacity, unless shown not to have that capacity. This is a decision for the person or body making a determination under *clause 14*. Where an adult does not have the requisite capacity to make a decision that is not a treatment decision, a substitute decision maker may make the decision on the person's behalf.

Clause 13 relates to a child making a decision about a matter relating to him or herself under the Bill. The Bill does not stipulate a minimum age at which a child (a person under the age of 18) may make a decision under the Bill. This takes account of different levels of maturity and developmental stages. The clause creates a rebuttable presumption that a child does not have capacity to make decisions under the Bill. That is, a child is deemed not to have the requisite capacity, unless shown to have that capacity. This is a decision for the person or body making a determination under *clause 14*. Where a child does not have the requisite capacity to make a decision that is not a treatment decision, the child's parent or guardian may make the decision on the child's behalf. *Clause 13* reflects the common law competent minor principle.

Clause 14 sets out the requirements for a person to be considered to have capacity to make decisions under the Bill that are not treatment decisions. If an adult does not meet the requirements in *clause 14*, then the presumption in *clause 12* is rebutted in relation to that adult (ie they do not have decision making capacity). If a child does meet the requirements in *clause 14*, then the presumption in *clause 13* is rebutted in relation to that child (ie they do have decision making capacity).

Division 2 - Informed consent to treatment

Where a treatment decision, as defined in *clause 4*, is being made, the more specific provisions in Division 2 apply and the general provisions in Division 1 do not apply.

Both Divisions contain stringent safeguards. However, it is recognised that some treatments can be, and are seen to be, intrusive. Therefore, the safeguards in Division 2 are stronger than in Division 1. The emphasis on the supported decision making approach required under Division 2 also reflects the significance of treatment decisions.

To clarify, a treatment decision is not a person's decision about whether to accept or refuse treatment in general. Rather, Division 2 applies to particular proposed treatments. This is reflected in the definition of 'treatment' in *clause 4*, which states that treatment means the provision of *a* psychiatric, medical, psychological, social or other therapeutic intervention (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of – (a) a mental illness; or (b) a condition that is a consequence of a mental illness.

Clause 15 provides that a person gives informed consent to the provision of treatment where the requirements of Division 2 are met; and the consent is given freely and voluntarily. In contrast to *clauses 12* and *13*, the default position in relation to both adults and children is that the person has not given implied consent. Therefore, consent must be actively given and not be a mere failure to offer resistance.

Clause 16 sets out who can give informed consent to a particular treatment. That is, the patient or, if the patient does not have the capacity required by *clause 17*, the person's substitute decision maker. *Clause 17* applies to patients and substitute decision makers. *Clause 16* notes that the principles of the Bill are to be read in conjunction with the principles of the *Guardianship and Administration Act 1990*, where relevant. Advance health directives are recognised in relevant provisions throughout the Bill. At present, an advance health directive made under the *Guardianship and Administration Act 1990* may be disregarded by clinicians once a person is made an involuntary patient under the current Act. To preserve the integrity of advance planning, the Bill requires clinicians to have regard to advance health directives when making treatment decisions with respect to involuntary patients. *Clause 172* creates procedural requirements that follow when a psychiatrist overrides an advance health directive (and patient's wishes more broadly).

Clause 17 sets out the requirements under Division 2 for a person to be considered to have capacity to make a treatment decision. *Clause 17* applies to patients, and extends to substitute decision makers. Patients and substitute decision makers may only make a decision in relation to themselves or the patient if they meet the requirements set out in *clause 17*. Because of the nature of treatment decisions in comparison with other decisions made under the Bill, the requirements in *clause 17* are more stringent than those in *clause 14*, and the two clauses are drafted differently. As an additional safeguard, the drafting of *clause 17* creates a position whereby a person does not have capacity to make a treatment decision unless positive requirements have been demonstrated.

Clause 18 requires a thorough and coherent explanation of proposed treatment to be given before informed consent can be considered to have been obtained. *Clause 18* applies to patients and substitute decision makers. One of the requirements is that the person be given sufficient information to enable the person to make a balanced judgment about the treatment. The amount of information to be given is largely a decision for the person providing the information, and would depend on the nature of the treatment. For example, in relation to the provision of treatment to a voluntary patient under Part 12, it is anticipated that the provision of information would extend beyond the nature and form of the treatment (such as oral antipsychotic medication), to include more specific matters such as dosage. Informed consent would need to be obtained before any of these factors were varied. Sub clause (3), which notes that sub clause (1) applies despite any privilege claimed by a person, emphasises the legal requirement for clinicians, particularly psychiatrists and other medical practitioners, to provide adequate information before seeking consent.

Clause 19 requires a patient or substitute decision maker making a treatment decision to be given sufficient time for consideration of the matters involved in the treatment decision; reasonable opportunity to discuss those matters with the medical practitioner or other health professional proposing the provision of the treatment; and reasonable opportunity to obtain any other advice or assistance in relation to the treatment decision that the person wishes to obtain. *Clause 19* promotes two-way communication between persons making treatment decisions and persons proposing the provision of the treatment. Persons making treatment decisions should be encouraged to ask questions and express concerns material to them, and have these issues addressed by the person proposing the provision of the treatment both orally and in written information. Best practice would require that, where a substitute decision maker is making a treatment decision in relation to a patient, the patient also be involved in the discussion.

Part 6 Involuntary patients

Division 1 - When a person will be an involuntary patient

Clause 20 defines an involuntary patient to be a patient on an inpatient treatment order or a community treatment order (CTO).

Clause 21 describes an inpatient treatment order and identifies provisions in the Bill under which an inpatient treatment order can be made.

Clause 22 describes a CTO and identifies the provisions in the Bill under which a CTO can be made.

Clause 23 allows an involuntary treatment order to be made where the requirements set out in *clause 23* and the criteria set out in *clause 24* are met. Under Part 6, only a psychiatrist may make an involuntary treatment order, which recognises the specialist training and skills of a psychiatrist and the restrictive nature of an involuntary treatment order.

Clause 24 sets out the criteria for an involuntary treatment order to be made. The current Act is unique in Australia in expressly allowing involuntary treatment and detention so as to prevent damage to property and self-inflicted harm to reputation, relationships, or finances. These references are largely considered to be inconsistent with accepted human rights standards and best practice mental health legislation in other jurisdictions. The Bill modernises the criteria, removing express references to certain criterion in the current Act. The criteria for an inpatient treatment order are of a higher threshold than the criteria for a CTO, reflecting the more restrictive nature of an inpatient treatment order. The additional ground for involuntary treatment on a CTO, being a significant risk of the person suffering serious physical or mental deterioration, promotes early intervention and assertive practice.

Clause 24 refers to a determination of lack of capacity, or if the person has capacity, the person unreasonably refusing treatment is one of the criteria for an involuntary treatment order to be made. A person may have capacity to make a treatment decision but, in the view of the psychiatrist, unreasonably refuse treatment. For example, a person experiencing psychosis may believe that people are trying to poison them, and therefore refuse treatment. This is likely to be considered to be unreasonable refusal. The relevant treatment is treatment deemed to be essential for the person's mental illness and is proposed to be provided to the person as a matter of priority upon an involuntary treatment order being made. Where a person refuses a treatment option but not other treatments, whether or not the criterion is satisfied is a clinical matter for the psychiatrist conducting the examination.

Division 2 – Referrals for examination

Prior to a psychiatrist determining whether or not a person needs to be made an involuntary patient other steps such as detention for assessment; the assessment itself; referral for examination by a psychiatrist; detention for examination; and transport to the place of examination may occur.

An examination (as conducted by a psychiatrist) has more stringent requirements than an assessment (as conducted by a medical practitioner or an authorised mental health practitioner), because an assessment is an initial stage in protecting the person and the community, and other more stringent safeguards must be met before an involuntary treatment order can be made.

An assessment may be conducted, and a referral may be made, by a medical practitioner, who may or may not be a psychiatrist, or by an authorised mental health practitioner (a registered nurse, psychologist, occupational therapist or social worker with at least 3 years experience in the management of people with mental illness who are authorised by the Chief Psychiatrist).

As stated above, only a psychiatrist may make an involuntary treatment order.

It is not acceptable for the same psychiatrist to complete both the assessment (and referral), and examination.

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

Clause 4 provides that a voluntary patient is a patient who is not an involuntary patient or a mentally impaired accused required to be detained in an authorised hospital. Therefore, referred persons and persons detained for assessment or examination are voluntary patients for the purposes of the Bill.

Subdivision 1 – Person suspected of needing involuntary treatment order:

Subdivision 1 applies to a person who is not a patient in an authorised hospital.

Clause 25 provides for a referral for examination at an authorised hospital or other place of a person suspected of needing an involuntary patient order or a patient on a CTO needing an involuntary inpatient order. A referral to a place other than an authorised hospital can be made only where the referrer believes that it is an appropriate place to conduct the examination, having regard to the guidelines published by the Chief Psychiatrist under *clause 513* of the Bill. For example, any medical practitioner or authorised mental health practitioner working in a hospital or in the community could refer a person for an examination at an emergency department, general hospital, community clinic, or the rooms of a private psychiatrist.

Clause 26 requires a referred person to be taken to the specified authorised hospital or other place as soon as practicable and, in any event, before the referral expires which is 72 hours from the time it was made.

Clause 27 provides for an order for detention for up to 6 hours to enable a person to be taken to the authorised hospital or other place specified in the referral. There is no corresponding provision in the current Act, however referred persons may be detained under a general duty of care a health professional has towards a patient. The new approach which provides legislative backing for detention will provide greater certainty to decision makers and, most importantly, protect referred persons from indeterminate detention. The detention could be anywhere, including a private home; however it is planned to include in the clinicians' guidelines to be published before implementation of the Bill those circumstances in which the person should be taken without delay to the place of examination which is safer for both patient and clinicians. The order for detention can be made only by a medical practitioner or an authorised mental health practitioner.

There is nothing preventing an order made under *clause 27* from being made by a different practitioner from the practitioner who made the order under *clause 25* recognising the practice issues that arise (this applies throughout the Bill, unless otherwise specified). Various protections are in place for such a person, including that the practitioner who made the order under *clause 27* must ensure that the person has opportunities and means to contact persons specified in the clause; and that the patient is given a copy of the order.

Clause 28 allows an order to be made to transport a referred person to the specified authorised hospital or other place. Transport orders are dealt with in more detail in Part 10. The transport order can be made by a medical practitioner or authorised mental health practitioner. Other clauses in the Bill related to different situations require a transport order to be made by a psychiatrist; however, at the referral stage, the person is not under the care of a psychiatrist.

Clause 29 states that a CTO is suspended while a referral for examination is in force in order for an examination to be conducted to determine whether or not the patient's CTO needs to be revoked so that an involuntary inpatient order can be made.

Clause 30 allows a medical practitioner or authorised mental health practitioner to revoke a referral if satisfied that the person is no longer in need of an involuntary treatment order. This could be done at any stage of the referral process. A medical practitioner or authorised mental health practitioner proposing to revoke an involuntary treatment order must, where he or she was not the practitioner who made the order, first consult with the practitioner who made the order unless, despite reasonable efforts, the referring practitioner cannot be contacted. This clause, as well as other clauses throughout the Bill, requires consultation as opposed to an

agreement between the two practitioners, because the subsequent practitioner may be in a better position to make a decision to revoke a referral order. The consultation will give the referring practitioner the opportunity to express their views, however in line with the principle of least restriction a referral order may still be revoked.

Subdivision 2 – Voluntary inpatient admitted by authorised hospital:

Clause 31 states that Subdivision 2 applies to a voluntary inpatient who is admitted by an authorised hospital.

Clause 32 states that a CTO is suspended while a person is a voluntary inpatient. As with a referred person (who is considered to be a voluntary patient, pursuant to the definition of voluntary patient in *clause 4*), the rationale is that an authorised hospital is not defined as part of the community and the person is accepting treatment as a voluntary inpatient.

Clause 33 applies where a voluntary inpatient admitted by an authorised hospital wants to leave the authorised hospital against medical advice and the person in charge of the ward, having regard to the criteria in *clause 24*, reasonably suspects that the voluntary inpatient is in need of an involuntary treatment order. The person in charge the ward may make an order that the voluntary inpatient be assessed by a medical practitioner or authorised mental health practitioner. The patient can be detained at the authorised hospital for up to 6 hours for that assessment to occur.

Clause 34 allows the person in charge of the ward who made an order under *clause 33* to revoke the order before the assessment, if satisfied that the patient is no longer in need of an involuntary treatment order. Where this occurs, the voluntary inpatient cannot continue to be detained.

Clause 35 applies where a voluntary inpatient has been assessed by a medical practitioner or authorised mental health practitioner at an authorised hospital (either because of an order for assessment made under *clause 33*, or in the course of the voluntary inpatient's treatment while admitted by the authorised hospital). The medical practitioner or authorised mental health practitioner can refer the patient to a psychiatrist at that authorised hospital for an examination if the practitioner reasonably suspects that the patient is in need of an involuntary treatment order.

Clause 36 allows a medical practitioner or authorised mental health practitioner to revoke a referral in relation to a voluntary inpatient if satisfied that the person is no longer in need of an involuntary treatment order. The voluntary inpatient is then allowed to leave.

Subdivision 3 – Requirements for referral:

Clause 37 states that Subdivision 3 applies where a medical practitioner or authorised mental health practitioner has made a referral under *clause 25* or *clause 35* for a person to be examined by a psychiatrist.

Clause 38 states that a practitioner can make a referral only after assessing a person.

Clause 39 sets out the maximum period of time that may elapse between an assessment being conducted and a referral being made. In relation to a person who is not a patient in an authorised hospital, the maximum period of time is 48 hours. In relation to a voluntary inpatient in an authorised hospital, the assessment must have been conducted immediately before the referral is made.

Clause 40 requires a referral to be in the approved form and lists what is to be included in that form.

Clause 41 requires the practitioner who makes a referral to provide the information in the form under *clause 40* to the referred person. However the practitioner does not have to provide information that was provided by someone other than the referred person where the person who provided the information to the practitioner provided it on the condition that the information not be provided to the other person.

Clause 42 requires the practitioner who makes a referral to put a copy of the referral on the referred person's medical record.

Clause 43 applies to a referral made under *clause 25*. The referral can remain in force for up to 72 hours from the time when it was made, subject to it being extended in accordance with *clause 44*.

Clause 44 provides for referrals that are made outside of a metropolitan area. Such a referral can be extended by 72 hours, but cannot be extended more than once.

Subdivision 4 - Conduct of assessment:

Clause 45 states that Subdivision 4 applies to the conduct of an assessment conducted by a medical practitioner or authorised mental health practitioner.

Clause 46 describes an assessment. It must be done in the least restrictive way, and least restrictive environment, practicable. The practitioner and the person must be in one another's physical presence or, if that is not practicable, be able to hear one another without using a communication device such as a telephone. For example, when a person refuses entry to their home and the practitioner is not able to actually see the person but is able to hear and communicate with the person through a door.

Clause 47 sets out the information to which the practitioner may have regard in conducting an assessment. Information obtained by the practitioner from the person, including information obtained by observing the person and asking them questions may be considered. The practitioner

may form a reasonable suspicion based on this information alone indicating that the person is in need of an involuntary treatment order. Information from other sources may also be considered, but will not be sufficient in itself for a practitioner to form a reasonable suspicion that the person is in need of an involuntary treatment order. The other sources of information that can be considered but are insufficient are information obtained from any other person, and information obtained from the person's medical records. For example where a person experiencing mental illness attends a medical centre, a general practitioner, in conducting an assessment can consider information obtained by anyone who saw the person before he or she was seen by the general practitioner, and consider the person's medical records, but cannot form a reasonable suspicion based on that information only that the person is in need of an involuntary treatment order without having conducted an assessment in person.

Clause 48 seeks to ensure that the particular needs and circumstances of patients of Aboriginal or Torres Strait Islander descent are taken into account. Assessments must be conducted in collaboration with listed groups of people, such as traditional healers and Aboriginal Mental Health Workers to the extent practicable and appropriate. It provides for treatment when an Aboriginal Mental Health Worker for example is not available and also for those circumstances where the patient does not want someone from the community involved in their treatment.

Division 3 - Examinations

Subdivision 1 – Examination at authorised hospital:

Clause 49 states that Subdivision 1 applies to a person referred to an authorised hospital for an examination.

Clause 50 provides for detention of a referred person in an authorised hospital for up to 24 hours. Various protections are in place for such a person, in line with *clause 27. Clause 50* clarifies that being received at an authorised hospital under that clause is not an admission.

Clause 51 applies to a voluntary inpatient in an authorised hospital. The person can be detained at the hospital for up to 24 hours from the time when the person was detained by the person in charge of the ward or independent of that process the referral was made by a medical practitioner or authorised mental health practitioner. Various protections are in place for such a person, in line with *clause 27.* In relation to detention under *clause 51*, notification under Part 9 is not necessary because a family member, carer, or other personal support person is already likely to be aware that the voluntary patient has been detained because they have been notified of the voluntary patient's referral.

Clause 52 states that Subdivision 6 applies to the conduct of examinations under *clauses 50* and *51.*

Clause 53 sets out the orders that can be made, and the procedural requirements that must be undertaken, by a psychiatrist upon completing an examination, such as making an involuntary inpatient order, a CTO or no order at all. One of the orders that can be made is that the person be detained for a further 72 hours from the time the person was received to enable a further examination. This recognises that at times, due to intoxication, effects of medication or the episodic nature of some mental illnesses, it may not be possible for a psychiatrist to conduct an examination or determine whether the person requires an involuntary treatment order within the 24 hour period. Once the psychiatrist has made an order, a relevant person specified in Part 9 must be notified.

Clause 54 states that, where an order is made under *clause 53* continuing detention for a further examination, the order is in effect until an involuntary order is made; or an order is made that the person can no longer be detained; or when the 72 hour time limit expires.

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

Clause 55 states that Subdivision 2 applies to a person referred for an examination at a place that is not an authorised hospital. For example, to an emergency department, general hospital or a public or private mental health clinic.

Clause 56 provides for detention of a referred person in a place other than an authorised hospital for up to 24 hours. Various protections are in place for such a person, in line with *clause 27*.

Clause 57 allows a person to be detained for an additional 48 hours where the place for examination is outside of a metropolitan area and it is not practicable to complete the examination within the 24 hours period provided for in *clause 56*. Various protections are in place for such a person, in line with *clause 27*.

Clause 58 states that Subdivision 6 applies to the conduct of the examination. The examination must be conducted in the same way whether it is at an authorised hospital or at some other place.

Clause 59 sets out the orders that can be made, and the procedural requirements that must be undertaken, by a psychiatrist upon completing an examination such as referring the patient to an authorised hospital, making the person subject to a CTO or making no order at all. One of the orders that can be made is that the person be admitted to a general hospital as an involuntary inpatient, with the consent of the Chief Psychiatrist, in circumstances where attempting to take the person to an authorised hospital poses a significant risk to the person's physical health. The requirement for consent from the Chief Psychiatrist recognises capacity constraints in general hospitals and a concern that such a provision may be misused. A report on the patient needs to be provided to the Chief Psychiatrist every 7 days and the patient transferred to an authorised

hospital when they no longer need to be cared for in the General Hospital. Once the psychiatrist has made an order, a relevant person specified in Part 9 must be notified.

Clause 60 applies when a psychiatrist at a place other than an authorised hospital orders that the person either be taken to an authorised hospital for an examination by a psychiatrist at the authorised hospital or made an involuntary inpatient in a General hospital. The person can be detained by a medical practitioner or authorised mental health practitioner for an additional 72 hours to enable the person to be taken to hospital, where this is necessary because of the person's physical or mental condition. The person must be assessed every 6 hours. Various protections are in place for such a person, in line with *clause 27*.

Clause 61 allows an order to be made to transport a referred person to the specified general or authorised hospital. A transport order can only be made where, because of the person's mental or physical condition, the person needs to be taken to the general or authorised hospital; and no other safe means of taking the person is reasonably available. Only a psychiatrist may make a transport order under *clause 61*.

Subdivision 3 – Inpatient treatment order authorising detention at general hospital:

Clause 62 states that Subdivision 3 applies to a person who is admitted to a general hospital under an involuntary inpatient treatment order.

Clause 63 requires the treating psychiatrist of the inpatient admitted under *clause 62* to report to the Chief Psychiatrist every 7 days.

Clause 64 requires the inpatient to be transferred from a general hospital to an authorised hospital when attempting to take the person to an authorised hospital no longer poses a significant risk to the inpatient's physical health. Alternatively, *clauses 85* and *86* allow involuntary patients detained at a general hospital (as well as an authorised hospital) to be discharged, and the patient's psychiatrist can also consider whether or not to make a CTO. Once the treating psychiatrist has made the transfer order, a relevant person specified in Part 9 must be notified.

Clause 65 relates to a patient who is to be transferred from a general hospital to an authorised hospital. A transport order may be made in relation to that person where there are no other safe means of taking the involuntary inpatient to the authorised hospital reasonably available.

Subdivision 4 – Order for further examination at authorised hospital:

Clause 66 states that Subdivision 4 applies to a person examined at a place other than an authorised hospital, where the psychiatrist orders that they be received and detained at an authorised hospital to be examined by a psychiatrist at the authorised hospital.

Clause 67 allows a person to whom Subdivision 4 applies to be detained at the authorised hospital for up 24 hours from the time when the person is received at the authorised hospital. The person cannot be received at the authorised hospital more than 72 hours after the time when it was ordered under *clause 59*. Various protections are in place for such a person, in line with *clause 27*. *Clause 67* clarifies that being received at an authorised hospital under that clause is not an admission.

Clause 68 states that Subdivision 6 applies to the conduct of the examination.

Clause 69 sets out the orders that can be made, such as making the person an involuntary detained patient, or making the person subject to a CTO or making no order at all and the procedural requirements that must be undertaken, by a psychiatrist upon completing an examination. It should be noted that the option of extending the detention for a further 72 hours from the time of receipt is not available. The notification provisions in Part 9 do not apply here because the relevant specified person will already be aware that the patient has been taken to hospital pursuant to other clauses requiring notification in accordance with Part 9.

Subdivision 5 – Examination without referral:

Clause 70 states that Subdivision 5 applies if a person is examined without a referral having been made.

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

Clause 72 gives a psychiatrist completing an examination under Subdivision 5 the discretion to make a CTO. That is, an involuntary inpatient treatment order cannot be made without a referral because, for accountability, it is considered to be necessary for two practitioners to be involved in the determination about whether or not a person needs to be made an involuntary inpatient.

Clause 73 is a safeguard in relation to *clause 72*. Because there has not been a referral by a medical practitioner or authorised mental health practitioner in relation to a CTO made under *clause 72*, confirmation of the CTO is required by another practitioner, either a psychiatrist or if a psychiatrist is not reasonably available, a medical practitioner or authorised mental health practitioner, within 72 hours from the time when the CTO is made. If it is not confirmed, it is no longer in force.

Subdivision 6 – Conduct of examination:

Clause 74 sets out the clauses to which Subdivision 6 applies.

Clause 75 states that the referring psychiatrist cannot conduct an examination to which Subdivision 6 applies, being an additional safeguard for referred persons and patients.

Clause 76 requires all examinations to be conducted in the least restrictive way, and least restrictive environment, practicable. The clause sets out different requirements for different circumstances. In some circumstances, such as an examination by a psychiatrist, the practitioner and the person being examined need to be in one another's physical presence. In other circumstances, such as a referral assessment, they do not. Where an examination is found not to have met the requirements in *clause 76*, there is nothing preventing a new examination being conducted and a new order being made.

Clause 77 sets out the information to which the psychiatrist or other practitioner may have regard in conducting an examination. *Clause 77* refers to a practitioner, in addition to a psychiatrist, because *clause 74* refers to some examinations under Part 8 in relation to CTOs, where a practitioner who is not a psychiatrist may conduct an examination. The information that can be considered is the same as the information that can be considered for an assessment pursuant to *clause 47*. However, the threshold is higher in *clause 77* than in *clause 47* because the consequences of an examination are greater than the consequences of an assessment. *Clause 47* refers to 'a *reasonable suspicion* that the person being assessed is in need of an involuntary treatment order'. *Clause 77* refers to a *conclusion* 'that the person being examined is in need of, is still in need of, or is no longer in need of, an involuntary treatment order'.

Part 7 Detention for examination or treatment

Division 1 - Preliminary matters

Clause 78 states that Part 7 does not apply to a mentally impaired accused person who is required to be detained in an authorised hospital.

Clause 79 sets out principles specifically relating to detention, which are broadly based on the Objects described in Part 3 of the Bill.

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

Clause 80 lists the clauses in Part 6 under which detention is authorised, and enables a person to be received at an authorised hospital or other place, and enables the person's detention there for the period authorised by the Bill. The relevant clauses authorising detention are specified in *clause 80*. In broad terms, the clause applies to persons who are under an order to be detained or continue to be detained at an authorised hospital, and persons who are under an order to be detained or continue to be detained at a place other than an authorised hospital.

Division 3 - Detention at hospital under inpatient treatment order

Clause 81 states that Division 3 applies to an involuntary inpatient at a hospital (which means authorised and general hospitals).

Clause 82 defines some of the terms used in Division 3.

Clause 83 provides a statutory basis for an involuntary inpatient's admission to, and detention in, an authorised or general hospital specified in the involuntary inpatient treatment order, and any other hospital to which the patient is transferred in accordance with the Bill.

Clause 84 specifies the time limits for an inpatient treatment order. For an adult, the period is 21 days; for a child, the period is 14 days, from the date on which the order is made. The timeframes have been reduced from 28 days for both adults and children under the current Act. This is in line with recommendations of the Holman Review.

Clause 85 states when an involuntary inpatient treatment order ends. That is, when the person becomes the subject of a CTO; when the psychiatrist revokes the involuntary inpatient treatment order; or upon the expiry of the inpatient treatment order (subject to a continuation order having been made under *clause 85*), whichever is first.

Clause 86 requires an involuntary inpatient to be examined on or within 7 days before the detention period ends. No time period is specified in the current Act. The clause sets out the orders that the psychiatrist may make

upon completing an examination. These orders include a continuation order, which can be made for 3 months for an adult; or 28 days for a child, reduced from 6 months for adults and children under the current Act. Where the psychiatrist makes an order revoking the involuntary inpatient treatment order, a relevant person specified in Part 9 must be notified.

Clause 87 allows an involuntary inpatient to be discharged from hospital during the detention period. That is, it allows a psychiatrist to make an order for a CTO, or revoke the involuntary inpatient treatment order, during the detention period where the psychiatrist is satisfied, having regard to the criteria in *clause 24*, that the person is no longer in need of an involuntary inpatient treatment order. In line with the principle of the least restrictive option, either of these orders can be made without an examination of the involuntary inpatient. Once the psychiatrist has made an order, a relevant person specified in Part 9 must be notified.

Clause 88 enables a psychiatrist to transfer an involuntary inpatient in an authorised hospital to another authorised hospital. The transfer order must include the reasons for making the order, amongst other things. Examples of reasons for transfer include locating the involuntary inpatient closer to their family; where there is a conflict with another patient in the same ward at the initial authorised hospital; or where there is a shortage of beds at the initial authorised hospital. Once the psychiatrist has made an order, a relevant person specified in Part 9 must be notified.

Clause 89 relates to a patient who is to be transferred between authorised hospitals under *clause 88*. A transport order may be made where there are no other safe means of transporting the involuntary inpatient reasonably available. Only a psychiatrist may make a transport order under *clause 88*.

Clause 90 requires an involuntary inpatient to be advised upon the expiry of an inpatient treatment order, and advised of the consequences, including that the patient may remain, with the psychiatrist's permission, as a voluntary patient or be discharged from the hospital. There is nothing preventing a new inpatient treatment order being made. Once the involuntary inpatient treatment order has expired, a relevant person specified in Part 9 must be notified.

Division 4 - Release from hospital or other place

Clause 91 is the application provision for Division 4. Division 4 applies to referred persons, and persons detained for assessment or examination (both of whom are considered to be voluntary patients); involuntary inpatients; and patients on a CTO detained at a place specified in an order to attend under *clause 126*.

Clause 92 requires a person to be allowed to leave when they cannot continue to be detained at a general hospital, authorised hospital, or other place (subject to *clauses 91* and *93*). The patient must be advised in writing by a medical practitioner or mental health practitioner. A relevant person

specified in Part 9 will be notified pursuant to other clauses throughout the Bill.

Clause 93 creates an exception to *clause 92*. Where the involuntary inpatient must be delivered into custody pursuant to another law, they must not be allowed to leave the hospital or other place until they have been delivered into that custody. This clause is substantively consistent with the current Act.

Division 5 - Absence without leave from hospital or other place

Clause 94 prescribes the circumstances in which a person is to be considered absent without leave. Absence without leave from an authorised hospital, general hospital or other place is an event to which Part 9 applies, so a relevant person specified in Part 9 must be notified.

Clause 95 provides discretion for an apprehension and return order to be made in respect of a person who is absent without leave. However the Clinicians' Guide to the legislation will explain that all steps to return the person without use of an apprehension and return order, such as use of relatives and community staff, should be undertaken before an apprehension and return order is made. The apprehension and return order must specify the reasons for making the order, and the hospital or other place to which the person must be returned, amongst other things. Under the current Act, a person who is on a leave of absence to a general hospital for medical treatment, and who absconds from the general hospital, can only be returned to the authorised hospital where the patient was detained. The Bill rectifies this, allowing the person, in this situation, to be returned to another hospital under the apprehension and return order if that is more appropriate in the circumstances.

Clause 96 describes an apprehension and return order and refers to the powers that a police officer or person prescribed by the regulations who is carrying out the order has with respect to the person who is absent without leave. *Clause 164* allows reasonable force and assistance to be used in carrying out an apprehension and return order.

Clause 97 states that the maximum period of an apprehension and return order is 14 days, and that this period cannot be extended. There is no need for the hospital or other place to notify anyone when the apprehension and return order expires, because the relevant police officer or person prescribed will have a copy of the order and know when it expires.

Clause 98 provides for the revocation of an apprehension and return order when it is no longer needed. The revocation order must include the reasons for the revocation, amongst other things. The person who makes a revocation order must advise the relevant police officer or person prescribed of the revocation as soon as practicable.

Clause 99 provides a safeguard in a situation where a person is apprehended under an apprehension and return order and the order expires or is revoked before the person has been returned to the place where the order specifies that the person is required to be returned. In that situation, the person must be returned to the place where the person was apprehended, or to a place reasonably nominated by the person.

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

Subdivision 1 - Preliminary matters:

Clause 100 states that Division 6 applies to an involuntary inpatient detained at an authorised hospital or general hospital.

Clause 101 defines a leave of absence.

Subdivision 2 - Grant, extension, cancellation etc of leave:

Clause 102 enables an involuntary inpatient to be granted a leave of absence where this would be likely to benefit the involuntary inpatient's mental or physical health, and where the leave of absence would not be inconsistent with the involuntary inpatient's need to be provided with treatment. The psychiatrist must first consider whether or not the making of a CTO or a revocation of the involuntary inpatient treatment order would be more appropriate. Although an examination is not required before granting a leave of absence, all of the persons specified in *clause 102* must be consulted, or have been attempted to be identified and consulted, before granting the leave of absence (subject to the exceptions specified in the clause). A leave of absence is for the period specified in the order, and may be granted subject to conditions. Where a leave of absence is granted, a relevant person specified in Part 9 must be notified.

Clause 103 enables an extension or variation of conditions of leave granted. The order must include the reasons for making the order, amongst other things. Where a leave of absence is extended or varied, a relevant person specified in Part 9 must be notified. The person notified pursuant to Part 9 must be notified of variations to conditions, because the involuntary inpatient may not be in a position to comply with the conditions without the assistance of the person notified, given that the person currently satisfies the criteria that justifies involuntary inpatient status and is therefore likely to be acutely unwell or still recovering.

Clause 104 requires the involuntary inpatient to comply with the conditions of a leave of absence.

Clause 105 applies where an involuntary inpatient is on a leave of absence for more than 21 consecutive days. The treating psychiatrist must consider whether or not it would be appropriate to discharge the patient to a CTO or

revoke the involuntary inpatient treatment order. The patient does not need to be examined for this purpose, as they will not be at the hospital.

Clause 106 allows the treating psychiatrist to change an involuntary inpatient's status while the involuntary inpatient is on leave. This requires a written opinion from a medical practitioner or mental health practitioner that this would be appropriate, and can be done without an examination by a psychiatrist.

Clause 107 allows a psychiatrist to cancel an involuntary inpatient's leave of absence if he or she forms the reasonable belief that it is inappropriate for the involuntary inpatient to continue to be away from the hospital. There is no requirement for an examination, given that the involuntary inpatient will be residing in the community at the time when the leave of absence is cancelled. The order must specify the reasons for that belief, amongst other things. The psychiatrist must orally advise the involuntary inpatient that the leave of absence has been cancelled, so that the patient can return to the hospital as required. Where a leave of absence is cancelled, a relevant person specified in Part 9 must also be notified.

Subdivision 3 – Transport to and from hospital

Clause 108 states that Subdivision 3 applies to an involuntary inpatient on a leave of absence (from an authorised hospital) for the purposes of obtaining medical or surgical treatment at a general hospital; and to involuntary inpatients who have had their leave of absence cancelled.

Clause 109 allows a transport order to be made where no other safe means of transporting the involuntary inpatient is reasonably available.

Part 8 Community treatment orders

The legislation provides for involuntary treatment in the community as a less restrictive alternative to being an inpatient in an authorised or general hospital.

Division 1 - Preliminary

Clause 110 defines some of the terms used in Part 8, including a supervising psychiatrist, who supervises the treatment for a patient on a community treatment order (distinct from the treating psychiatrist for an inpatient treatment order), and treating practitioner (medical practitioner or mental health practitioner) who is responsible for ensuring the treatment is delivered.

Division 2 - Making order

Clause 111 sets out the things that a psychiatrist must be satisfied of before making a community treatment order (CTO). *Clause 111* is to be distinguished from *clause 24* which sets out the criteria for a person's need to be provided with treatment and involves a clinical decision with regard to the individual patient. *Clause 111* articulates the other factors which need to be in place for a CTO to be operative, such as the availability of a supervising psychiatrist and treating practitioner, and that the treatment proposed is consistent with the need for the involuntary order. For example, if the patient lives in a region of the state where the proposed treatment cannot be provided, then there may not be any good purpose for which to impose a CTO.

Clause 112 sets out the terms that must be included in a CTO such as: the names of the supervising psychiatrist and treating practitioner; when the order will come into force; the expectation that the patient will comply with the treatment proposed as well as informing the psychiatrist of any change of address or plan to go interstate or overseas. The term of the CTO must not be more than 3 months.

Division 3 - Operation of order

Clause 113 sets out when a CTO ends which is: when an involuntary inpatient treatment order is made by a psychiatrist for the patient to be detained in an authorised or general hospital; or when the CTO is revoked and the person is made no longer involuntary; or when the treatment period expires (unless the order is continued under a continuation order). It is important to note that CTOs are suspended upon voluntary admission to an authorised or general hospital or when a patient is referred under clause 24.

Clause 114 requires the supervising psychiatrist to advise the patient in writing of when and where treatment is to be provided. The supervising psychiatrist is allowed up to 14 days for this information to be provided to

the involuntary community patient and must include details of their first appointment, whether that appointment is with the treating practitioner or otherwise, allowing the patient time to make arrangements to attend. The Clinicians' Guide to the legislation will emphasise that this essential information is provided to the community patient as soon as is practicable.

Clauses 115 and 116 prescribe when a patient must be examined, which is monthly, and allow a supervising psychiatrist to request a medical practitioner or mental health practitioner to conduct an examination of an involuntary community patient as an alternate to an examination by a psychiatrist. The practitioner must provide a report regarding the examination to the supervising psychiatrist and an important aspect of the examination is to determine whether the CTO continues to be required. The medical or mental health practitioner cannot do the examination if the two previous examinations were not conducted by the supervising psychiatrist. These clauses reflect the less restrictive nature of CTOs compared to involuntary inpatient treatment orders (where examinations must be conducted by a psychiatrist).

Clause 117 sets out what a supervising psychiatrist may do after an examination has been conducted, which includes consideration as to whether or not the CTO should continue to be in force. Options include making the patient subject to an involuntary inpatient treatment order, or revoking the CTO. Where the supervising psychiatrist makes an order under *clause 116*, the relevant persons specified in Part 9 must be notified.

Clause 118 provides for a continuation order in relation to a CTO, with various protections for the involuntary community patient. The clause enables the supervising psychiatrist to make an order (not exceeding 3 months), on or within 7 days before a CTO is due to expire, continuing the CTO from the end of the treatment period. The supervising psychiatrist must personally examine the involuntary community patient first. The order must specify the reasons for the continuation order, amongst other things. The patient has the right to *request* that the supervising psychiatrist obtain a further opinion from another psychiatrist about whether or not a continuation order is appropriate within 14 days. *Clause 118* and Part 12 set out the rights of the patient in relation to o*btaining* the further opinion and the process conducted by the supervising psychiatrist. If no further opinion is obtained within that time frame, or if the further opinion indicates that the CTO is not required then the CTO does not come into force or ceases to be in force. If the patient does not attend the examination then the CTO remains in force.

Clause 119 provides for changes during the period of the CTO enabling the supervising psychiatrist to vary the terms of a CTO—for example, by changing the frequency of attendance at a clinic for treatment. The order must specify the reasons for the variation, amongst other things. A copy of the order must be given to the patient.

Clause 120 sets out options and procedures in relation to an involuntary community patient who may either require involuntary inpatient treatment or no longer requires a CTO. Where the supervising psychiatrist makes an order under *clause 120*, the relevant persons specified in Part 9 must be notified.

Clause 121 requires the supervising psychiatrist to advise an involuntary community patient, in writing, when their CTO has expired, and of the consequences of the expiry.

Division 4 - Breach of order

Clause 122 prescribes the circumstances when an involuntary community patient will be considered to be in breach of a CTO, which includes non-compliance with the order and the possibility of deterioration of the patient's mental illness.

Clause 123 sets out the procedures a supervising psychiatrist must follow to record a breach of a CTO, including giving notice of the breach to the involuntary community patient, as well as information about the consequences of further non-compliance.

Clause 124 makes provision for an order for the patient to attend a specified place at a specified time, and that failure to attend may result in a transport order whereby the patient is apprehended and brought to a place for treatment.

Clause 125 allows a transport order to be made by a psychiatrist or a medical practitioner or mental health practitioner, to take a patient on a CTO to a specified place for treatment.

Clause 126 prescribes the circumstances in which an involuntary community patient can be detained at a place specified in an order to attend. The person can leave after the treatment has been provided or when 6 hours has lapsed from the time the person was received at the place that they were ordered to attend. Alternatively, the supervising psychiatrist may revoke the CTO and make an involuntary inpatient treatment order. Where a person is released from detention following an order to attend, the relevant person specified in Part 9 must be notified.

Clause 127 provides an alternative to the 'order to attend' process whereby if a patient is non-complaint with the order or fails to comply with the order to attend, the supervising psychiatrist may either revoke the CTO without examining the patient, and make an involuntary inpatient order allowing the patient to be detained at an authorised or general hospital, or decide to revoke the order and make the person no longer involuntary. If the patient is not examined by the psychiatrist then the basis for the decision can be information provided by clinical observation by another person such as a mental health practitioner, or information in the patient's medical record.

Division 5 - Transport to hospital

Clause 128 states that Division 5 applies where the supervising psychiatrist makes an involuntary inpatient treatment order.

Clause 129 enables a transport order to be made under Division 5 where, because of the person's mental or physical condition, the person needs to be taken to an authorised or general hospital, and no other safe means of taking the person is reasonably available. A medical practitioner or mental health practitioner may make the transport order.

Division 6 - Supervising psychiatrist and treating practitioner

Clause 130 requires the supervising psychiatrist under the CTO to carry out the CTO. To clarify, the supervising psychiatrist does not necessarily have to be the psychiatrist who made the CTO, but it must be a psychiatrist.

Clause 131 enables a supervising psychiatrist to transfer his or her responsibility under the CTO to another psychiatrist. The clause also enables the Chief Psychiatrist or a person authorised under the clause to transfer the responsibility of the supervising psychiatrist to another psychiatrist. For example, in circumstances where the supervising psychiatrist is suddenly unable, for example due to illness, to perform his or her functions and has not had the time or opportunity to transfer the care of the patient to another supervising psychiatrist, then the Chief Psychiatrist may transfer a supervising psychiatrist's responsibility for a patient to another psychiatrist. The patient must be advised in writing.

Clause 132 states: a treating practitioner must be a medical practitioner or mental health practitioner and can be the supervising psychiatrist or another psychiatrist; and what the treating practitioner is responsible for.

Clause 133 allows a supervising psychiatrist to transfer a practitioner's responsibility as the treating practitioner to another practitioner. The patient must be advised in writing.

Part 9 Notification of certain events

This Part of the Bill emphasises the importance of other people, such as family members, carers or other personal support persons, being aware of what is happening with regard to the patient, and places a duty on staff to inform by notification these people when certain events occur. In particular, matters relating to a person's physical location and treatment status are of critical importance to families, carers, and other personal support persons.

Division 1 - Preliminary matters

Clause 134 states that Part 9 applies when a provision in the Bill requires notification under Part 9.

Division 2 - Notification of close family member, carer or other personal support person

Clause 135 requires notification of any event to which Part 9 applies to be given to a carer, close family member, or other personal support person, subject to *clause 137*. The person responsible for notification varies throughout the Bill, depending on the nature of the event and who made the relevant order. *Clause 135(1)* does not refer to a nominated person specifically, however a carer or close family member may also be the nominated person. If the nominated person is not a carer or close family member, they may fall within in the definition of 'personal support person', which is defined in *clause 7* to include a nominated person). For that reason, *clause 135(2)* specifically refers to a nominated person.

Clause 136 sets out what needs to happen for the person responsible to have complied with *clause 135*. The person responsible needs to have notified at least one of the persons specified in *clause 135* of the event; however it is also reasonable to conclude because it has not been possible to contact the person, that no person can be notified of the event. The person responsible must ensure that the person's medical record includes a record of notification of a person or efforts to notify persons.

Clause 137 creates an exception to *clause 135* where it is not in the person's best interests for a specified person to be notified of an event (Part 2 Division 3). As stated under *clause 135*, the person responsible for the notification varies throughout the Bill, depending on the nature of the event and who made the relevant order. The person who is responsible for notifying a relevant person specified in Part 9 generally determines whether or not notification is in the best interests of the person in relation to whom the order is made. Where a relevant specified person requests notification of an event, a practitioner or psychiatrist who decides that a person is not to be notified because of *clause 137*, must advise that relevant specified person of that decision and the reasons for decision. The practitioner or psychiatrist must also give a copy of the record of advice to the person

referred or detained. A relevant specified person can obtain a written record of advice, including reasons.

Division 3 – Notification of other persons and bodies

Clause 138 relates to the making, revocation or expiry of an involuntary treatment order. The person responsible for notification of relevant persons specified in relation to *clauses 135*, *136* and *137*, must also notify the Chief Mental Health Advocate, the MHT and, if the involuntary patient is a mentally impaired accused person required to be detained in an authorised hospital, the Mentally Impaired Accused Review Board.

Part 10 Transport orders

Part 10 sets out the circumstances in which transport orders may be made, as well as the powers exercisable under transport orders, and the procedures required for making, extending and revoking transport orders. In comparison to the current Act, the Bill contains a considerable number of new requirements relating to the form and process for transport orders and, for this reason it is desirable to create a new Part containing these requirements. The new requirements for transport orders are intended to provide greater accountability, clarity and transparency.

Clause 139 lists the circumstances in which a transport order may be made. Provisions in Part 10 governing transport orders are intended to apply to all of these situations.

Clause 140 provides for a new class of person, a transport officer. It is intended that the regulations will authorise classes of persons or individuals as transport officers and specify requirements for such authorisation. Transport officers are intended to provide a safe and appropriate means for transporting involuntary patients and referred persons. The Bill does not remove the possibility for police officers to also transport people under transport orders where appropriate.

Clause 141 sets out the information which must be recorded on a transport order, including requirements to record certain decisions in which discretion may be exercised by the person making the transport order, such as those specified in *clause 141(1)(d)*, *(e)* and *(f)*. These requirements are intended to ensure a high level of accountability and transparency in the decision making process. It is the intention that this information should always be made available to the person who is the subject of the transport order.

Clause 142 deals with the operation of transport orders.

Clause 142(1) sets out the powers which, under a transport order, a transport officer or police officer is authorised to exercise. The powers are authorised for the purpose of enabling transport orders to be executed, and provide for apprehension, transportation and detention. The powers of apprehension are set out more fully in *clause 152(2)*, and authorise the transport officer or police officer to enter premises, search persons and seize items, all of these powers being subject to restrictions and only to be exercised for the authorised purpose. The power of transport officers to enter premises is further restricted by *clause 152(3)*, which limits the premises to which transport officers can enter to those prescribed by the regulations. There are good human rights reasons to restrict the capacity for transport officers to enter premises. It is likely that transport officers will initially have a limited purpose of conducting transfers of patients between hospitals in the metropolitan region, rather than from the community to hospitals, and not generally in regional areas. This role of transport officers may from time to time require them to exercise limited powers of entry to

premises, for example to enter various parts of the hospital and apprehend the person to be transported, and possibly to nearby premises such as a shop, if necessary. However, it is not intended that transport officers will have unrestricted powers to enter and search private residences. Given the functions and roles of police officers, and the legislative and professional safeguards and protections that prescribe the exercise of these, it is appropriate that, under transport orders, police have more extensive powers of entry than transport officers. *Clause 164* allows reasonable force and assistance to be used in carrying out a transport order.

Clause 142(2) sets out the circumstances in which a transport order can authorise a police officer, rather than a transport officer, to undertake a transport order. It is intended that, wherever possible, a transport officer should be the preferred means of transfer of persons on transport orders between hospitals in the metropolitan area. However, it is appropriate that there be discretion on the part of the person writing the transport order to authorise a police officer to undertake the order in certain situations. These are set out in *clause 142(2)*, intending to take account of situations where the risk of serious harm is sufficiently high that the circumstances warrant police involvement. This risk of harm may exist due to security concerns about a particular patient, or because delay before a transport officer can carry out a particular transport is likely to result in a significant risk of harm to the person being transported or another person. It is not expected that such circumstances will be common, but it is considered necessary to retain the role of police for such events. *Clause 141(1)(e)* and *(f)* require the practitioner or psychiatrist making the transport order to document whether the order is to be carried out by a transport officer or a police officer, and if a police officer is required, to provide reasons why a transport officer could not carry out the order.

Clause 143 makes provision for the period for which a transport order remains in force, if not extended under clauses 144(2) or 145(3). Transport orders made under *clause 28*, for the purpose of transporting a person referred for examination by a psychiatrist, are intended to expire when the referral itself expires. In a metropolitan area, the referral can remain in force for up to 72 hours under *clause 44*, and it is intended that at the time that these 72 hours lapse the transport order will also lapse. These two powers are explicitly linked because it is intended that the power to transport should not outlast the time period of a referral.

It is noted that *clause 44* provides that outside the metropolitan area a referral for examination may be sought to be extended for a maximum of a further 72 hours. The clause is designed to recognise the particular difficulties that a person transporting a person may face in remote areas where communications may be limited. It allows for an oral request to extend the referral, and provides several options as to who may make the decision to extend the referral. *Clause 144* provides that where the referral is extended in these circumstances the transport order is similarly extended.

Clause 143 goes on to make provision for transport orders made under *clause 61(1),* where either an inpatient treatment order or an order for further examination have been made. In these cases the transport order lapses 72 hours after the other order was made.

In the remaining circumstances set out in *clause 143(2)(c)* the transport order lapses 72 hours after it is made.

Clause 144 is discussed above and relates to extension of transport orders where they relate to referrals for examination.

Clause 145 relates to extension of other transport orders and applies only outside a metropolitan area. A transport order may be extended once only for a maximum period of 72 hours if the criteria set out in *clause 145(1)* are met.

Clause 146 is intended to ensure that if a referral order is revoked under *clause 30* then the transport order made in respect of the referral order is also revoked.

Clause 147 enables a medical practitioner or authorised mental health practitioner to revoke a transport order if satisfied that it is no longer needed. The person revoking the order is not required to be the same person who made the transport order. This is intended to take account of circumstances where the person who made the order is not available or is not in a position to revoke the order. It is expected that in the normal course of events the person who revokes the order will be the same person who made the order. Where that is not possible it is anticipated that the person revoking the order would consult with the person who made the order.

Clause 148 deals with what should happen to the person being transported if the transport order expires or is revoked before the person is received at the place where they were to be transported. In this case it is intended that the person being transported is able to elect whether they would prefer to be taken back to the place where they were transported from or to another place reasonably nominated by them. In this situation the transport officer or police officer is obliged to take reasonable steps to ensure that the person is taken to the place chosen by the person. This is intended to protect the person from being left in an inconvenient place, but not impose an unreasonable burden on the transport officer or police officer. *Clause 148(3)* is intended to ensure that complying with this clause will not result in a person being placed at serious risk.

Part 11 Apprehension, search and seizure powers

Division 1 - Apprehension powers

Clause 149(1) permits a police officer to apprehend a person where: the officer reasonably suspects that the person has a mental illness; and because of the mental illness, needs to be apprehended to protect the health or safety of the person or the safety of another person, or prevent the person causing, or continuing to cause, serious damage to property. That is, there must be a perceived causal connection between mental illness and the risk, which provides an additional safeguard against unnecessary apprehension.

It is noted that damage to property is not one of the express criteria for an involuntary treatment order being made under *clause 24*. The inclusion of damage to property in *clause 149* recognises the difficulties that police face when responding to incidents involving people who have a suspected mental illness. In the absence of a clinician, the decision about whether criteria in *clause 24* are met is challenging. The continued inclusion of a power to apprehend to prevent damage to property is intended to respond to a need identified by consumers and their families for police to be able to act in such circumstances.

For the purpose of apprehending a person under *clause 149(1)*, a police officer may exercise the powers under *clause 152(2)*. *Clause 149(3)* requires a police officer exercising powers of apprehension under *clause 149* to arrange for an assessment of the person, and allows the police officer to detain the person until the person is received at the place where the assessment is to be conducted; the person is delivered into the care of the practitioner who will assess the person; or the police officer is satisfied that the grounds for suspecting that the person needs to be apprehended no longer exist. This is intended to take account of situations such as where it initially appears that a person has a mental illness, but after apprehension has taken place it emerges that the person had been affected by drugs for example, which lose their effect and remove the grounds for apprehension. Nothing in *clause 149* prevents a person from being charged with an offence.

Clause 150 applies where a police officer arrests a person whom the police officer reasonably suspects has a mental illness for which the person is in need of immediate treatment. The police officer must arrange an assessment. Nothing in *clause 150* prevents a person from being charged with an offence.

Clause 151 applies where a police officer arranges an assessment, and the practitioner who conducts the assessment decides not to refer the person for an examination; or where the person has been referred for examination, but cannot continue to be detained under the Bill; for example where the referral has expired under *clause 43*. A police officer must be informed of the above, and information about the police being informed must be

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

Clause 152 applies to a person who has not been arrested, but where the person can be apprehended for another reason. Firstly, where a police officer or person prescribed is authorised to carry out an apprehension and return order under *clause 96*. Secondly, where a transport officer or police officer is authorised to carry out a transport order under *clause 142*. Thirdly, where a police officer is authorised to apprehend a person suspected of having a mental illness under *clause 149*. *Clause 152* lists the powers of the relevant police officer, person prescribed, or transport officer, in apprehending the person. They include powers to enter premises (limited to prescribed premises in relation to transport officers), and the search and seizure powers that are described in Divisions 2 and 3. *Clause 164* allows reasonable force and assistance to be used in searching a person and seizing any article.

Division 2 - Search and seizure powers

Clause 153 defines 'approved form' for the purposes of Division 2, being a form approved by the Commissioner of Police under *clause 162*, or a form approved by the Chief Psychiatrist under *clause 511*.

Clause 153 provides that the regulations may authorise a person (an 'authorised person') to exercise powers under Division 2.

Clause 155 allows search of a person when admitted or detained, and periodically throughout admission or detention, in circumstances where a police officer, or authorised person, reasonably suspects that the patient has an article listed in *clause 157*. A search can only be conducted in accordance with *clause 156*, and reasonable force can be used. The search can be of the person, and any article found on or with the person (limited by *clause 156*). The clause also allows seizure of an item listed in *clause 157* that is found on or with the person. There is no provision for search of a visitor or staff member at a mental health service or other place where a person is being detained. *Clause 164* allows reasonable force and assistance to be used in searching a person and seizing any article under *clause 155*.

Clause 156 sets out strict requirements in relation to how searches must be conducted. The provision is in accordance with the Objects of the Bill, and balances the importance of the safety, dignity and privacy of the person being searched; and the safety of the person conducting the search and other persons who may be placed at risk by an item found on or with the person being searched. This clause is intended to ensure that searches are as consistent as possible with the safeguards provided in other legislation, such as the *Criminal Investigation Act 2006*.

Clause 157 identifies the articles that may be seized from a person. In broad terms, they are items that may create a risk to the person or another

person. Further, in line with the current Act, the person conducting the search may seize any article that he or she believes is likely to materially assist in determining any question in relation to the person that is likely to arise for determination under this Act. For example, seizure of a large amount of medication from a person is likely to assist a practitioner in determining whether or not the person has a mental illness (although this would not be sufficient to determine that the person has a mental illness, because of the exclusion regarding past treatment in *clause 6(2)(l)(i)*).

Clause 158 sets out stringent recording requirements following the exercise of search or seizure powers, which are considered to be necessary for transparency.

Clause 159 sets out the options for dealing with seized articles when a person is apprehended. If the person is received at a mental health service or other place, or delivered into the care of a medical practitioner or authorised mental health practitioner, the article must be given to the staff member of the mental health service or other place in accordance with the clause. If the person is released without being taken to a mental health service or other place and without being delivered into the care of a practitioner specified in the clause, the article must be returned to the person upon release. As an alternative to both of these options, the article may be dealt with according to a law other than the Bill, such as the *Misuse of Drugs Act 1981* or the *Crimes Act 1914* (Cth).

Clause 160 provides for the return of an article that has been given to, or seized by, a mental health service. Such an article must be returned to the person or another person or stored, as required by the clause. Where an item has been stored for more than 6 months from the release or discharge of the person, it may be destroyed or otherwise disposed of. The method of disposal of the article must be recorded in the approved form and that form must be placed on the person's medical record.

Clause 161 applies where an article was given to a practitioner pursuant to *clause 158* and the practitioner decides not to refer the person for an examination. The practitioner must return the article to the person, or have the article otherwise dealt with according to law, as soon as practicable. A record of how the article was dealt with must be put on the person's medical record and a copy of the record of how the article was dealt with must be given to the person. It is intended that a form will be created under *clause 161* for the purposes of recording such information.

Clause 162 allows the Commissioner of Police to approve forms for use by a police officer under Division 2. This is intended to remove the need for police officers to record searches and seizures more than once, by providing for common forms across police and mental health legislation. It is noted that, for persons other than police officers, *clause 511* allows the Chief Psychiatrist approve forms for use under Division 2.

Division 3 – Miscellaneous matters

Clause 163 states that in Division 3, a 'prescribed provision' is *clause 96*, *clause 142(1)*, and Part 11.

Clause 164 permits a person exercising a power under a prescribed provision to require another person to provide reasonable assistance in exercising that power. It also permits the person exercising the power or assisting the person exercising the power to use reasonable force. Use of unreasonable force may be punished under other clauses in the Bill, in addition to criminal law and other civil laws.

Clause 165 applies where a person is assisting a person who is exercising a power under Part 11. The person assisting must obey all lawful and reasonable directions of the person exercising the power under Part 11. A failure to do so is an offence with a fine of $6,000. It is noted that, as with all offence provisions throughout the Bill, the specified penalty is the maximum penalty.

Clause 166 creates an offence in relation to a person who, without reasonable excuse, obstructs or hinders a person exercising, or assisting a person in exercising, a power under a prescribed provision. The penalty is a fine of $6,000.

Clause 167 provides that a prescribed provision does not affect any other written law relating to apprehension or search of a person or the seizure of an article from a person. For example, powers under the *Criminal Investigation Act 2006* and the *Crimes Act 1914* (Cth) can be exercised in relation to a person experiencing mental illness.

Part 12 Provision of treatment generally

Division 1 - Voluntary patients

As stated above in relation to Part 6, a voluntary patient is a patient who is not an involuntary patient or mentally impaired accused person required to be detained in an authorised hospital. Therefore, referred persons and persons detained for assessment or examination are voluntary patients for the purposes of the Bill.

Clause 168 states that a voluntary patient cannot be provided with treatment without informed consent being given to the provision of the treatment. This does not apply to the treatments specified in the clause, because the Bill makes specific provision in respect of each of them. They are electroconvulsive therapy (ECT), emergency psychiatric treatment, psychosurgery, and treatments prohibited under *clause 199*. It is noted that seclusion and bodily restraint may also be used on a voluntary patient (or involuntary patient) without consent. However, as clarified in the definition of 'treatment' in *clause 4*, seclusion and bodily restraint are not treatments. They are considered to be interventions under Part 13.

Clause 169 requires informed consent that has been given to be recorded on the voluntary patient's medical record. This formalises what is currently good practice. It is noted that *clause 167* applies together with the *Guardianship and Administration Act 1990*. The patient can give consent by making an advance health directive. A substitute decision maker may give informed consent on behalf of the voluntary patient, except in relation to the performance of psychosurgery, where personal consent is required, as stated in relation to Part 13.

Division 2 - Involuntary patients and mentally impaired accused

Clause 170 states that Division 2 applies to involuntary patients and mentally impaired accused persons required to be detained at an authorised hospital.

Clause 171 provides that a patient to which Division 2 applies can be provided with treatment without informed consent being given to the provision of the treatment. This does not apply to the treatments specified in the clause, because the Bill makes specific provision in respect of each of them. They are ECT, emergency psychiatric treatment, psychosurgery, and treatments prohibited under *clause 199*. In any case, provision for emergency psychiatric treatment (in *clause 191*) is only in relation to voluntary patients. As with *clause 168*, it is noted that seclusion and bodily restraint may also be used on an involuntary patient (or voluntary patient) without consent. However, as clarified in the definition of 'treatment' in *clause 4*, seclusion and bodily restraint are not considered to be treatments. Rather, they are interventions (that may in some circumstances have

therapeutic value, such as reducing external stimuli causing distress, or preventing deliberate self harm).

Clause 172 requires a patient's psychiatrist to have regard to the patient's wishes in relation to the provision of the treatment, to extent that it is practicable to ascertain those wishes. The clause sets out administrative procedures to be followed after obtaining the patient's wishes. It is noted that generally regard also must be had to the views of the each of the persons specified in the clause such as a carer, close family member or nominated person.

Clause 173 requires the patient's psychiatrist to ensure that the patient's medical record includes a record of the treatment provided to the patient. There is no corresponding provision in the Bill relating to voluntary patients, as this is dealt with in policies and protocols external to mental health legislation.

Clause 174 gives patients and other specified persons broad rights to request a further opinion from a psychiatrist other than their treating psychiatrist or supervising psychiatrist. The request may be made to the patient's psychiatrist or to the Chief Psychiatrist. The request must be complied with unless refused under *clause 173* or, if the request was made by a person other than the patient, where the patient objects to the further opinion being obtained. If a further opinion is to be obtained, the request must be complied with as soon as practicable. No express timeframe is specified. This is because flexibility is required to prevent possible abuse of the entitlement, and to accommodate contingencies that may delay the provision of a further opinion. The psychiatrist responsible for the further opinion cannot provide a report without having examined the patient. Specified administrative procedures must be complied with in relation to recording the request and related matters.

Clause 175 relates to a patient who has made a request under *clause 172*. The patient's psychiatrist or the Chief Psychiatrist may refuse to comply with the request if satisfied that, having regard to the guidelines published by the Chief Psychiatrist, provision of the additional opinion is unwarranted. However, the reasons for any refusal must be provided to the patient and, in certain circumstances where the patient has requested the further opinion from his or her treating psychiatrist, additional psychiatric opinions may be provided at the discretion of the Chief Psychiatrist.

Clause 176 applies where a further opinion has been obtained and the person who requested it remains dissatisfied. The Chief Psychiatrist may request reconsideration by, and a report from, the patient's psychiatrist. The patient's psychiatrist must comply as soon as practicable and provide the report to the Chief Psychiatrist and the patient and, if another person made the request, that other person. The powers of the Chief Psychiatrist under Part 21, division 2, subdivision 3 to affirm, vary, revoke or substitute a decision by a psychiatrist in relation to an involuntary patient is relevant to this clause.

Division 3 - Treatment, support and discharge planning

Division 3 introduces a requirement for treatment, support and discharge planning. This formalizes and makes mandatory a practice already embedded in mental health services and is designed to provide the patient and persons involved with some knowledge of what to expect from treatment and support provided by mental health services, and to ensure, as far as possible, continuity of care following discharge.

Clause 177 states that Division 3 applies to all involuntary patients (involuntary inpatients and involuntary community patients), and to mentally impaired accused persons required to be detained at an authorised hospital.

Clause 178 requires the preparation of a treatment, support and discharge plan, which is described in the clause. The treatment, care and support provided to a patient must be governed by the plan. It must outline treatment and support to be provided while the patient is being cared for by a mental health service, and the aftercare that will be offered to the patient once they are discharged from involuntary inpatient status or no longer on a CTO. The plan must be 'offered' to the patient, but there is no obligation on the patient to comply with the treatment after discharge (unless they are an involuntary inpatient discharged from hospital to a CTO). There is no corresponding requirement in relation to a voluntary patient. However, best practice would support the creation of such a plan.

Clause 179 requires a patient's psychiatrist to ensure that a plan is prepared as soon as practicable after the patient is admitted, a CTO is made, or the patient is released, in effect discharged from hospital, either by the psychiatrist or the MHT, and that it is reviewed regularly and as necessary. The provision for a patient being 'released' includes provision for referred persons being released from detention if the decision by the examining psychiatrist is to make a CTO or no order at all. The clause sets out administrative procedures to be followed after preparing or reviewing the plan.

Clause 180 identifies who should be involved in preparation and review of the plan and in what circumstances. Patients, whether they have capacity or not, must always be involved and, where appropriate, carers, family members, clinicians and other persons in the community such as staff at a recovery or rehabilitation centre who will play a part in the aftercare of the patient.

Division 4 - Miscellaneous matters

Clause 181 seeks to ensure that the particular needs and circumstances of patients of Aboriginal or Torres Strait Islander descent are taken into account. Treatment must be provided in collaboration with listed groups of people, to the extent practicable and appropriate. It reinforces the

importance of including significant members of the patient's community, including traditional healers, where this is appropriate.

Part 13 Regulation of certain kinds of treatment and other interventions

Division 1 - Electroconvulsive therapy

Division 1 is founded on clinical evidence that ECT has valid therapeutic application in appropriate circumstances. However, the Bill takes account of the fact that there is also concern in some parts of the community regarding this treatment and for that reason, the performance of ECT is regulated in the Bill.

Clause 182 defines ECT.

Clause 183 prohibits performance of ECT on a person other than in accordance with Division 1. The penalty is a fine of $15,000 and two years imprisonment.

Clause 184 prohibits the performance of ECT on children under 14 years of age, reflecting concerns that ECT may not be an appropriate treatment for younger children. This is an important change from the current Act, which does not differentiate between adults and children in regard to the performance of ECT. It is noted that prescribing ECT for people under 18 is very uncommon in Western Australia. To clarify, *clause 188* relating to emergency ECT does not create an exception to *clause 184* because emergency ECT can only be used on an adult.

Clause 185 sets out the requirements for ECT to be performed on a child aged between 14 and 18 who is a voluntary or involuntary patient. Approval from the MHT is required. That is, the same level of oversight is required for ECT on a child who is a voluntary patient as for an involuntary adult patient. Even if a parent or guardian, or the child, gives consent for the treatment, further review by the MHT is required.

Clause 186 sets out the requirements for ECT to be performed on a voluntary patient who is an adult. Informed consent is required from the patient or a substitute decision maker. In relation to the patient, informed consent in the form of an advance health directive is sufficient. *Clause 188* relating to emergency ECT does not create an exception to *clause 186* because emergency ECT can only be performed on an involuntary patient or a mentally impaired accused person required to be detained in an authorised hospital.

Clause 187 sets out the requirements for ECT to be performed on an adult involuntary patient or mentally impaired accused person required to be detained at an authorised hospital. Approval from the MHT is required, unless the ECT is performed as emergency ECT, described in *clause 188*. The change from approval from a second psychiatrist under the current Act, to the MHT in the Bill, is in line with other jurisdictions in Australia. Given that one of the members constituting a hearing of the MHT will be a psychiatrist,

and that there will be two other members, this clause is considered to be an increased safeguard for patients.

Clause 188 provides for emergency ECT on adult involuntary patients and mentally impaired accused persons required to be detained at an authorised hospital. Emergency ECT may be performed where it is needed to save the patient's life or because there is an imminent risk of the patient behaving in a way that is likely to result in serious physical injury to the patient or another person. Approval from the MHT is not required, but approval must be obtained from the Chief Psychiatrist. The rationale is that the MHT may not be able to schedule a hearing to accommodate the urgent need for ECT to be performed. Therefore, the Bill provides that, in the interim, the Chief Psychiatrist can approve ECT until the MHT can consider the matter (under *clause 187*). It is envisaged that this will only be in exceptional circumstances, as the MHT can prioritise a matter such as this. Nevertheless, at times there may be a delay in scheduling a hearing for ECT to be approved, and the patient may require the treatment more urgently, and therefore the Chief Psychiatrist's interim approval may be required. Emergency ECT is permitted under the current Act under provisions for emergency psychiatric treatment.

Clause 189 requires the performance of ECT (under *clause 187* or *188*) on a mentally impaired accused person required to be detained at an authorised hospital to be reported to the Mentally Impaired Accused Review Board as soon as practicable after the ECT has been performed.

Clause 190 recognises the importance of recording of information about ECT performed. Mental health services performing ECT must report statistics to the Chief Psychiatrist monthly. *Clause 190* sets out 11 matters that must be reported, including details of any serious adverse event that occurred during or after ECT being performed on a patient. This is an additional requirement to address the concerns of some stakeholders about the use of ECT. Statistics on ECT will be included in the Chief Psychiatrist's Annual Report.

Division 2 - Emergency psychiatric treatment: voluntary patients

Clause 191 describes emergency psychiatric treatment for the purposes of Division 2. Emergency psychiatric treatment may be given to voluntary patients where it is necessary to save the person's life or prevent serious physical injury to that person or another person. Under the current Act, emergency psychiatric treatment is typically in the form of a psychotropic medication. It is anticipated that this will be the same under the Bill. Emergency psychiatric treatment does not include the other treatments and interventions set out in Part 13. Given that voluntary patients include referred persons and persons detained for assessment or examination, there is nothing preventing the administration of medication on such patients if they meet the criteria. For example, while they are being transported to an authorised hospital and become acutely distressed.

Clause 192 permits a medical practitioner to administer emergency psychiatric treatment to a voluntary patient without informed consent, and despite the voluntary patient's refusal. It is noted that the additional requirements in the *Guardianship and Administration Act 1990* regarding urgent treatment do not apply in relation to emergency psychiatric treatment.

Clause 193 requires comprehensive records of emergency psychiatric treatment given to be kept and provided to the voluntary patient; the Chief Psychiatrist and, if the patient is a mentally impaired accused person required to be detained at an authorised hospital, to the Mentally Impaired Accused Review Board. Statistics regarding the use of emergency psychiatric treatment will be included in the Chief Psychiatrist's Annual Report.

Division 3 - Psychosurgery

Psychosurgery has not been performed in Western Australia since the 1970s. However, provisions in relation to psychosurgery are included in the Bill so as not to deny patients the right to access emerging forms of treatment that may be considered to fall within the definition of psychosurgery. The safeguards in place for psychosurgery under the Bill are more stringent than for any other treatment permitted under the Bill, reflecting concern about the efficacy and safety of psychosurgery.

Clause 194 defines psychosurgery.

Clause 195 creates an offence for performing psychosurgery on a person other than in accordance with Division 3. The offence is prescribed to be a crime with a penalty of 5 years imprisonment.

Clause 196 prohibits the performance of psychosurgery on children under 14 years of age.

Clause 197 sets out the requirements for psychosurgery to be performed. Informed *personal* consent is required, together with approval from a specially constituted MHT which includes a neurosurgeon. Informed consent in the form of an advance health directive is sufficient.

Clause 198 requires the performance of psychosurgery to be reported to the Chief Psychiatrist and, if the person is a mentally impaired accused person required to be detained at an authorised hospital, it must also be reported to the Mentally Impaired Accused Review Board as soon as practicable after the psychosurgery has been performed.

Division 4 - Deep sleep and insulin coma therapy

Clause 199 creates an offence for performing deep sleep therapy, insulin coma therapy, or insulin sub-coma therapy, on a person. The offence is

prescribed to be a crime with a penalty of 5 years imprisonment. These prohibited treatments are also prohibited under the current Act.

Division 5 - Seclusion

Division 5 provides for seclusion in an authorised hospital. There is no provision in the Bill authorising seclusion in a general hospital.

Clause 200 defines some of the terms used in Division 5.

Clause 201 defines seclusion.

Clause 202 creates an offence for keeping a person in unauthorised seclusion. There are two types of authorisation – oral authorisation, and written authorisation (a seclusion order). The provision for oral authorisation recognises the urgent need for seclusion in many situations. However, at times despite the urgency there may be time to complete a written order before the person is placed in seclusion.

Clause 203 provides for an oral authorisation of seclusion by a medical practitioner, a mental health practitioner or the person in charge of a ward and applies to voluntary patients, referred persons and involuntary patients. Following oral authorisation the person who gave the authorisation must complete a seclusion form. If the person who gave the oral authorisation is a mental health practitioner or person in charge of the ward they must as soon as practicable and within 2 hours (pursuant to *clause 211(4)*) inform a medical practitioner.

Clause 204 allows a medical practitioner, mental health practitioner, or person in charge of the ward, to make a seclusion order in relation to specified persons. The provisions in *clause 204* are similar to those in *clause 201* in relation to an oral authorisation, but with additional procedural requirements. Further, where the seclusion order is made by a mental health practitioner or person in charge of a ward, the person must inform a medical practitioner of specified matters, including the reasons for the urgency that justified the mental health practitioner or person in charge of a ward making the seclusion order, as opposed to seeking a seclusion order from a medical practitioner.

Clause 205 prescribes the criteria for authorising seclusion which are that the person needs to be secluded to prevent the patient from physically injuring himself or herself or another person; or persistently causing serious damage to property. The clause reflects the fact that safety issues are important, and that a decision as to the least restrictive method to manage safety issues must be made. *Clause 205* states that a mental health practitioner or the person in of the ward must not give an oral authorisation or make a seclusion order unless the person needs to be secluded urgently and a medical practitioner is not reasonably available to give an oral authorisation or make a seclusion order in respect of the person.

Clause 206 applies where the person secluded has a treating psychiatrist. A referred person, for example, who can be secluded, may not yet have a treating psychiatrist. The treating psychiatrist must be informed of the seclusion, but is not required to attend.

Clause 207 enables a medical practitioner to extend a seclusion order. A Form must be completed, including the reasons for the extension.

Clause 208 provides for revocation of a seclusion order.

Clause 209 requires release of a person upon revocation or expiry of a seclusion order (expiry is subject to a seclusion order having been extended).

Clause 210 requires a Form to be completed when a seclusion order expires.

Clause 211 relates to what must occur while the patient is in seclusion. The patient must be observed at least every 15 minutes by a mental health practitioner or a nurse, including an Enrolled Nurse, and any observations made must be recorded. A copy of the observations noted on the seclusion form must be provided to the patient. The medical practitioner must examine the patient at least every 2 hours and record the results of that examination. The person must be provided with any bedding and clothing appropriate in the circumstances; sufficient food and drink; access to toilet facilities; and any other care appropriate to the person's needs, whilst they are in seclusion. The person in charge of the ward where the person is secluded must ensure that the requirements specified in the clause, and any other requirements prescribed by the regulations for the clause, are complied with.

Clause 212 requires a person to be examined within 6 hours by a medical practitioner after they are released from seclusion. There is an exception where the person has been released, discharged, or has otherwise left the authorised hospital before the end of that period.

Clause 213 requires a report of seclusion to be given to the Chief Psychiatrist. Where a mentally impaired accused person required to be detained at an authorised hospital has been secluded, a report must also be given to the Mentally Impaired Accused Review Board. Statistics on the use of seclusion will be included in the Chief Psychiatrist's Annual Report.

Division 6 - Bodily restraint

Division 6 provides for bodily restraint in an authorised hospital. There is no provision authorising bodily restraint in a general hospital.

Clause 214 defines some of the terms used in Division 6.

Clause 215 describes bodily restraint. It includes physical and mechanical restraint. It does not include chemical restraint. The current Act only refers to 'mechanical bodily restraint'. The term used in the Bill omits the word 'mechanical', because bodily restraint is a well known term and it is commonly used in the mental health profession to include physical restraint and mechanical bodily restraint. The definition is intended to differentiate between bodily restraint and other types of restraint applied for the safety of patients, particularly elderly patients.

Clause 216 creates an offence for using unauthorised bodily restraint on a person. There are two types of authorisation – oral authorisation, and a bodily restraint order.

Clause 217 provides for an oral authorisation of restraint by a medical practitioner, a mental health practitioner or the person in charge of a ward and applies to voluntary patients, referred persons and involuntary patients. Following oral authorisation the person who gave the authorisation must complete a restraint form. If the person who gave the oral authorisation is a mental health practitioner or person in charge of the ward they must as soon as practicable and within 30 minutes inform a medical practitioner. The medical practitioner must examine the patient within 30 minutes whether or not the patient has been released from restraint by the time the examination occurs. Details of the type of restraint authorised and other matters must be included in the Restraint Form and a copy provided to the patient. If no Restraint form is completed the person must be released from restraint within 3 hours. It is expected that clinicians will always be expected to complete a Restraint Form so *clause 217(8)* will be the exception.

Clause 218 allows a medical practitioner, mental health practitioner, or person in charge of the ward at an authorised hospital, to make a bodily restraint order in relation to specified persons. The provisions in *clause 218* are similar to those in *clause 217* in relation to oral authorisation of bodily restraint, but with additional procedural requirements. Further, where the bodily restraint order is made by a mental health practitioner or person in charge of a ward, the person must inform a medical practitioner of specified matters, including the reasons for the urgency that justified the mental health practitioner or person in charge of a ward making the bodily restraint order rather than seeking a bodily restraint order from a medical practitioner.

Clause 219 prescribes the criteria for authorising bodily restraint, which are that the person needs to be restrained to provide the person with treatment; or to prevent the person from physically injuring himself or herself or another person; or prevent the person from persistently causing serious damage to property. *Clause 219* states that a mental health practitioner or the person in charge the ward must not give an oral authorisation or make a bodily restraint order unless the person needs to be restrained urgently and a medical practitioner is not reasonably available to

give an oral authorisation or make a bodily restraint order in respect of the person.

Clause 220 applies when the patient who has been restrained has a treating psychiatrist; the treating psychiatrist does not give the oral authorisation or make the bodily restraint order; and the medical practitioner informed of the restraint under *clause 217* or *218* is not the treating psychiatrist. The treating psychiatrist must be informed where he or she was not the person who gave the oral authorisation or made the seclusion order; and has not already been informed pursuant to *clause 216* or *217*, as soon as practicable and, in any event, within 3 hours of the person being secluded.

Clause 221 recognises that a person's needs may change during a period of bodily restraint. The clause provides for variation of a bodily restraint order. For example, the restraint may need to be more or less restrictive; or the order may need to be extended or shortened.

Clause 222 allows a medical practitioner or mental health practitioner or person in charge of a ward at an authorised hospital to make an order revoking a bodily restraint order in force in respect of a person, followed by specified recording requirements.

Clause 223 requires release of a person upon revocation or expiry of a seclusion order (expiry is subject to a bodily restraint order having been extended pursuant to *clause 221*).

Clause 224 requires a Form to be completed when a bodily restraint order expires.

Clause 225 sets out the requirements that must be complied with while a person is subject to bodily restraint. The person in charge of the ward where the person is restrained must ensure that the requirements specified in the clause, and any other requirements prescribed by the regulations for the clause, are complied with. A mental health practitioner or a nurse, including an Enrolled Nurse, must be in physical attendance on the person at all times and, as soon as practicable, record any observations about the person, and give a copy of those observations to the person. The word 'observation' is to be interpreted as understood in the medical profession. Where a person is restrained for more than 6 hours, a psychiatrist must review the use of bodily restraint on the person. The person must be provided with the items and facilities set out in *clause 225*, including bedding appropriate in the circumstances, food and drink.

Clause 226 requires a person to be examined within 6 hours after they are released from seclusion. If the person is to be released or discharged, or wants to leave the hospital against medical advice (in relation to a voluntary patient) the person must be offered an examination first, to be conducted before the person leaves.

Clause 227 requires a report of bodily restraint to be given to the Chief Psychiatrist. Where a mentally impaired accused person required to be detained at an authorised hospital has been restrained, a report must also be given to the Mentally Impaired Accused Review Board. Statistics on the use of bodily restraint will be included in the Chief Psychiatrist's Annual Report.

Part 14 People in hospitals: health care generally

Division 1 - Examination to assess person's physical condition

Clause 228 relates to the physical condition of persons who are admitted to, or received at, an authorised or general hospital. A physical examination is required within 12 hours of the person being admitted and includes the taking of samples such as blood. The prevalence of certain physical illnesses in persons with a mental illness has been shown to be a significant health issue and this new clause is intended to ensure that the physical health needs of many persons experiencing mental illness are fully met.

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

Clause 229 applies to involuntary inpatients and mentally impaired accused persons required to be detained in an authorised hospital. The clause allows such persons to be provided with urgent non-psychiatric treatment without consent, in line with the *Guardianship and Administration Act 1990*. This is to clarify that a duty of care towards any person who requires urgent medical treatment overrides issues of consent. Where treatment is given under *clause 228*, a report must be provided to the Chief Psychiatrist and, if the patient is a mentally impaired accused person required to be detained in an authorised hospital, the Mentally Impaired Accused Review Board.

Part 15 Protection of patients' rights

The Bill expands patients' rights from those under the current Act. The ability of a psychiatrist to prevent an involuntary patient voting in any State election has been deleted.

Division 1 - Patients' rights generally

Subdivision 1 – Explanation of rights:

Clause 230 sets out the persons to whom Subdivision 1 applies. In broad terms, this includes in-patients both voluntary and involuntary, people on CTOs and people referred for an examination.

Clause 231 requires the person responsible under *clause 233* to explain a person's rights to them. The explanation must be communicated in a way that enables the person to understand with the use of an interpreter if necessary and practicable.

Clause 232 requires the person responsible under *clause 233* to explain a person's rights to another person such as a carer, close family member or other personal support person. The explanation must be communicated in a way that enables that other person to understand with the use of an interpreter if necessary and practicable.

Clause 233 puts the onus on persons identified in the clause such as psychiatrists and medical practitioners to ensure that the above explanations are provided.

Subdivision 2 – Access to records about patients and former patients:

Clause 234 defines the term 'relevant document' for the purposes of Subdivision 2.

Clause 235 gives a person who is being provided with, or was provided with, treatment or care by a mental health service the right to inspect and be provided with a copy of any relevant document that the mental health services has. The mental health service may refuse to provide access in circumstances set out in *clause 236*. This clause applies in addition to rights that exist under other laws, such as the *Freedom of Information Act 1992* which allows or prevents a person obtaining access to their medical record.

Clause 236 sets out the circumstances in which a person is not entitled to be given access to a whole or part of a document under *clause 235*. Those circumstances take account of possible adverse effects that access could have on a patient; as well as the need for protection of personal information regarding other persons, and confidential information, that may be included in a relevant document.

Clause 237 states that, where a person has been refused access to a relevant document, the person may nominate a medical practitioner and/or legal practitioner who can be given access to the relevant document.

Clause 238 prohibits a medical practitioner or legal practitioner granted access under *clause 237* from disclosing information to the person.

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

Clause 239 defines 'mental health service' to include a private psychiatric hostel for the purposes of Subdivision 3 only. This definition is in addition to the mental health services identified in *clause 4*.

Clause 240 creates an offence for a staff member of a mental health service who ill-treats or wilfully neglects a person who the Chief Psychiatrist is responsible for such as a voluntary or involuntary patient, referred person, a mentally impaired accused person in an authorised hospital or an identified person residing in a private psychiatric hostel. The penalty has more than doubled from that in the current Act. This offence may be addition to legal actions under other laws.

Clause 241 creates a mandatory requirement whereby a staff member of a mental health service must report any reasonable suspicion of unlawful sexual contact, or unreasonable use of force, by a staff member, against a person such as voluntary and involuntary patients, referred persons, mentally impaired accused required to be detained in an authorised hospital, and identified persons in private psychiatric hostels. The report is made to the person in charge of the mental health service or the Chief Psychiatrist. It is noted that unreasonable use of force is of a higher threshold than an 'assault'. Day-to-day interactions and functions carried out in the course of duty by staff in relation to patients such as restraining a patient do not in themselves constitute 'unreasonable force' for the purposes of Division 1. However, even in those situations a staff member may reasonably suspect the use of unreasonable force.

Division 2 - Additional rights of inpatients in hospitals

Subdivision 1 – Admission of voluntary inpatients by authorised hospitals:

Clause 242 states that a voluntary patient can only be admitted as an inpatient of an authorised hospital by a medical practitioner.

Clause 243 requires an admission under *clause 242* to be confirmed by a psychiatrist.

Clause 244 states that, where a medical practitioner refuses to admit a person to a mental health service, or a psychiatrist refuses to confirm an admission of a person as a voluntary patient, the person must be given reasons for the refusal, and is entitled to make a complaint.

Subdivision 2 – Rights of inpatients generally:

Clause 245 states that Subdivision 2 applies to involuntary inpatients and mentally impaired accused persons required to be detained at an authorised hospital.

Clause 246 allows patients to retain their personal possessions in an authorised hospital, except in circumstances where this may pose a risk to the patient or other persons. The clause also deals with what happens where a person leaves any possessions when they are discharged from an authorised hospital.

Clause 247 provides patients in hospitals with a right to interviews with a psychiatrist and sets out procedures in relation to this. There is an exception in relation to patients who have a history of making repeated requests where the psychiatrist is satisfied that the patient is acting unreasonably in making the request.

Clause 248 gives patients the right to lawful communication such as use of telephones, email and postal services, subject to *clause 249*.

Clause 249 allows a psychiatrist to restrict a patient's right under *clause 248* where the restriction is in the patient's best interests. However, visits with a legal practitioner or mental health advocate can be restricted only in the exceptional circumstances set out in *clause 249*. In this case, there must be a serious risk to safety of the legal practitioner or advocate and there are no steps that could reasonably be taken to reduce that risk. The psychiatrist who makes the order restricting the patient's right under *clause 248* must give a copy of the order to the patient and to one of the other persons specified in the clause.

Division 3 - Nominated persons

For the first time in Western Australia, a patient is able to formally choose another person (such as a family member or friend) to help ensure that the patient's rights are observed, to provide independent assistance to the patient, and to ensure that the patient's interests are taken into account. This other person is called a nominated person.

Subdivision 1 – Purpose and effect of nomination:

Clause 250 describes the role of the nominated person, as stated above.

Clause 251 sets out some of the entitlements of the patient in relation to the nominated person, and entitlements of the nominated person themselves. These entitlements include uncensored communications between the patient and the nominated person, involvement, and exercising of rights on behalf of the patient. A nomination, in itself, does not authorise the nominated person to admit or discharge the patient, or to make a

treatment decision on the patient's behalf. *Clause 251* is subject to *clauses 249, 253* and *256*.

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

Clause 252 states that Subdivision 2 does not apply to the notification of an event to which Part 9 applies. That is, the entitlements in Subdivision 2 are in addition to the nominated person's rights under Part 9.

Clause 253 sets out the information that a nominated person is entitled to, and matters that they are entitled to be involved in, subject to *clause 256*.

Clause 254 places the onus on the patient's psychiatrist to ensure that the nominated person has their entitlements observed, subject to other provisions in the Bill that place the onus on another person.

Clause 255 provides for situations where a nominated person cannot be identified or contacted. Reasonable efforts need to have been made to identify the nominated person and to provide them with information or to involve them in a matter, as the circumstances provided for in the clause require.

Clause 256 creates an exception to a nominated person's rights under *clause 251* where provision of information, or involvement in matters, would not be in the patient's best interests. The clause sets out procedures and protections in relation to this.

Clause 257 states that Subdivision 2 does not affect a nominated person's entitlements, under the Bill or elsewhere, to be provided with information in another capacity. For example, a child's nominated person may also be the child's parent or guardian.

Subdivision 3 – Making and ending nomination:

Clause 258 allows any person, including a child, to make a nomination, provided that they understand the effect of making the nomination.

Clause 259 restricts eligibility to be a nominated person to a person who has reached 18 years of age.

Clause 260 lists the formal requirements for making a nomination, including witnessing requirements.

Clause 261 clarifies that a person may only have one nominated person.

Clause 262 states that a person who made a nomination can revoke it at any time, by any means whatsoever, including by making another nomination. It is noted that *clause 409* provides for the MHT to revoke a nomination (if satisfied that the nominated person is not an appropriate person).

Clause 263 allows a nominated person to resign a nomination.

Clause 264 deals with notification of revocation of a nomination, and resignation of a nominated person, whereby a nominated person must notify the mental health service, or a mental health service must take reasonable steps to notify a nominated person, as the case requires.

Part 16 Recognition of rights of families and carers

The current Act is silent on the roles and rights of close family members and carers in the lives of persons experiencing mental illness.

Provisions promoting increased participation of close family members and carers feature prominently throughout the Bill, particularly in Part 16.

Part 16 refers to 'persons', rather than 'patients', recognising the role of close family members and carers with respect to referred and detained persons.

Division 1 - Role of families and carers

Clause 265 lists general principles with respect to Part 16, including recognition that, even though a family member may be a person's carer, the person may not identify the family member as a carer, or the family member may not identify him or herself as the person's carer.

Clause 266 identifies 'close family members', for the purposes of the Bill.

Clause 267 requires acknowledgement of, and respect for, the role of close family members and carers.

Clause 268 requires compliance with provisions in the Bill with respect to one close family member or carer. That is, where a person has more than one close family member or carer involved in their treatment, care and support, it is sufficient for a mental health service to inform and involve one of those people in accordance with Part 16.

Division 2 - Right to information about, and to be involved in, patient's care and treatment

Clause 269 states that Division 2 does not apply to the notification of an event to which Part 9 applies. That is, the entitlements in Division 2 are in addition to the person's rights under Part 9.

Clause 270 lists what information close family members and carers are to be provided with, and what matters close family members and carers are entitled to be involved in.

Clause 271 states that, where a voluntary patient has capacity to consent to the provision of treatment the involvement of the close family member or carer can be granted only with the consent of the voluntary patient.

Clause 272 is the converse of *clause 271*. Where a voluntary patient does not have capacity to consent, the close family member or carer may be informed or involved with or without the patient's consent unless it is not in the best interest of the patient.

Clause 273 states that, where an involuntary patient or mentally impaired accused person required to be detained at an authorised hospital has capacity to consent to the provision of treatment to, or involvement of, their close family member or carer, the close family member or carer can be informed or involved only with the consent of the patient, or where the patient has unreasonably refused to give consent.

Clause 274 is the converse to *clause 273*. Where an involuntary patient or mentally impaired accused person required to be detained at an authorised hospital does not have capacity to consent, the close family member or carer may be informed and involved with or without the patient's consent unless it is not in the best interest of the patient.

Clause 275 requires the patient's psychiatrist to inform and involve a close family member or carer, unless another provision of the Bill places that responsibility on another person. *Clause 277* creates an exception to this.

Clause 276 describes the reasonable efforts that must be made to identify and contact a carer or close family member. Reasonable and continuing efforts need to be made by the service to comply with this clause, however, if despite the efforts made, no person can be identified or contacted it is also reasonable for the person responsible to conclude that no carer, close family member or other personal support person can be identified and provided with the information or involved in the matter.

Clause 277 recognises an interface between acknowledging and respecting the rights of close family members and carers, and acting in the best interests of the patient. *Clause 277* gives a psychiatrist discretion to withhold information where he or she reasonably believes that to comply with *clause 272* or *274* would not be in the best interests of the patient. As a safeguard against clinicians omitting to provide information or involve close family members or carers where they do not have adequate grounds to do so, *clause 277* sets out additional accountability measures in relation to a decision not to inform or involve a close family member or carer.

Clause 278 states that Division 2 does not affect any right of a close family member or carer to be informed or involved (under the Bill or elsewhere), that the close family member or carer has in another capacity. For example, a child's carer could also be the child's parent or guardian, and would therefore have the rights of the guardian pursuant to the *Guardianship and Administration Act 1990*.

Division 3 - Identifying close family member or carer of person admitted by or received at mental health service

Clause 279 requires the person in charge of the mental health service to ensure that every person admitted by or received at a mental health service is asked whether or not they have a close family member (as defined in *clause 266*) or carer and, if they do have such a person, whether or not they

give consent to the close family member or carer being informed and involved as prescribed in *clause 270*.

Clause 280 requires a patient who has refused consent under *clause 279* to be asked periodically whether or not they now consent.

Clause 281 clarifies that a person can, at any time, withdraw or give consent to their close family member or carer being informed or involved.

Part 17 Children

The Holman Review recommended in the review of the *Mental Health Act 1996* a specific Part dealing with the protection of people under 18 years old receiving treatment and care for mental illness from a mental health service. Part 17 has been inserted into the Bill in response to that recommendation. However, it does not set out all of the rights and protections for children, as they are more easily referred to in the relevant Parts throughout the Bill. Part 17 sets out only broad provisions that apply to children and not adults. For example, Part 20 affords children the right to regular reviews of involuntary patient status. No minimum age limit is set for the application of the Bill in general except in relation to ECT and psychosurgery.

Clause 282 enshrines a best interests principle in the Bill whereby, in performing a function under the Bill in relation to a child, the best interests of the child must be a primary consideration.

Clause 283 provides that, in performing a function under the Bill in relation to a child, regard must be had to the child's wishes, to the extent that it is practicable to ascertain those wishes.

Clause 284 recognises that the role of family members and other support persons in the decision making process is central to discussion surrounding the treatment of children. The clause provides that, in performing a function under the Bill in relation to a child, regard must be had to the views of the child's parent or guardian.

Clause 285 applies to a child who is a voluntary patient. If the child has the requisite capacity to make an application for admission or discharge for him or herself, the child may make such an application. If the child does not have that capacity, the child's parent or guardian may make an application. The same applies in relation to a treatment decision for the child. It is noted that Part 5 sets out what is required to show that a child has the capacity to make a decision about applying for admission or discharge, or a treatment decision.

Clause 286 relates to children who are inpatients in a mental health services and their segregation from adults. It is preferable for children to receive services in a children's hospital or in a part of the hospital separate from adults. However, if the person in charge of the hospital feels it is appropriate given the child's age, maturity, gender, culture and spiritual beliefs, for them to receive services in a part of the hospital where adults are also admitted then that is allowable. In those circumstances the person in charge of the hospital may take steps such as having a chaperone for the child, or locating the child in a single room easily supervised from the nurses' station. The reason for this flexibility is that there is currently only one authorised hospital specifically catering for children and, for example, where a child is living in a rural area and needs to be admitted to an

authorised hospital, it would not be in the child's best interests to transport him or her to the metropolitan area for admission to that hospital. When a child is admitted to a mental health service that is not specifically for children, the person in charge of the mental health service must provide a written report as to why admission to the adult facility was felt to be appropriate and what measures have been taken to protect the child and meet the child's individual needs in relation to treatment and care. The report must be provided to the child's parent or guardian and to the Chief Psychiatrist, and a copy of the report must be placed on the child's medical record. *Clause 286* notes that Part 16 applies to a child's carer who is not also the child's parent or guardian.

Part 18 Complaints about mental health services

The existing role of the Health and Disability Services Complaints Office (HaDSCO) is strengthened in the Bill. The changes incorporate Holman recommendations.

For the most part, the provisions of Part 18 of the Bill reflect Part 6 of the *Disability Services Act 1993* (which relates to complaints about some disability services), but with the amendments necessary to apply to mental health services.

For the purposes of the explanation of this Part, reference to HaDSCO is reference to the Director of HaDSCO, with the necessary changes.

Division 1 - Preliminary matters

Clause 287 defines some of the terms used in Part 18. The meaning of 'mental health service' in Part 18 includes a service provided specifically for carers of people who have a mental illness, as well as a service provided specifically for people who have or may have a mental illness. 'Service provider' in Part 18 means an individual, individuals or a body that renders or provides mental health services, but does not include the Chief Psychiatrist, a mental health advocate or the Mental Health Tribunal. Complaints about these excluded bodies can be made to the Ombudsman, or to the Mental Health Commission, as the department principally assisting the Minister in the administration of the Bill.

Clause 288 provides an express right for a person to make a complaint about a mental health service to the service itself, or to HaDSCO. A person may make a complaint under Part 18 even if they do not believe they have (or may have) a mental illness or do not consider themselves to be a 'carer'.

Division 2 - Complaints to service providers

Clause 289 requires mental health services to maintain a complaints procedure, and to ensure it is readily available to others.

Clause 290 requires mental health services prescribed by the regulations to report complaints to HaDSCO every year. Failure to do so is an offence. This clause is based on section 75 of the *Health and Disability Services (Complaints) Act 1995*. Regulation 4 subsidiary to that Act prescribes providers and classes of providers, being the CEO of the department of the Public Service principally assisting in the administration of the *Prisons Act 1981*; the CEO of St John Ambulance (Western Australia); the CEO of the Royal Flying Doctor Service (Western Australia); and the CEO of Silver Chain Nursing Association Incorporated.

Division 3 – Complaints to Director of Complaints Office

Subdivision 1 – Preliminary matters:

Clause 291 requires Division 3 to be read in conjunction with the *Health and Disability Services (Complaints) Act 1995*, the legislation that establishes HaDSCO.

Clause 292 allows parties to a complaint made to HaDSCO to resolve the complaint themselves, or with the help of HaDSCO, before or during the complaint being investigated by HaDSCO. If this happens, the complainant is to notify HaDSCO without delay and HaDSCO must stop dealing with the complaint.

Subdivision 2 – Director of Complaints Office:

Clause 293 sets out HaDSCO's functions, which are broadly in line with HaDSCO's existing duties.

Clause 294 requires HaDSCO to comply with any general policy directions issued by the Minister in relation to the performance of functions under the Bill. For example, the Minister may direct HaDSCO to inquire into a specified systemic issue. HaDSCO may also request the Minister to issue a direction about general policy to be followed.

Clause 295 requires HaDSCO to share specified information relating to the functions of HaDSCO with the Minister. This extends to allowing the Minister to access personal information, without the need for informed consent by parties.

Subdivision 3 – Right to complain:

Clause 296 identifies persons who can make a complaint to HaDSCO under Part 18. The type of complaint determines who can make a complaint.

Clause 297 identifies persons who are representatives of a person who has or may have a mental illness, for the purposes of Part 18. A representative must be acting without remuneration and, except for relatives, must not have a financial interest in the outcome of the complaint. Mental health advocates may, however, act as a representative.

Clause 298 prohibits a representative (other than a mental health advocate or a person prescribed by the regulations to act as a representative) from demanding or receiving payment for acting as a representative.

Clause 299 allows a service provider to make a complaint about another service provider on behalf of a person who has or may have a mental illness, if that person has died or is unable to make the complaint due to ill health or other reason.

Clause 300 allows a registration board to complain on behalf of a person who has or may have a mental illness or on behalf or that person's carer, in specified circumstances.

Clause 301 prescribes what can be complained about.

Clause 302 limits the time for complaining to two years, subject to an extension by HaDSCO where the complainant has shown good reason for delay.

Subdivision 4 – Initial procedures:

Clause 303 sets out an informal procedure for making a complaint, which may be oral or in writing. An oral complaint must be confirmed in writing, unless the complainant has good reason for not doing so.

Clause 304 prevents a complaint being made against a mental health service that is provided without fee in a rescue or emergency situation, such as the existing Mental Health Emergency Response Line, to HaDSCO. Where a complaint relates to such a service, HaDSCO may, with consent of the complainant, refer the complaint to an appropriate person or body, such as the responsible department or the Ombudsman.

Clause 305 clarifies that a complainant may withdraw a complaint at any time, and what HaDSCO is to do following withdrawal.

Clause 306 encourages resolution of complaints between the parties themselves by allowing HaDSCO to reject the complaint if reasonable steps have not been taken to resolve the matter.

Clause 307 allows HaDSCO to deal with a complaint about a service provider if it cannot be dealt with by a National Board under the *Health Practitioner National Law (WA) Act*.

Clause 308 sets out what happens in relation to a complaint about a health practitioner that is being dealt with by a National Board under the *Health Practitioner National Law (WA) Act*. HaDSCO must notify the complainant that the National Board is dealing with the complaint.

Clause 309 sets out what HaDSCO must do upon receiving a complaint other than a complaint about a health practitioner that is being dealt with by a National Board. HaDSCO must accept, reject, defer or refer the complaint depending on the circumstances.

Clause 310 sets out the circumstances in which HaDSCO must reject, defer or refer a complaint. It must defer the complaint if it is already being dealt with, or, with the written consent of the complainant, refer it to a more appropriate body or person (other than a National Board or a court) to deal with it.

Clause 311 sets out the procedures and time periods with which a respondent to a complaint must comply.

Subdivision 5 – Negotiated settlements and conciliation:

Clause 312 allows HaDSCO to resolve complaints by negotiating settlements and sets out the relevant procedures.

Clause 313 enables the appointment of a HaDSCO conciliator, and sets out relevant requirements, functions and procedures for conciliation.

Subdivision 6 – Investigations:

Clause 314 provides that HaDSCO may, at any time during an investigation, encourage settlement of a complaint. The purpose of investigations by HaDSCO is to assist HaDSCO to decide whether or not specified unreasonable conduct has occurred. The clause also sets out procedural matters for the conduct of an investigation, promoting informality within the bounds of the rules of natural justice.

Clause 315 enables HaDSCO to obtain relevant information and records from a person that are required for an investigation. Failure to provide information and records is an offence, unless one of the exceptions in the clause applies.

Clause 316 permits HaDSCO to apply for a warrant to enter and inspect premises, under the *Health and Disability Services (Complaints) Act 1995*. The offences relating to warrants prescribed in the *Health and Disability Services (Complaints) Act 1995* also apply for the purposes of the Bill, with a higher penalty of a $6,000 fine. This brings the penalty in line with the other penalties in the Bill, and recognises that fines were lower when the *Health and Disability Services (Complaints) Act 1995* was drafted.

Clause 317 prevents a conciliator who has conciliated, or attempted to conciliate, a complaint, from investigating that complaint.

Subdivision 7 – Consequences of investigation:

Clause 318 requires HaDSCO, on completing an investigation, to make a decision whether any unreasonable conduct has occurred and provide written notice of the decision in accordance with the clause.

Clause 319 requires a person who receives a notice under *clause 318* to take remedial action and report this to HaDSCO. Failure to do so within the specified time of 45 days is an offence. HaDSCO has broad powers to extend this period if it considers it appropriate to do so.

Clause 320 requires HaDSCO to report to the Minister on whether or not a person has taken remedial action required by HaDSCO, and the nature of the remedial action taken. Personal information about a complainant must not

be included in the report without the complainant's consent. The Minister has discretion to table the report in Parliament.

Subdivision 8 – Other matters relating to investigations:

Clause 321 deals with a situation where HaDSCO becomes aware that a complaint is being dealt with under another provision of the Bill; another written law; a law of the Commonwealth; or in a court. HaDSCO must stop dealing with the complaint, and must notify the complainant and respondent.

Clause 322 provides the Minister with discretion to direct HaDSCO to conduct an investigation if the Minister is of the opinion that circumstances exist in relation to a person who has or may have a mental illness that justify a complaint being made, or it would be in the public interest.

Clause 323 is a confidentiality clause relating to information obtained in relation to a complaint, which is broadly consistent with the *Health and Disability Services (Complaints) Act 1995*.

Division 4 - Miscellaneous matters

Clause 324 provides HaDSCO with the discretion to table a report in Parliament on a matter arising from performance of HaDSCO's functions under the Bill. Personal information about a person must not be included in the report without the person's consent. For the avoidance of doubt, the clause states that it does not limit the *Financial Management Act* Part 5, which deals with reports about agencies, amongst other things.

Clause 325 creates an offence for providing information or documents to HaDSCO that, to the provider's knowledge, are false or misleading information or documents.

Clause 326 prohibits a person from, by threats or intimidation, persuading or attempting to persuade another person, in relation to not making a complaint, withdrawing a complaint, discontinuing proceedings, or not providing information or otherwise assisting HaDSCO in performing its functions. The clause also prohibits a person from being penalised for making a complaint to HaDSCO and similar listed situations.

Clause 327 requires HaDSCO to establish and maintain a register of complaints, together with matters referred by the Minister for investigation.

Clause 328 gives the Director of HaDSCO the right to delegate to HaDSCO staff. The delegate cannot sub delegate.

Part 19 Mental health advocacy services

Advocacy support for involuntary patients and residents of private psychiatric hostels is presently provided by the Council of Official Visitors. Because individual Visitors are appointed by the Minister, the Head of the Council has limited control over how functions are performed. To encourage consistency, the Council of Official Visitors is to be replaced by a statutory office of Chief Mental Health Advocate, who will be empowered to engage or appoint professional advocacy service providers. The Chief Mental Health Advocate will not have specific facilities inspection powers, they will still be expected to consider, and report on, issues relating to the physical environment of facilities that impact upon consumers.

It is implied in the provisions of Part 19 that the treating team remain in charge of the treatment and care of the patient.

Division 1 - Preliminary matters

Clause 329 defines 'identified person' for the purposes of Part 19, being the categories of persons to whom advocacy services will be provided.

This clause extends the categories of persons who can access advocacy support from the current Act to include referred persons and, in some circumstances, other classes such as sub-groups of voluntary patients if directed by the Minister.

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

Subdivision 1 – Appointment, functions and powers:

Clause 330 creates the statutory office of the Chief Mental Health Advocate, appointed by the Minister (effectively Cabinet).

Clause 331 enables the Chief Mental Health Advocate to engage or appoint mental health advocates. The clause requires the appointment of at least one mental health advocate who has qualifications, training or experience relevant to children and young people (a youth advocate). It is anticipated that the Chief Mental Health Advocate will also engage advocates with specialist expertise in working with a range of groups in our community, including indigenous people, and those with co-occurring issues such as intellectual disability.

Clause 332 describes the functions of the Chief Mental Health Advocate.

Clause 333 sets out the functions of mental health advocates. Some of the functions listed are mandatory; others are discretionary or subjective, or both. Functions include visiting or otherwise contacting identified persons in accordance with *clause 337*. The functions do not include inspecting mental health services, as prescribed in the current Act. The rationale for this is that the core function of advocates is individual advocacy. However, their

functions do include inquiring into and investigating any matter relating to the physical environment of a mental health service that impacts on the safety and/or wellbeing of identified persons.

Clause 334 empowers a mental health advocate to do anything necessary or convenient for the performance of functions under the Bill.

Clause 335 gives the Minister the power to issue directions of a general policy nature. For example, it allows the Minister to include additional classes of voluntary patients in the scope of the work of the service. The CEO of the Commission has the authority to issue directions about administrative policies and procedures. Examples could include compliance with Public Sector policies and procedures, contracting requirements and budget management. This provides for more transparency and accountability and will ensure due diligence in public administration is adhered to and is implicit in the current Act.

Subdivision 2 – Contacting identified person or person with sufficient interest:

Clause 336 enables specified persons to request a mental health advocate to contact an identified person. Those persons are the identified person, the identified person's psychiatrist, and a person who has a sufficient interest in the identified person.

Clause 337 creates a duty for a mental health advocate to contact an identified person within specified time limits. The listed duties are mandatory, as opposed to the functions under *clause 333* and the powers under *clause 334*. The current Act does not include such a duty, and the time limits in the Bill are considered to be sufficiently short; with requirements for initial contact of identified persons who are adults within 7 days, and identified persons who are children within 24 hours. That is, initial contact will be within 7 days or 24 hours and, after initial contact, within the timeframe specified in *clause 337* in relation to a request under *clause 336*.

Clause 338 allows a mental health advocate to contact an identified person on the mental health advocate's own initiative, or the initiative of another mental health advocate (including the Chief Mental Health Advocate) unless there is a direction from the Chief Mental Health Advocate to the contrary.

Subdivision 3 – Specific powers of mental health advocates:

Clause 339 vests specific powers in mental health advocates, including the power to inspect any part of a mental health service that they visit. *Clause 339* also creates a default position that a mental health advocate can see, speak with, and access records of, an identified person. The powers of a mental health advocate in this regard will be overridden by a patient who objects to any of these powers being exercised with respect to them.

Clause 340 allows a mental health service to prevent a mental health advocate from disclosing information to a patient where access by the patient has been restricted for the reasons specified in Part 15.

Clause 341 creates an offence for a mental health advocate to disclose information to a patient in circumstances set out in *clause 336*.

Clause 342 sets out offences in relation to a person who interferes with a mental health advocate's exercise of powers.

Clause 343 allows a mental health advocate to attempt to resolve issues by dealing directly with staff members of a mental health service.

Division 3 - Mental health advocates: terms and conditions of appointment

Subdivision 1 – Chief Mental Health Advocate:

Clause 344 provides for the term of appointment of the Chief Mental Health Advocate, not exceeding 5 years, with eligibility for reappointment.

Clause 345 states that the Chief Mental Health Advocate is entitled to the remuneration determined by the Minister on the recommendation of the Public Sector Commissioner. Remuneration is defined in *clause 4*.

Clause 346 sets out how the Chief Mental Health Advocate may resign, being to the Minister.

Clause 347 gives the Minister the power to remove a person from the position as Chief Mental Health Advocate in circumstances set out in the clause.

Clause 348 gives the Minister the power to appoint an Acting Chief Mental Health Advocate for up to 12 months. The clause also confirms the validity of anything done by an Acting Chief Mental Health Advocate in circumstances specified in the clause, such as where there is a defect of irregularity in the appointment.

Subdivision 2 – Other mental health advocates:

Clause 349 provides for the terms and conditions of engagement or appointment of mental health advocates other than the Chief Mental Health Advocate. This clause allows for flexible arrangements to cater for the different requirements across the State and for advocates with different skills and experiences to meet the needs of consumers, such as people of Aboriginal or Torres Strait Islander descent, young people and people from culturally and linguistically diverse backgrounds.

Clause 350 sets out how a mental health advocate other than the Chief Mental Health Advocate may resign, being to the Chief Mental Health Advocate.

Clause 351 gives the Chief Mental Health Advocate the power to remove a person from a position of mental health advocate in circumstances set out in the clause.

Division 4 - Mental health advocates: miscellaneous matters

Division 4 relates to all mental health advocates, including the Chief Mental Health Advocate.

Clause 352 sets out circumstances in which a mental health advocate will be considered to have a conflict of interest. The mental health advocate cannot perform functions as a mental health advocate in relation to an identified person where the mental health advocate has a conflict of interest.

Clause 353 requires mental health advocates to be issued with, and display, an identity card. It is noted that section 87 of the Criminal Code makes it an offence to impersonate a public officer.

Clause 354 allows the Chief Mental Health Advocate to delegate powers or duties to any advocacy services officer (as defined in the clause). The delegate cannot sub delegate.

Division 5 - Staff and facilities

Clause 355 requires advocacy services staff to be appointed as public service officers to assist the Chief Mental Health Advocate.

Clause 356 allows the Chief Mental Health Advocate to use government staff and facilities provided for in the clause.

Division 6 - Annual Reports

Clause 357 requires the Chief Mental Health Advocate to provide an Annual Report to the Minister at the end of each financial year.

Clause 358 requires the Minister to table the Annual Report in Parliament within 21 days of receiving it, strengthening transparency and accountability.

Part 20 Mental Health Tribunal (MHT)

The current Act established the Mental Health Review Board (MHRB). The MHRB essentially deals with review of involuntary treatment orders and the Board has the power to overturn the decision of a psychiatrist and make an involuntary patient no longer involuntary.

The MHT will replace the MHRB under the Bill. The core function of reviewing involuntary treatment orders will remain. Reviews will occur earlier and more frequently than under the current Act. The MHT will also conduct reviews in relation to regulated treatments such as ECT and psychosurgery; review and provide recommendations in relation to the extent to which patients' treatment, support and discharge plans meets the requirements of the Bill; and issue compliance notices where a mental health service has not complied with a prescribed statutory obligation.

Division 1 - Preliminary matters

Clause 359 defines some of the terms used in Part 20.

Division 2 - Establishment, jurisdiction and constitution

Clause 360 establishes the MHT.

Clause 361 states that the MHT has the jurisdiction conferred on it by Part 20.

Clause 362 requires the MHT to be, subject to *clauses 363* and *364*, constituted by the members specified by the President of the MHT, when exercising its jurisdiction.

Clause 363 relates to the constitution of the MHT for reviews, other than for psychosurgical matters. Reviews will always be constituted by a legal practitioner; psychiatrist; and a member who is not a legal practitioner, medical practitioner, nor a mental health practitioner who currently works at a mental health service and informally referred to as the Community Member. The clause is based on the current Act, but introduces a new limitation placed on mental health practitioners working at a mental health service from being a member. It is intended that the third member specified will effectively ensure that community standards and expectations are upheld by the MHT, so the new limitation is considered to be necessary to avoid any bias and conflicts of interest. *Clause 363* also introduces an expectation that, for reviews relating to children, a child and adolescent psychiatrist will be involved. There is an exception where a child and adolescent psychiatrist is not available. In such a situation, there must be a psychiatrist, but there is nothing preventing the views of a child and adolescent psychiatrist, or a person who a medical practitioner or mental health practitioner who has experience relevant to children, from being sought.

Clause 364 sets out the constitution of the MHT for psychosurgical matters. In addition to the members in *clause 362*, a neurosurgeon and an additional psychiatrist are required. In the unlikely event that that the patient is a child, a child and adolescent psychiatrist is required.

Clause 365 enables two or more types of reviews, differently constituted in accordance with *clauses 363* and *364*, to be conducted at the same time.

Division 3 - Involuntary treatment orders: review

Clause 366 requires that, subject to some narrow exceptions, the MHT is to *commence* (to allow for adjournments, for example to obtain a further psychiatric opinion or more information) an initial review of an involuntary patient order as soon as practicable and, in any event, within the specified time limits. For an adult, the time limit is 35 days reduced from 56 days under the current Act; for a child, the time limit is 10 days. The MHT must consider whether or not the criteria for an involuntary treatment order are still met.

Clause 367 provides for periodic reviews while an order is in force. Reviews must be *commenced* by the MHT within specified time limits, which vary depending on the circumstances. In general, this is 3 months for adults and 28 days for children. The MHT must consider whether or not the criteria for an involuntary treatment order are still met. It is noted that the periodic review period for a CTO is 3 months, being the same as the maximum of period of a CTO (subject to a continuation order being made). This takes account of logistical problems in prescribing more frequent reviews, particularly in remote areas. However, reviews can always occur sooner than the maximum time limits.

Clause 368 relates to *clauses 366* and *367*. *Clauses 367* and *368* provide an exception where an involuntary patient has not been an involuntary patient for a continuous period. It explains the requirement for an involuntary patient to be considered to have been an involuntary patient for a continuous period which is a gap of 7 days or less between two orders.

Clause 369 enables the MHT to extend the review period in *clauses 363* or *364* outside the specified time limits but not beyond the time limits in *clause 366*, in circumstances where the MHT has already reviewed the involuntary patient within the prescribed period.

Clause 370 allows an involuntary patient or other persons specified in the clause to request a review at any time, but it will not be conducted if it would be within the number of days from the time the MHT has already made a decision that is specified in the clause. In other words if the MHT have conducted a mandatory (or requested) review and then the patient requests a review then the review in relation to an adult need not be scheduled for a period of 28 days or for a child 7 days. An involuntary

patient can also request a review in relation to other specified matters, including a change of psychiatrist, or transfer between authorised hospitals.

Clause 371 enables the MHT to conduct a review of certain matters on its on initiative.

Clause 372 allows the MHT to suspend an involuntary patient order pending a review.

Clause 373 identifies who the parties to the proceeding will be. To clarify, the persons expressing their views are not considered to be parties to a proceeding. This is the case for all provisions relating to parties to proceedings in Part 20. *Clause 373*, and other provisions in Part 20 specifying the parties to proceedings, does not necessarily require that all of these people attend a MHT hearing. Even a patient cannot be obliged to attend a part or full hearing. For example, where the person is unwilling or unable to attend, or where the person is an involuntary community patient where the MHT has forwarded a notice of hearing to the patient's last known address and the patient has changed residences.

Clause 374 sets out the matters to which the MHT must have regard when conducting a review. They include the patient's wishes and the patient's treatment, support and discharge plan, amongst other things.

Clause 375 allows the MHT to make orders and give directions upon completing a review under Division 3. The MHT cannot make orders or give directions in relation to a treatment, support and discharge plan, but may make recommendations for review and amendment by the patient's psychiatrist. That is, the MHT's role in relation to treatment, support and discharge plans is to ensure that the plans exist and that they meet the guidelines published by the Chief Psychiatrist under *clause 513*. There is no requirement in *clause 449* that the patient's psychiatrist give effect to a recommendation in relation to a treatment, support and discharge plan. A copy of the MHT recommendation in relation to a treatment, support and discharge plan may also be given to the Chief Psychiatrist.

Clause 376 gives psychiatrists to whom the MHT has given a direction to make an involuntary detained patient subject to a CTO the right to apply to the MHT for a review of the direction.

Division 4 - Involuntary treatment orders: declarations about validity

Clause 377 states that Division 4 applies to treatment orders, being involuntary treatment orders, continuation orders, and variations of CTOs.

Clause 378 enables the MHT to, on the application of a person specified in *clause 379* or on its own initiative, declare that a treatment order is valid or invalid, or make an order varying the terms of the treatment order in the manner the Tribunal considers most likely to give effect to the intention of the psychiatrist who made the treatment order. The MHT cannot make a

declaration that a treatment order is valid if the treatment order is invalid because of a failure to comply with the Bill. A declaration made under *clause 378* has effect according to its terms.

Clause 379 sets out who can make an application for a declaration under *clause 378* such as the involuntary patient, the psychiatrist who made the treatment order, a mental health advocate or any other person who, in the Tribunal's opinion, has a sufficient interest in the matter.

Clause 380 sets out the grounds on which a treatment order may be declared to be invalid. These are that there has been a failure by the practitioner to comply with the Bill when making the order or conducting the assessment or examination, and because of that failure, the rights or interests of the involuntary patient have been substantially prejudiced. There is nothing preventing a new order from being made following a declaration of invalidity.

Division 5 - Long-term voluntary inpatients: review of admission by authorised hospitals

Division 5 recognises the vulnerability of voluntary inpatients in authorised hospitals who are so chronically unwell that they have been an inpatient for long periods of time.

Clause 381 states that Division 5 applies to long-term voluntary inpatients, as described in the clause.

Clause 382 lists who can make an application for review of a long-term voluntary inpatient's admission in an authorised hospital such as the patient, a mental health advocate or any person the Tribunal considers has sufficient interest in the matter.

Clause 383 sets out who the parties to a proceeding under Division 5 will be.

Clause 384 sets out the matters to which the MHT must have regard when conducting a review under Division 5. They are the same matters as provided for in *clause 374*, but do not include the patient's treatment, support and discharge plan, given that such a plan is only required for involuntary inpatients and mentally impaired accused persons required to be detained at an authorised hospital. Although the Bill does not include a requirement for a treatment, support and discharge plan to be made with respect to a voluntary patient, best practice would support the creation of such a plan, and *clause 384* allows the Tribunal to have regard to 'any other things that the Tribunal considers relevant', which may include a treatment, support and discharge plan.

Clause 385 allows the MHT to make recommendations to the treating psychiatrist, including that the patient be discharged; that any treatment, support and discharge plan be prepared and reviewed regularly; and that

the treating psychiatrist consider whether or not there is still a need for the admission.

Division 6 - Electroconvulsive therapy: approvals

Clause 386 states that Division 6 relates to obtaining the MHT's approval for ECT to be performed on (a) a voluntary patient who is aged 14-18 years; (b) an involuntary patient or mentally impaired accused person required to be detained in an authorised hospital who is aged 14-18; and (c) an involuntary adult patient or mentally impaired accused adult who is required to be detained in an authorised hospital.

Clause 387 allows a patient's psychiatrist to apply to the MHT for approval to perform ECT on a patient. The clause sets out the matters that must be specified in the application, including the clinical and ethical reasons why the patient's psychiatrist is recommending the ECT; the maximum number of treatments proposed; and the duration over which they would be performed if the application were to be approved.

Clause 388 sets out who the parties to a proceeding under Division 6 will be.

Clause 389 sets out the capacity and consent issues that the MHT must be satisfied of to approve the ECT as well as the qualifications of the medical practitioner performing the ECT and the place where the treatment will be performed is suitable. The capacity and consent issues are complex, but essentially provide for the giving of consent in patients who have capacity and what may be done where a patient does not have capacity or refuses to consent. If a person aged 14-18 is a voluntary patient (as in *clause 185 (1)*), ECT cannot be performed unless the MHT is satisfied that informed consent has been given. If the person is an involuntary patient or a mentally impaired accused person required to be detained in an authorised hospital, whether aged 14-18 or an adult, and is unable to consent because they lack capacity to consent to the treatment, or refuse to consent, ECT can still be given with the approval of the MHT, if it is satisfied that ECT is the most appropriate treatment for the health and wellbeing of the patient. However, the views of the person must be taken into account, as well as the views of persons specified in *clause 390*.

Clause 390 sets out what the MHT must have regard to if a person does not have capacity to provide informed consent. The views of the patient, even if the patient is a child, the views of parents, carers, close family members and nominated persons. They must also consider the clinical and ethical reasons why the patient's psychiatrist is recommending that the ECT be performed; the consequences for the treatment and care of the patient if the ECT is not performed; the nature and degree of any significant risk of performing the ECT; whether the treatment is likely to promote and maintain the health and wellbeing of the patient; whether any alternative treatment is available; the nature and degree of any significant risk of providing any alternative treatment that is available and any other things that the Tribunal considers relevant to making the decision.

Clause 391 specifies the decisions that the MHT can make after hearing an application under Division 6. They can approve or refuse to approve the application; or approve the application subject to reducing the number of treatments to be performed on the person. To clarify, the MHT may also adjourn the matter to obtain a further opinion or additional information.

Division 7 - Psychosurgery: approvals

Clause 392 is the application provision. Division 7 applies for the purposes of the MHT considering whether or not to approve psychosurgery being performed.

Clause 393 allows a patient's psychiatrist to apply to the MHT for approval to perform psychosurgery on the patient. The clause sets out the matters that must be specified in the application, including a treatment plan in relation to the proposed psychosurgery, and the reasons why the psychiatrist is recommending that it be performed.

Clause 394 identifies who the parties to a proceeding under Division 7 will be.

Clause 395 sets out the things that the MHT must be satisfied of to approve the psychosurgery. The requirements include informed personal consent (consent from the patient himself or herself, not a substitute decision maker). *Clause 395* is drafted in a way that implies that psychosurgery will be used only where earlier treatments and interventions have not resulted in sufficient and lasting benefit to the patient.

Clause 396 sets out the matters to which the MHT must have regard when hearing an application in relation to Division 7. They include the consequences for the treatment and care of the patient if the psychosurgery is not performed; and whether the psychosurgery is likely to promote and maintain the health and wellbeing of the patient.

Clause 397 specifies the decisions that the MHT can make after hearing an application under Division 7. They can approve or refuse to approve the application. To clarify, the MHT may also adjourn the matter to obtain a further opinion or additional information.

Division 8 - Non-clinical matters: compliance notices

The introduction of provisions in relation to compliance notices is an addition to the tasks of the MHT from their current role. Breaches of the Bill that may give rise to a compliance notice may include failing to place particular information on a patient's file, where this is required by the Bill. Division 8 applies to mandatory and discretionary requirements of the Bill. However, in relation to discretionary requirements, the MHT may only order a person to consider doing something, rather than ordering them to do it. For example, where a clinician is required to provide information to a family

member or carer, but the clinician is of the view that to do so would not be in the best interests of the patient, the MHT can require the clinician to consider providing the information, but cannot require the clinician to provide the information. The MHT will not be empowered to direct clinical treatment through the use of compliance notices.

Clause 398 defines some of the terms used in Division 8.

Clause 399 allows the MHT to issue a compliance notice to a service provider. The compliance notice may direct the service provider to take specified actions within the specified period; and to report to the MHT on remedial action taken or not taken. Before deciding whether to issue a compliance notice the MHT can refer the matter to another person or body listed in *clause 399*. The consequence of a failure to comply with a compliance notice relates to *clause 449* whereby a person who does not give effect to a compliance notice is committing an offence. If the MHT refers a matter to another person or body listed in *clause 399*, the MHT must advise the service provider in writing of the referral, given that the MHT is required to advise all parties of its decision (and provide reasons, if requested).

Clause 400 states who can make an application to the MHT for the service of a compliance notice.

Clause 401 identifies who the parties to the proceeding will be under Division 8. Not all of these persons are required to attend the hearing, but the MHT will not proceed if the members do not have sufficient information to make a decision.

Clause 402 requires compliance notices to be reported in the MHT's Annual Report.

Division 9 - Restrictions on patients' freedom of communication: review of orders

Clause 403 allows persons specified in the clause to apply to the MHT for a review of restrictions on freedom of communication.

Clause 404 identifies who the parties to a proceeding under Division 9 will be.

Clause 405 sets out the matters to which the MHT must have regard when conducting a review under Division 9. These include, if the patient is a child and a Child and Adolescent Psychiatrist is not available to sit on the Tribunal, the views of a medical practitioner or mental health practitioner who has qualifications, training or experience relevant to children and is authorised by the Chief Psychiatrist

Clause 406 specifies the decisions that the MHT can make after hearing an application under Division 9. The MHT can confirm the order as made or amended; amend or further amend the order; or revoke the order.

Division 10 - Jurisdiction in relation to nominated persons

Division 10 relates to nominated persons, discussed in Part 15.

Clause 407 allows any person who, in the opinion of the MHT, has a sufficient interest in the matter, to apply to the MHT for a decision under Division 10.

Clause 408 allows the MHT to make a declaration about the validity of a nomination.

Clause 409 allows the MHT to revoke a nomination in specified circumstances.

Clause 410 identifies who the parties to a proceeding under Division 10 will be.

Division 11 - Review of decisions affecting rights

Division 11 is relevant where a person's rights are affected in a way that is not dealt with in another Division in Part 20.

Clause 411 allows any person who, in the opinion of the MHT, has a sufficient interest in the matter to apply to the MHT for a review of a decision made under the Bill affecting a person's rights under the Bill. The MHT can only review such a decision if satisfied that the matter cannot be heard and determined by the MHT under another Division in Part 20.

Clause 412 identifies who the parties to a proceeding under Division 11 will be.

Clause 413 allows the MHT to, upon completing a review under Division 11, and subject to the Bill, make any orders and give any directions that the MHT considers appropriate.

Division 12 - Procedural matters

Subdivision 1 – Proceedings generally:

Clause 414 requires an application or other document required to be made or given to the MHT to be lodged at the office of the MHT.

Clause 415 requires the President to determine where and when the MHT will sit.

Clause 416 provides that the MHT must exercise its jurisdiction with as little formality and technicality, and as speedily, as a proper consideration of the matter permits; within the bounds of the rules of natural justice. This provision reflects the fact that the MHT is a quasi-judicial body, where the purpose is to produce the correct and preferable decision at the time of the MHT's decision on the reviewable proceeding. In relation to the rules of natural justice, it is implied in the Bill that there must not be any conflict between the MHT members hearing a proceeding, and any other interest. For example, a neurosurgeon hearing an application for neurosurgery to be performed on a patient must not be the neurosurgeon proposed to perform the neurosurgery.

Clause 417 states that the presiding member of the MHT for a proceeding must be a legal practitioner.

Clause 418 requires a question of fact in a proceeding before the MHT to be decided by majority; and a question of law to be decided by the presiding member hearing the matter. For the purposes of this clause, a question of law includes a question of mixed law and fact. The definition of question of law in this clause differs from the definition of question of law in relation to the State Administrative Tribunal. This reflects the fact that the MHT has jurisdiction to hear matters from the beginning, while the State Administrative Tribunal reviews matters without rehearing them.

Clause 419 allows the MHT to engage or appoint assistants. For example, the MHT could appoint an interpreter; or a member of an Aboriginal or Torres Strait Islander community, to assist with proceedings.

Clause 420 clarifies that no payment of fees is required for any application or proceeding before the MHT under Part 20.

Clause 421 states that each party to a proceeding must bear their own costs. For example, any travel costs (for a patient on a CTO), or the cost of obtaining a report from a private psychiatrist, if sought.

Clause 422 restricts persons from bringing proceedings that are frivolous, vexatious, or for an improper purpose.

Subdivision 2 – Notice of proceedings:

Clause 423 specifies who the MHT must give notice of applications to; being the parties and, often, their representative or representatives. An exception applies where it is not in the best interests for a specified person to be notified of an application.

Clause 424 specifies who the MHT must give notice of hearings to; being the parties and, often, their representative or representatives. An exception applies where it is not in the best interests for a specified person to be notified of an application.

Clause 425 enables the MHT to obtain the name and contact details of a person's guardian from the State Administrative Tribunal to comply with *clauses 423* and *424*. The State Administrative Tribunal is not required to comply with such a request from the MHT, given that there may be circumstances that would justify the information not being disclosed.

Subdivision 3 – Appearance and representation:

Clause 426 applies to adults. The person may appear in person or be represented by another person. The MHT may make an order that the person be represented. The clause states that being represented at a hearing does not prevent a person from expressing their views in person.

Clause 427 applies to children who have capacity to consent to treatment. The child may appear in person or be represented by a parent or guardian; or any other person who is, in the MHT's opinion, willing and able to represent the child's interests. This may include a mental health advocate, whether or not that be a youth mental health advocate, given that a youth mental health advocate may not always be available. Being represented does not prevent the child from expressing their views in person.

Clause 428 applies to children who do not have capacity to consent to treatment. The child must be represented by a parent or guardian (unless the MHT orders that the parent or guardian be excluded from the hearing); or any other person who, in the MHT's opinion, can represent the child's interests. This may include a mental health advocate, whether or not that be a youth mental health advocate, given that a youth mental health advocate may not always be available. Being represented does not prevent the child from expressing their views in person.

Clause 429 allows the MHT to make arrangements for representation of a person at the person's request.

Clause 430 clarifies an issue that remains unclear under the current Act. It states that the fact that a person has a mental illness, or is being provided with treatment for a mental illness, is presumed not to be an impediment to the representation of the person by a legal practitioner before the MHT. This extends to a legal representative being engaged, taking instructions, accessing information, and representing a person at a MHT hearing.

Clause 431 provides that a representative of a person at a MHT hearing must not be paid unless they are a legal practitioner, a mental health advocate or another person prescribed in regulations.

Subdivision 4 – Hearings and evidence:

Subdivision 4 is modelled on Schedule 2 of the current Act.

Clause 432 describes the purpose and nature of review proceedings before the MHT. The MHT is not confined to the matters that were before the

decision maker under the Bill at the time that a decision was made. New information can be considered. The purpose of a review proceeding is to produce the correct and preferable decision at the time of the MHT's decision on the reviewable proceeding.

Clause 433 states that a hearing in a proceeding is not open to the public, unless the MHT orders otherwise. This is due to the personal and confidential nature of information being disclosed. Further, the MHT may choose whether or not to allow a specified person to be present (including a witness). Where the MHT does not allow a specified person to be present, the MHT must give reasons.

Clause 434 allows the person concerned in a proceeding to choose another person (or persons) to be present. It is intended that that other person give assistance and support to the patient and present the patient's views and wishes as appropriate. However, *clause 434* also recognises that it is not always in a person's best interests for a particular person to be present, so, in limited circumstances, the MHT may exclude that other person.

Clause 435 allows the MHT, on the application of a psychiatrist, to exclude a parent or guardian from a hearing in relation to a child if the attendance of that parent or guardian would not be in the best interests of the child.

Clause 436 requires the MHT to give each party to a proceeding a reasonable opportunity to call evidence, give evidence, examine witnesses, cross-examine witnesses, and make submissions. However, as stated in relation to *clause 416*, the MHT must exercise its jurisdiction with as little formality and technicality, and as speedily, as a proper consideration of the matter permits; within the bounds of the rules of natural justice.

Clause 437 states that the MHT is not bound by the rules of evidence, but may inform itself of a matter relevant to a proceeding in any manner that the MHT considers to be appropriate.

Clause 438 aims to ensure that information that should not be accessed by a person (described in *clause 236*) is not revealed in oral evidence in proceedings before the MHT. The MHT may request a person to leave a part of a hearing. As a last resort, the MHT can order a person to leave a part of a hearing. Failure to comply with the order can be considered to be contempt of the MHT, and *clause 444* imposes a penalty in relation to this.

Clause 439 gives the MHT the power to compel a person to attend a proceeding to give evidence or produce a document or both.

Clause 440 states that no privilege against self-incrimination applies in relation to proceedings before the MHT. That is, a person is not immune from obligation to provide information where that information would incriminate the person or expose that person to conviction for an offence.

Clause 441 allows the MHT to inspect, retain for a reasonable time, and copy a whole or part of any document.

Clause 442 creates offences in relation to not giving evidence and giving false or misleading evidence.

Clause 443 allows the MHT to receive evidence from a transcript from judicial proceedings and to make findings, decisions or judgments in relation to judicial proceedings.

Clause 444 creates an offence for contempt of the MHT.

Clause 445 requires hearings in proceedings before the MHT to be recorded, recognising the need for accountability and transparency. To clarify, this does not extend to discussions held by the members of the MHT hearing the proceeding in making a decision in the absence of the parties to the proceeding.

Clause 446 creates an offence for publication of information about proceedings before the MHT, subject to specified exceptions. The provision is modelled on Schedule 1 clause 12 of the *Guardianship and Administration Act 1990*. The offence is prescribed to be a crime, where the penalty depends on whether it was an individual or a body corporate who committed the offence.

Subdivision 5 – Decisions in proceedings:

Clause 447 allows a party to a proceeding to obtain reasons for a decision of the MHT, providing a balance between confidentiality, accountability, and transparency. The request must be made within specified time limits. Reasons must be communicated in a way that the party is likely to understand.

Clause 448 enables the President of the MHT to grant an extension of time for a person to obtain reasons where it would be in the interests of justice to provide the reasons despite the delayed request.

Clause 449 creates an offence for not giving effect to a decision of the MHT according to its terms. This does not apply to *recommendations* of the MHT. For example, there is no penalty in relation to failure by a psychiatrist to give effect to a recommendation for amendment to a treatment, support and discharge plan.

Division 13 - Rules

Clause 450 allows the President of the MHT to make rules for the MHT, in consultation with the members of the MHT.

Clause 451 provides a non-exhaustive list of examples of things that can be included in the rules of the MHT that are made pursuant to *clause 447*.

Clause 452 requires rules to be published, and tabled in Parliament.

Division 14 - Tribunal members

Clause 453 provides that the Governor may appoint a person recommended by the Minister to be the President of the MHT.

Clause 454 provides that the Governor may appoint persons recommended by Minister to be members of the MHT, in addition to the President of the MHT.

Clause 455 provides for the duration of appointment to the MHT, being a maximum of 5 years, with eligibility for reappointment.

Clause 456 provides that, in relation to the President, remuneration determined by the Salaries and Allowances Tribunal under the *Salaries and Allowances Act 1975*. Other members have the remuneration determined by the Minister on the recommendation of the Public Sector Commissioner. The term 'remuneration' is defined in *clause 4*.

Clause 457 sets out how a member may resign, being to the Minister.

Clause 458 gives the Governor the power to remove a person from the office of member in circumstances set out in the clause.

Clause 459 gives the Minister the power to appoint an acting President and acting members of the MHT for up to 12 months. The clause also confirms the validity of anything done by an acting member (including the President) in circumstances specified in the clause, such as where there is a defect or regularity in the appointment.

Clause 460 allows the President to delegate administrative powers or duties to another member or the registrar. The office of the registrar is established in Division 15. The delegate cannot sub delegate.

Division 15 - Registrar and other staff

Clause 461 requires a registrar of the MHT to be appointed.

Clause 462 sets out the functions of the registrar, being a broad range of administrative duties.

Clause 463 allows the President to give directions to the registrar, and requires the registrar to comply.

Clause 464 requires other persons to be appointed as public service officers to assist the registrar.

Clause 465 allows the registrar to delegate powers or duties to a registry officer. The registry officer cannot sub delegate.

Division 16 - Annual Reports

Clause 466 requires the MHT to provide an Annual Report to the Minister within 3 months of the end of each financial year.

Clause 467 requires the Minister to table the Annual Report in Parliament within 21 days of receiving it.

Division 17 - Miscellaneous matters

Clause 468 requires the MHT to have a seal.

Clause 469 requires a court or other judicial person or body to take judicial notice and provide judicial authority of specified matters such as the signatures of Tribunal members and the Registrar or use of the seal. Judicial notice is a rule of evidence that allows a fact to be introduced into evidence if the truth of that fact cannot reasonably be doubted.

Part 21 Review by State Administrative Tribunal

The MHT has jurisdiction to hear matters from the beginning. A person concerned, defined in *clause 470*, may apply to the State Administrative Tribunal (SAT) for a review of a decision of the MHT. The SAT has review jurisdiction, as opposed to jurisdiction to hear a matter from the beginning or to hear an appeal.

However, section 105 of the *State Administrative Tribunal Act 2004* provides for an avenue of appeal from the SAT to the Supreme Court.

Division 1 - Preliminary matters

Clause 470 lists definitions of some of the terms used in Part 21.

Division 2 - Jurisdiction

Clause 471 gives a person in respect of whom the MHT has made a decision, the ability to apply to the SAT for a review of the decision. Any other person who, in the opinion of the SAT, has a sufficient interest in the matter may also apply to the SAT for review of the decision of the MHT. This takes into consideration more acutely unwell patients who may not be in a position to make an application.

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

Division 3 - Constitution

Clause 473 sets out the constitution of reviews by the SAT for matters other than psychosurgical matters. The constitution of the SAT will change from the current Act. In particular, it introduces a general requirement for a child and adolescent psychiatrist; and limits a mental health practitioner who is a staff member of a mental health service from constituting the SAT. The rationale for the limitation on staff members of mental health services is to reduce any perceived conflict of interest between the two roles.

Clause 474 sets out the constitution of reviews by the SAT for psychosurgical matters.

Clause 475 applies where the SAT is determining a question of law for the MHT pursuant to *clause 472*. In such a case, the SAT must be constituted by a judicial member.

Division 4 – Procedural matters

Clause 476 states that no fees are payable for any application or proceeding before the SAT under Part 21.

Clause 477 allows a person to appear at a hearing in a proceeding before the SAT under Part 21 either for themselves, or represented by another person. It is noted that section 39 of the *State Administrative Tribunal Act 2004* sets out a requirement that, subject to some exceptions, representation at the SAT must be by a legal practitioner. The Bill enables representation of a person at the SAT by persons who are not legal practitioners. This more specific clause in the enabling Act is effective despite the variation from section 39(1) of the *State Administrative Tribunal Act 2004*. *Clause 477* permits the SAT to make an order that the person must be represented where representation would be in the person's best interests. It also allows the SAT to make arrangements for representation at the request of the person. Further, the clause has the effect of clarifying that mental illness, or being treated for a mental illness, is no impediment to a person being represented by a legal practitioner before the SAT.

Clause 478 states that a hearing in a proceeding is not open to the public unless the SAT orders otherwise. The SAT may choose whether or not to allow a specified person to be present (including a witness). To clarify, this clause does not allow the SAT to exclude the person in respect of whom the MHT made the relevant decision, from a hearing.

Clause 479 creates an offence for publication of information about proceedings before the SAT, subject to specified exceptions. The offence is prescribed to be a crime, where the penalty depends on whether it was an individual or a body corporate who committed the offence.

Part 22 Administration

Part 22 deals with the appointment, powers and functions of the Chief Psychiatrist, and other administrative matters relating to mental health practitioners, authorised hospitals, approved forms, and guidelines and standards.

This green Bill provides for the Chief Psychiatrist to be located within the MHC. This represents a change from the current Act, in which the Chief Psychiatrist is located within the Department of Health.

This issue is subject to further discussion and is yet to be determined.

The Chief Psychiatrist will be appointed by the Governor and, in relation to general policy and administrative matters only, will be responsible to the CEO of the agency in which the office is located. The Bill makes it clear that the CEO cannot issue a direction in regard to a particular person, medical practitioner, mental health service or other particular person or body.

Division 1 - Preliminary matters

Clause 480 must be read in conjunction with clause 4 of the Bill. *Clause 4* defines 'mental health service' for the purposes of the entire Bill. *Clause 480* includes a private psychiatric hostel within that definition for the purposes of Part 22.

Division 2 - Chief Psychiatrist

Section 6(1)(d) of the existing *Health Legislation Administration Act 1984* (WA) provides for the appointment of a Chief Psychiatrist within the Department of Health. The intent is for the appointment of the Chief Psychiatrist to be brought under the Bill, and for the Chief Psychiatrist to be more independent, appointed by the Governor. This will require consequential amendments to the *Health Legislation Administration Act 1984* (WA), which will be referred to in a supplementary Explanatory Memorandum.

Part 22 includes additional reporting obligations that were not in the current Act. It also inserts a requirement that persons in charge of mental health services report 'notifiable incidents' to the Chief Psychiatrist, being a recommendation arising from the Holman Review.

Subdivision 1 – Appointment, terms and conditions:

Clause 481 establishes the statutory office of the Chief Psychiatrist. The Chief Psychiatrist is to be appointed by the Governor on the recommendation of the Minister. The change will ensure that the Chief Psychiatrist's functions are performed in a way that is, and is understood to be, independent of service provision. The Chief Psychiatrist will hold office

for the period specified in the instrument of appointment, not exceeding 5 years, and be eligible for reappointment.

Clause 482 states that the Chief Psychiatrist is entitled to the remuneration determined by the Salaries and Allowances Tribunal under the *Salaries and Allowances Act 1975*.

Clause 483 sets out how the Chief Psychiatrist may resign at any time in writing to the Minister.

Clause 484 gives the Governor the power to remove a person from the office of Chief Psychiatrist in circumstances set out in the clause.

Clause 485 gives the Minister the power to appoint an acting Chief Psychiatrist for up to 12 months. The clause also confirms the validity of anything done by an acting Chief Psychiatrist in circumstances specified in the clause, such as where there is a defect of irregularity in the appointment.

Subdivision 2 – Functions and powers generally:

Clause 486 lists the responsibilities of the Chief Psychiatrist in relation to the persons being provided with treatment and care pursuant to the Bill. The Chief Psychiatrist must publish standards for treatment and care to be provided by mental health services; and oversee compliance with those standards. Examples of standards published by the Chief Psychiatrist pursuant to the current Act are prerequisites to authorising a hospital; a Guide to the use of ECT in WA, a guide to clinical governance reviews and requirements for the role of authorised mental health practitioners Under the current Act, the Chief Psychiatrist is only responsible for the medical care and welfare of involuntary patients and the monitoring of standards in mental health facilities.

Clause 487 has the effect of allowing the CEO[1] to issue directions about matters of general policy and administrative policies and procedures. The Chief Psychiatrist must comply with any direction issued in accordance with this clause. Directions must be laid before Parliament within 14 days after being issued, and must be included in the Annual Report of the Chief Psychiatrist. A direction cannot be issued in regard to a particular referred person, involuntary patient, mentally impaired accused person, medical practitioner, mental health practitioner, mental health service or other particular person or body.

Clause 488 is a more general provision than the clauses above under Subdivision 2. It enables the Chief Psychiatrist to do anything necessary or

[1] Clause 4 defines the CEO as the CEO of the Mental Health Commission. This represents a change from the current Act, in which the Chief Psychiatrist is located within the Department of Health and under the direction and control of the CEO of that Department. This issue is subject to further discussion and is yet to be determined.

convenient for the performance of functions conferred on the Chief Psychiatrist.

Subdivision 3 – Specific powers relating to treatment and care:

Clause 489 allows the Chief Psychiatrist to review treatment being provided by a psychiatrist to an involuntary patient or mentally impaired accused person required to be detained in an authorised hospital, after informing the psychiatrist that such a review will be undertaken. Following the review the Chief Psychiatrist can issue directions, affirming, varying, revoking or substituting the decision with another decision. The decision of the Chief Psychiatrist will be conveyed to the psychiatrist in writing and it is an offence for the psychiatrist not to comply. This clause does not affect the operation of Part 12 in relation to the provision of treatment to an involuntary patient.

Clause 490 allows the Chief Psychiatrist to visit mental health services. The power to visit an authorised hospital is wider than the power to visit a mental health service that is not an authorised hospital. A visit may take place at any time and without prior notice. The clause sets out the powers that the Chief Psychiatrist has whilst conducting a visit. To clarify, the Chief Psychiatrist can delegate this power pursuant to *clause 506*, as with other provisions throughout Part 22 Division 2.

Clause 491 creates an offence for interfering with a visit permitted under *clause 490*. The clause protects patient confidentiality in this regard by stating that, where a prosecution notice is lodged in relation to a failure to answer a question, provide information, or provide a document, it is enough to state that the answer, information or document was knowingly false or misleading.

Clause 492 provides the Chief Psychiatrist with the power to issue directions to mental health services to disclose relevant information, and creates an offence in relation to a person in charge of a mental health service who does not comply with such a direction.

Subdivision 4 – Notifiable incidents:

Clause 493 is the application provision for Subdivision 4 which applies to a person to whom the Chief Psychiatrist is responsible for treatment and care pursuant to *clause 483*, or a person who is, for the purposes of the *Hospitals and Health Services Act 1927* Part IIIB, a resident of a private psychiatric hostel.

Clause 494 prescribes specific incidents that the Chief Psychiatrist must be notified of. In broad terms, they are incidents that had or are likely to have an adverse effect on the person.

Clause 495 requires a person in charge of a mental health service to report any notifiable incident to the Chief Psychiatrist as soon as practicable after becoming aware of the incident.

Clause 496 states what the Chief Psychiatrist may do upon receipt of a report in relation to a notifiable incident, including investigating the incident; referring it to specified persons or bodies; or taking no acting.

Clause 497 requires the Chief Psychiatrist to inform the person in charge of the relevant mental health service of a decision made under *clause 492*.

Clause 498 sets out the broad powers of the Chief Psychiatrist when conducting an investigation under *clause 496*.

Clause 499 requires the Chief Psychiatrist to inform the person in charge of the relevant mental health service of the outcome of the investigation and may make recommendations about the outcome.

Subdivision 5 – Staff and facilities:

Clause 500 requires public services officers to be appointed to assist the Chief Psychiatrist.

Clause 501 allows the Chief Psychiatrist to use government staff and facilities provided for in the clause.

Subdivision 6 – Annual Reports:

Clause 502 requires the Chief Psychiatrist to provide the Minister with an Annual Report which contains, amongst other things, statistics about use of the treatments and other interventions specified in the clause.

Clause 503 requires the Minister to table a copy of the Annual Report of the Chief Psychiatrist in Parliament within 21 days of receiving it, reaffirming the statutory independence of the statutory office of the Chief Psychiatrist.

Subdivision 7 – Miscellaneous matters:

Clause 504 allows a person to make a request to the Chief Psychiatrist about whether or not a particular person has been admitted or detained. The Chief Psychiatrist has discretion as to whether or not to provide the information, depending on whether the person making the request has a sufficient interest in the matter.

Clause 505 gives the Chief Psychiatrist the right to obtain, from the Mentally Impaired Accused Review Board, a list of mentally impaired accused persons who are required to be detained in an authorised hospital.

Clause 506 enables delegation by the Chief Psychiatrist of powers to another psychiatrist. The delegate cannot sub delegate.

Division 3 - Mental health practitioners and authorised mental health practitioners

Clause 507 defines a mental health practitioner as a nurse, psychologist, occupational therapist or social worker with at least 3 years experience in the management of people who have a mental illness. The definition acknowledges the importance of mental health practitioners in the mental health system in WA having appropriate expertise to perform their functions; and also the need for a sufficient number of mental health practitioners in Western Australia.

Clause 508 allows the Chief Psychiatrist to designate a mental health practitioner to be an authorised mental health practitioner, where that practitioner has the appropriate qualifications, training and experience. An authorised mental health practitioner is a practitioner more likely to be in a position to perform the function of referral of a person for an examination by a psychiatrist such as a community mental health practitioner or Emergency Department liaison officer.

Division 4 - Authorised hospitals

Clause 509 sets out the meaning of an authorised hospital. It includes a public hospital, or part of a public hospital (such as a unit or ward), in respect of which an order is in force under *clause 505*; or a private hospital the licence for which is endorsed under the *Hospitals and Health Services Act 1927* section 26DA. A hospital will not be deemed to be authorised unless it is contained on the Chief Psychiatrist's register of authorised hospitals. Therefore, there is no requirement for a consequential amendment to the *Hospitals and Health Services Act 1927*.

Clause 510 relates to the authorisation of public hospitals. The Governor may make, amend or revoke an authorisation by order published in the *Gazette*.

Division 5 - Approved forms

Clause 511 provides a statutory basis for forms approved by the Chief Psychiatrist for use under the Bill. The Bill provides more forms than the Current Act. It will ensure that records are in the approved form and include all of the required information. It emphasises the importance of standardisation, and promotes transparency. Technological advancements since the introduction of the current Act should streamline the administrative burden on practitioners despite the increased number.

Clause 512 relates to publications of approved forms and guidelines about how to complete any of the approved forms.

Division 6 - Guidelines and standards

Clause 513 requires the Chief Psychiatrist to publish guidelines in relation to the provision of treatment and care by mental health services. Guidelines will include matters such as ensuring the independence of second opinions; practices for the preparation of treatment, support and discharge plans; and may also extend to narrower matters such as use of photographic equipment in mental health services, and catchment areas for the purposes of determining the suitable authorised hospital a patient should be admitted to for inpatient treatment.

Clause 514 provides that guidelines published under *clause 513* may apply, adopt, or incorporate, the whole or part of an existing document. For example the Chief Psychiatrist's guidelines with regard to standards may include the National Mental Health Standards.

Clause 515 provides that it is sufficient compliance with *clause 513* if a copy of the guidelines is published on a website maintained by the Mental Health Commission[2]. However, it is expected that documents such as the clinicians' guide will be available in hard copy to be distributed to clinicians.

Division 7 - Miscellaneous matters

Clause 516 allows the Minister and CEO to delegate their powers and duties to specified persons. The delegate cannot sub delegate.

[2] Or the agency to which the office attached.

Part 23 Interstate arrangements

Part 4 of the Current Act empowers the Minister to enter into an agreement for the interstate care and treatment of persons with mental illness with the Government of another State or Territory. No such agreement has ever been entered into.

A recommendation arising from the Holman Review was that Part 4 be replaced with a stronger legislative basis upon which the Minister may enter into agreements with other states and territories for the return of involuntary patients absent without leave, and that the Minister should enter into such agreements with each State and Territory. This legislation is modelled largely on the South Australian legislation.

Part 23 of the Bill permits the making of intergovernmental agreements and the recognition of corresponding laws.

Division 1 - Preliminary matters

Clause 517 defines some of the terms used in Part 23.

Division 2 - Intergovernmental agreements

Clause 518 enables the Minister to enter into an agreement with a Minister in another State or Territory, and to publish a notice in the *Gazette* declaring (or revoking such declaration) that an agreement entered into before the commencement of Part 23 has effect.

Clause 519 provides that a person cannot perform a function under Part 23 unless there is an intergovernmental agreement with a relevant State or Territory in place.

Clause 520 permits a person authorised to perform a function pursuant to Part 23 to perform any similar function under a corresponding law or intergovernmental agreement in another State or Territory.

Division 3 - Transfer to or from interstate mental health service

Clause 521 allows an inpatient in an authorised or general hospital in Western Australia to be transferred from that hospital to an interstate mental health service. This extends to a person who is absent without leave. That is, arrangements may be made with respect to an involuntary patient who leaves the State without leave from hospital, for that patient to be admitted to a specified interstate mental health service. Various procedural requirements are in place to protect patients in this regard. A relevant person specified in Part 9 must be notified.

Clause 522 allows a transport order to be made in respect of an inpatient in an authorised or general hospital in Western Australia, to transport the patient to a mental health service in another State or Territory. A transport order can only be made pursuant to this clause where there is no other safe means of transfer reasonably available.

Clause 523 allows the making of an order approving the transfer of a person who is under an interstate inpatient treatment order, and who is detained at or absent without leave from an interstate mental health service, to an authorised or general hospital in Western Australia. A relevant person specified in Part 9 must be notified.

Clause 524 applies to an order made under *clause 518* and allows a person authorised to transport interstate patients under a corresponding law or an interstate agreement to exercise those powers in Western Australia.

Division 4 - Community treatment orders

Clause 525 provides involuntary community patients with a degree of freedom of movement, stating that the terms of a CTO may include a requirement that a patient be provided with treatment by an interstate mental health service.

Clause 526 allows a transport order to be made in respect of a patient on a CTO in Western Australia where the patient does not comply with the requirement that he or she be provided with treatment by an interstate mental health service. This can only be made where no other safe means of transfer is reasonably available.

Clause 527 applies where a CTO is made interstate and requires an interstate community patient to be provided with treatment by a mental health service in Western Australia. The CTO is in force with the same terms, and for the same period, as the CTO made in the interstate jurisdiction.

Clause 528 enables a person authorised under a corresponding law of another State or Territory, to perform a function in relation to an interstate CTO in Western Australia.

Part 24 Ministerial inquiries

Division 5 of Part 10 of the current Act provides for the Minister to appoint a person to conduct an inquiry and provides details as to how an inquiry should be conducted. Part 24 of this Bill includes detail in relation to how inquiries must be conducted.

Clause 529 enables the Minister to appoint a person to conduct an inquiry and to report to the Minister in relation to specified matters.

Clause 530 sets out the powers of investigation of a person appointed under *clause 526*.

Clause 531 creates an offence for interfering with an inquiry conducted under Part 24.

Clause 532 provides that an inquiry under Part 24 must be conducted with as little formality and technicality, and as speedily, as a proper consideration of the subject matter of the inquiry permits. However, the person conducting the inquiry is bound by the rules of natural justice.

Clause 533 states that the rules of evidence do not apply in relation to an inquiry being conducted under Part 24.

Clause 534 allows a person to be summoned to give evidence and/or produce documents.

Clause 535 states that no privilege against self-incrimination applies in relation to a direction or summons given to a person in relation to an inquiry being conducted under Part 24.

Clause 536 gives the person appointed under *clause 529* powers in relation to documents produced.

Clause 537 creates offences in relation to answering questions, producing documents, and providing information.

Part 25 Information

There is no Part in the current Act that is similar to Part 25. Part 25 includes detail in relation to how information may be shared among agencies. It reflects some of the principles included in the *Hospital and Health Services Act 1927* (HHSA), but specifically in relation to mental health services. It includes, not only the powers to collect and exchange information among services, but also specifies the safeguards to ensure confidentiality is maintained.

Division 1 - Collection of information from service providers

Clause 538 defines some of the terms used in Part 25.

Clause 539 sets out the information that the CEO of the Commission (defined in *clause 4* as the agency principally assisting the Minister in the administration of the Bill) may collect. The intent is to limit any personal information to that which is necessary to support those individualised programs coordinated by the Commission.

Clause 540 is similar to section 26S of HHSA providing the same powers to the CEO of the Commission to issue directions with respect to mental health services as are afforded the CEO of the Department of Health for all health services. The penalty of $5,000 is consistent with other penalties in this Bill. Information collected must be relevant to the matters listed in *clause 539*.

Division 2 - Voluntary disclosure of information by public authorities and mental health services

Clause 541 provides that the CEO of the Commission may disclose, and may request, relevant information (including personal information) from public authorities and mental health services.

Clause 542 provides that CEOs of prescribed State authorities may disclose, and may request, relevant information (including personal information) from one another. In order to be prescribed, it is expected that the authority would be required to have sufficient protocols in place to protect the confidentiality of personal information. The intent is that bodies providing support to the same person may, where relevant, request or disclose information about that person that is relevant to their duties or to the health and safety on another person. For instance, there may be times when one body is aware of a matter that they believe another body should know about and it is not in the best interests of all parties for the permission to be sought from the individual for the information to be exchanged.

Clause 543 applies to the CEO of a prescribed State authority where the CEO does not have the power under another provision of the Bill to delegate any power or duty of the CEO under *clause 542*. *Clause 542* allows CEOs of

prescribed State authorities to delegate their powers to disclose or request information under *clause 542*. The delegate cannot sub delegate.

Division 3 - Miscellaneous matters

Clause 544 provides for a penalty of $5,000 to any person who discloses or uses information obtained by virtue of this or previous mental health legislation in Western Australia. The clause does not apply to the recording, disclosure or use of statistical or other information that is not personal information (as defined in *clause 4*). *Clause 545* creates an exception to this.

Clause 545 describes those circumstances where recording, disclosure and use of information are permissible.

Clause 546 provides for regulations pertaining to the receipt, storage and access to information disclosed under various parts of this legislation. This will provide safeguards to maintain confidentiality of personal and other information.

Part 26 Miscellaneous matters

Clause 547 is similar to sections 193 and 194 of the current Act which ensure that psychiatrists and other medical practitioners do not have the power to admit involuntary patients to a private hospital the licence for which is held by the practitioner or a related person. *Clause 547* also restricts medical practitioners (which include psychiatrists) and mental health practitioners from exercising powers under the Bill in respect of certain persons, such as relatives.

Clause 548 creates an offence for, without reasonable excuse, obstructing or hindering a person from performing functions under the Bill

Clause 549 provides for when an order may have a formal defect such as a clerical error or an error because of an accidental omission; or an evident material error in the description of a person. In those circumstances the person who may have performed a function subsequent to the order being submitted may request from the person who made the order that the order be rectified. If that request is not complied with the person may revoke the order. This does not prevent a new order being made and the validity of any thing done, or omitted to be done, in reliance on the referral or order is not affected.

Clause 550 requires mental health services to keep medical records in the form set out in the clause.

Clause 551 protects persons performing functions or purporting to perform functions under the Bill in good faith from liability in tort.

Clause 552 provides a defence against a charge of deprivation of liberty when a voluntary patient, usually an elderly person with dementia, is prevented from wandering and putting themselves at risk by the door to the ward being locked for example. However the defence is limited and does not include restraining the person if the person attempts to leave. In those circumstances duty of care may be used as a defence.

Clause 553 provides that the Bill has effect despite the *Freedom of Information Act 1992*. The *Freedom of Information Act 1992* will apply in some situations throughout the Bill; for example, in relation to the Chief Mental Health Advocate and other mental health advocates being able to obtain records.

Clause 554 gives statutory force to regulations made by the Governor pursuant to the Bill. The regulations will be accompanied by explanatory notes in due course.

Clause 555 provides for a review of the Bill after 5 years.

Schedule 1 Charter of Mental Health Care Principles

A key objective of Bill is to place consumer rights at the forefront of treatment and care. The establishment of a Charter as a Schedule to the Bill will elevate the status and visibility of consumer rights and provide for common understandings and expectations. This approach mirrors that taken in the *Carers Recognition Act 2004* and the *Disability Services Act 1993*.

Schedule 1 contains a preamble explaining the purpose of the Charter, and lists 15 Principles which mental health services must have regard to. It promotes a collaborative and accountable approach to patient wellness, with attitudes and processes conducive to recovery. It also recognises the impact of mental illness on families and carers.

The Charter uses the term 'must' throughout. Compliance with the Charter is aspirational, given its subjective nature, and for consistency with the *Carers Recognition Act 2004* and *Disability Services Act 1993*.