



**annual report**  
**2017-18**



10 September 2018

The Honourable Roger Cook MLA  
Deputy Premier; Minister for Health; Mental Health  
13th Floor  
Dumas House  
2 Havelock Street  
WEST PERTH WA 6005

Dear Minister

I am pleased to present the Mental Health Tribunal's Annual Report in accordance with section 488 of the *Mental Health Act 2014* for the period 1 July 2017 to 30 June 2018.

Yours faithfully

A handwritten signature in grey ink, appearing to read 'Karen Whitney'.

Karen Whitney  
President  
Mental Health Tribunal

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# Overview of the Mental Health Tribunal

The Mental Health Tribunal (the Tribunal) is an independent statutory tribunal established under the *Mental Health Act 2014* (WA) (the Act). The Tribunal plays an oversight role over involuntary treatment imposed, and certain decisions made, under the Act.

The Tribunal's primary role is to safeguard the rights of involuntary patients in Western Australia. An involuntary patient is a person who receives psychiatric, medical, psychological or psychosocial treatment without informed consent.

The Tribunal conducts informal hearings for a range of matters, inviting the attendance of the patient, the patient's legal representative and or advocate, as well as carers, close family members and personal support persons. Representatives of the patient's treating team also attend the hearing.

## Our vision

Our vision is accessible justice for those whose rights are affected by decisions made under the *Mental Health Act 2014*.

## Our mission

Our mission is safeguarding rights and promoting compliance and accountability under the *Mental Health Act 2014* by:

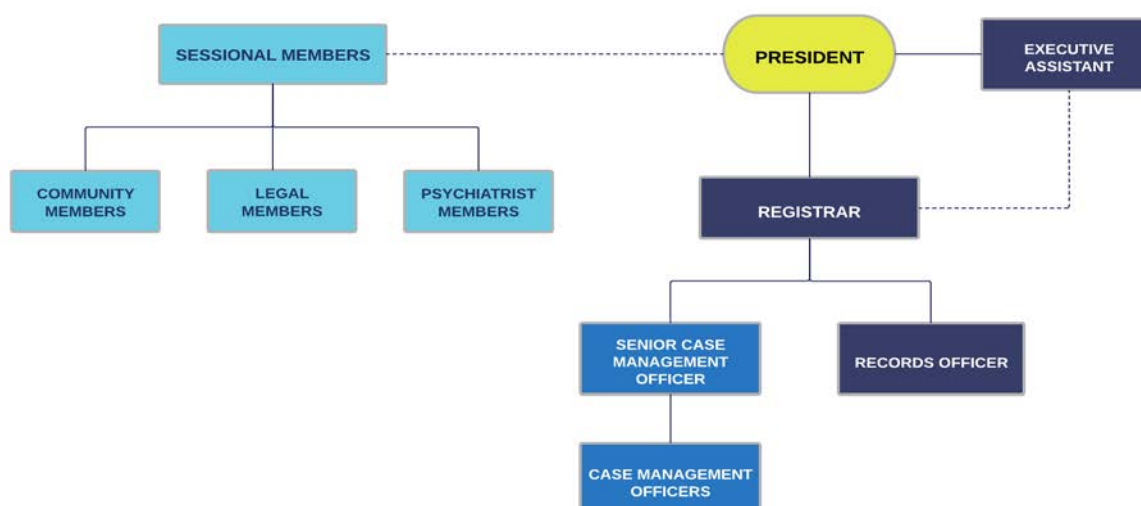
- ensuring involuntary treatment authorised under the Act strictly complies with the provisions and objects of the Act;
- determining applications for treatment by electroconvulsive therapy and psychosurgery;
- addressing non-compliance with prescribed requirements under the Act; and
- providing independent review of the validity of involuntary treatment orders, the admission of long-term voluntary patients, the validity and appropriateness of nominated persons, and the reasonableness of certain decisions under the Act restricting freedoms and affecting rights.

## Our values

We value respect for the law, equality before the law, fairness, impartiality, independence, accessibility, efficiency, accountability, competence, and integrity.

## Our structure

The Tribunal is comprised of a number of Tribunal members whose functions are supported by a Registry. Our organisational chart is set out on the following page.



## Tribunal members

The Tribunal is comprised of a number of Tribunal members. The Act provides that the Tribunal must consist of a President and at least two other members, including:

- at least one lawyer;
- at least one psychiatrist; and
- at least one member who is not a lawyer, a medical practitioner, or a mental health practitioner who is a staff member of a mental health service or private psychiatric hospital (referred to as a 'community member')

All members are appointed by the Governor on the recommendation of the Minister for up to five years and are eligible for reappointment. The President can be appointed on a full time or part time basis. All other members can be appointed on a full time, part time, or sessional basis.

The current President of the Tribunal, Ms Karen Whitney, was appointed on 30 December 2017 for a five year term. As at 30 June 2018, the Tribunal had 15 legal members (including the President), 28 psychiatrist members, one neurosurgeon member, and 17 community members. A list of members (as at 30 June 2018) and the expiration dates of their appointments is at Appendix One.

## Registry

The Tribunal's operations are supported by a Registrar. The current Registrar of the Tribunal is Ms Karen Jones. The Registrar is supported in carrying out Registry functions by a staff of six: a Senior Case

Management Officer; three Case Management Officers; a Records Officer and an Executive Assistant (who provides executive support to the President and corporate support to the Registry). Registry staff are employees of the Mental Health Commission.

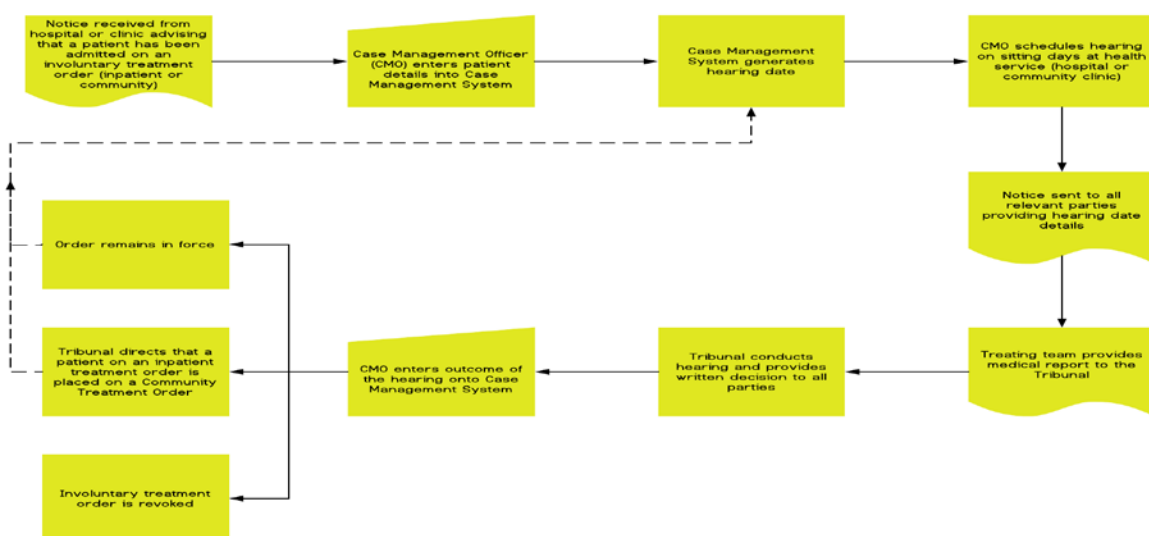
The Registrar has statutory functions under the Act as follows:

- keeping, in accordance with the regulations, particulars of each involuntary patient;
- ensuring that a proceeding for a review under Division Three of an involuntary treatment order is brought before the Tribunal within the period specified under that Division or, if no period is specified, as soon as practicable;
- ensuring that any other proceeding is brought before the Tribunal as soon as practicable;
- receiving any document that must be given under the Act to the Tribunal and arranging for it to be dealt with as soon as practicable;
- ensuring that any document that must be given under the Act by the Tribunal is given in accordance with the Act and as soon as practicable;
- generally being the executive officer of the Tribunal; and
- any other functions conferred on, or delegated to, the Registrar by or under the Act or another written law.

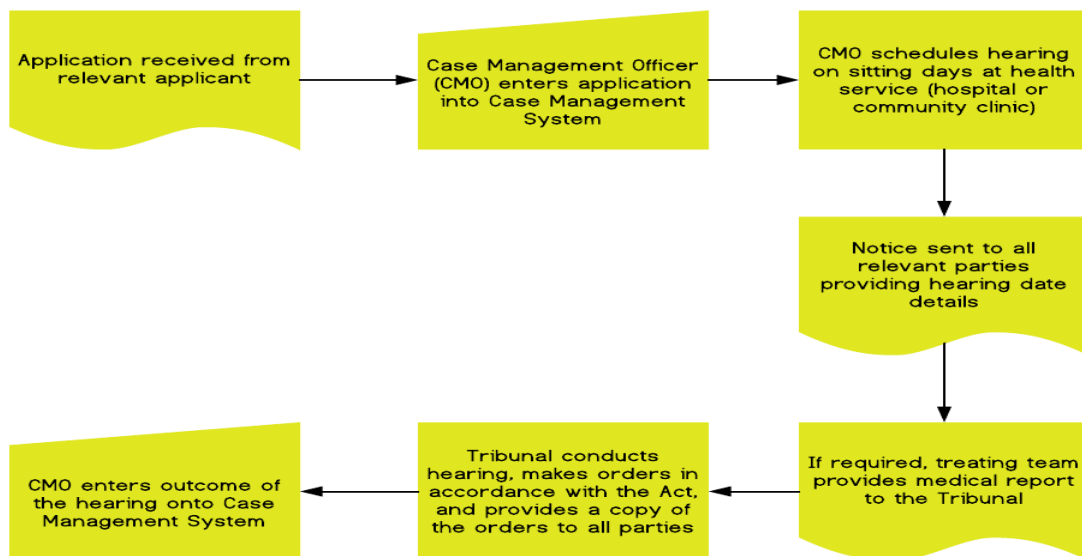
The Registry uses a case management model (sometimes referred to as case flow management) to meet its statutory functions. Case management is the process of managing the progression of cases from their initiation through to their completion. It is mechanistic and highly structured process designed to ensure that cases are treated with consistency. There is limited scope for the exercise of discretion in case management. Complex issues are escalated to the Registrar and President for decision.

The case management processes for Tribunal operations are described below.

### Case management for initial and periodic reviews



## Case management for other hearing types





# President's Report

Since commencing my term as President of the Tribunal on 30 December 2017, the Tribunal has embarked on an ambitious and comprehensive program of change to ensure compliance with statutory requirements and to achieve best practice in all aspects of its operations. I highlight below the Tribunal's key achievements, its most significant issues, and noteworthy events for the past financial year.

## Key Achievements

### Mental Health Tribunal Strategic Plan 2018 - 2020

One of the Tribunal's major achievements has been the delivery and ongoing implementation of the Tribunal's first strategic plan. A full copy of the strategic plan is at Appendix Two.

The strategic plan has four overarching objectives:

- to achieve high quality patient-centred outcomes in every matter;
- to support stakeholder participation in the hearing process;
- to improve how we work and maximise our use of technology; and
- to build our capacity and make best use of our resources.

The strategic plan will guide the Tribunal through the period of change to be undertaken over the next three years and have a significant impact on the Tribunal's longer term service delivery.

### Restructure and developments

During 2018, the Tribunal commenced implementation of the Council of Australasian Tribunals' *Australia and New Zealand Tribunal Excellence Framework* (June 2017) (the COAT Tribunal Excellence Framework). The COAT Tribunal Excellence Framework identifies eight aspects of tribunal excellence, and uses 95 indicators to measure framework implementation. Full implementation of the COAT Tribunal Excellence Framework is a long term project for the Tribunal. However, during 2018 we made an excellent start.

First, during 2018, we implemented a restructure of Registry staffing to improve quality and achieve efficiencies. Registry roles are now aligned to the model used in other Australian courts and tribunals, and Registry operations are moving towards best practice in case flow management.

Second, during 2018, we prepared a suite of new application forms and standard orders which reflect the Tribunal's powers in every matter type within its jurisdiction under the current Act. This will provide greater specificity in the Tribunal's orders, and ensure consistency in decision-making. The Tribunal is, however, unable to roll out these materials until its case management system is customised to incorporate them. This is discussed further below.

Third, we have adopted the practice of recruitment by an open process for all member appointments and reappointments. This is consistent with the *COAT Tribunal Independence in Appointments Best Practice Guide* (2017) and contemporary Australian practice and expectations. The Tribunal needs to conduct an open

recruitment process in 2018-19 to increase its capacity in targeted areas, particularly diversity and expertise. Both of these areas were the subject of recommendations in the 2018 *Post-Implementation Review of the Mental Health Act 2014* conducted by the Mental Health Commission (the Post-Implementation Review). A recruitment process is essential to resolving the Tribunal's critical shortage of available members who are Child and Adolescent Psychiatrists within the meaning of the Act.

Fourth, we commenced implementation of the *COAT Tribunal Competency Framework* (the COAT Competency Framework). The COAT Competency Framework identifies eight key competencies for tribunal members, with associated qualities and performance indicators. These will eventually form the basis for developing a formal professional development programing (including new member induction and training), a performance appraisal program, and will provide a framework for objectively assessing future candidates for appointment to the Tribunal.

### **Draft Tribunal Rules**

During 2018, I commenced drafting proposed Rules for the Tribunal pursuant to section 472 of the Act. Rules are needed to ensure consistency in Tribunal practices, an issue which was the subject of comment in the Post-Implementation Review. Internal and external consultation will commence later in 2018-19.

### **New Branding**

The Tribunal has undertaken a short, sharp rebranding project to ensure that development of new forms, brochures, the Annual Report, key performance indicator reporting and the website incorporate the modern branding that will see the Tribunal through several years without needing further refreshment.

### **New Home**

Finally, the Tribunal's lease of its current premises expired in 2017. During 2018, I commenced the process of negotiating a new home for the Tribunal in accordance with the McGowan Government's Government Office Accommodation Policy. That process remains ongoing.

### **Significant Issues**

There are several issues effecting the Tribunal's operation and effective delivery of services which need to be addressed. In general, the Tribunal needs to modernise its operations to prepare itself for a future that makes greater use of technology. The Tribunal currently operates in a paper based environment which is inefficient and less effective.

### **Case Management System**

The most immediate issue for the Tribunal's operations is the case management system. In its present form, it is not fit for purpose. It is neither aligned to the legislation nor effective as a tool for managing the day-to-day operations of the Tribunal. Without extensive customisation, or alternatively replacement with a court and tribunal specific system, the objectives of the strategic plan cannot be achieved, and the Tribunal is unable to guarantee delivery of its statutory functions.

The most concerning issue with the Tribunal's case management system is that it remains customised to reflect the repealed *Mental Health Act 1996*. It does not reflect the range of hearings the Tribunal presently conducts. The orders which can be produced by the case management system do not reflect the Tribunal's current statutory powers and functions. Although the Tribunal's suite of new application forms and standard orders will address this, the Tribunal is currently unable to roll out these materials until its case management system is customised to incorporate them.

Furthermore, the Tribunal's case management system is not customised to monitor key performance indicators, such as compliance with statutory timeframes for hearings. Of further concern, it is unclear whether the component of the case management system which calculates and schedules hearing timeframes was programmed with regard to the provisions for time computation in the *Interpretation Act 1984* (WA). We are unable to assess whether the Tribunal meets its statutory obligations and timeframes in every matter.

The Tribunal's inability to collect quantitative data to determine compliance with the Act was the subject of specific recommendations in the Post-Implementation Review. The Post-Implementation Review recommended that the Tribunal 'facilitate the ongoing collection of all relevant quantitative data regarding [the Tribunal's hearings] for further data analysis and to contribute to the statutory review of the Act'. The Post-Implementation Review further recommended that:

*The MHT to improve systems and processes to improve data collection to determine compliance with the requirements of the Act, which will assist with obtaining evidence of the MHT's functions, to better identify and ensure compliance with the Act in this regard and inform the statutory review of the Act.*

The Tribunal must comply with its statutory functions in every matter, and its orders must clearly correspond to its statutory powers. To ensure that the Tribunal does so, the Tribunal must address its technological issues urgently. Until these matters are addressed, the Tribunal remains unable to monitor and report on its compliance with its statutory obligations or to contribute data to any meaningful statutory review of the Act.

The Tribunal purchases IT support from the Mental Health Commission. Accordingly, we are working closely with the Mental Health Commission in deciding whether to invest in the extensive work that needs to be done to customise the current case management system to bring it to a fit for purpose standard or, alternatively, to invest in a different system altogether.

## **Document management**

The Tribunal's record keeping processes do not currently comply with public sector standards, nor do they make use of the document management system supplied by the Mental Health Commission. A project to rectify this issue is underway to ensure that corporate knowledge is appropriately captured and that state records are recognised, classified and retained in accordance with the Tribunal and Registry obligations under the *State Records Act 2000* (WA).

## Website

The present website was developed approximately 16 years ago, and is no longer fit for purpose.

The Tribunal requires a new website which functions as an information portal for patients, carers, families and supporters, where they can easily access information about what to expect at a Tribunal hearing, the different ways they can contribute to and participate in hearings, how they can provide written information for the Tribunal to consider in hearings, and how their involvement impacts upon Tribunal decision-making.

The Tribunal's website should also function as an information portal for stakeholders such as the Mental Health Advocacy Service, the Mental Health Law Centre, and treating teams at mental health services and provide access to all relevant forms.

## Funding for technology

The greatest challenge to the Tribunal in addressing these issues will be securing the necessary funding to update the Tribunal's technology. Approximately 90% of the Tribunal's expenditure each year is allocated to salaries for Members and Registry staff. In 2017-18, the Tribunal's entire budget for computer services and software was \$16,500. The Tribunal is exploring the most cost effective way to achieve its technological goals, as well as alternative funding options.

## Public confidence in the Tribunal's role

Finally, I specifically note two comments from an online survey conducted as part of the Post-Implementation Review process:

*MHT seems mostly to just reinforce the hospital view. [H]ospital fails to listen to issues that have impact [personal support person].*

*My son had two MHT. Both times the people on the tribunal did seem to be respectful, caring and listened to what we had to say. However it still seems like a whitewash because of course they defer to the doctors opinion. Pretty much what the doctors say is what they will agree with [personal support person].*

Although the Post-Implementation Review concluded that the survey's response size made it difficult to draw any firm conclusions from the survey, these comments are deeply troubling.

In other jurisdictions such as Victoria, Mental Health Tribunal members receive training in conducting solution-focused hearings, with the aim of engaging participants in hearings as active partners in the discussion and decision-making processes of the Tribunal. This model is grounded in therapeutic jurisprudence. I will consider incorporating such training into its professional development program with a view to increasing both participation and satisfaction of patients, carers, families and supporters in the hearing process.

## Notable events and thanks

During the 2017-18 financial year, the Tribunal has had several notable changes in personnel.

On 29 December 2017, the term of the Tribunal's former President Michael Hawkins ended. Mr Hawkins was President of the Mental Health Review Board and then the Tribunal between 2012 and 2017. He guided the Tribunal through the challenging transition to the new legislation in 2014 and was a good friend to many members and staff. On behalf of the Tribunal I wish him well in his retirement.

The following Tribunal members also resigned, retired, or did not seek reappointment when their terms expired during the past financial year:

- Dr Simon Byrne (psychiatrist)
- Dr Nadine Caunt (psychiatrist)
- Dr Hugh Cook (psychiatrist)
- Dr Catherine Nottage (psychiatrist)
- Dr Vicki Pascu (psychiatrist)
- Lynne McGuigan (community member)

Two of these members, Dr Hugh Cook (psychiatrist member) and Ms Lynne McGuigan (community member) were inaugural members of the Mental Health Review Board appointed in November 1997. On behalf of the Tribunal, I thank both of them for their exemplary commitment to the Mental Health Review Board and the Tribunal, and wish them both well in the future.

I also take this opportunity to thank all Tribunal members and Registry staff, particularly Registrar Karen Jones, for their support during the first six months of my term. The change process is never easy, particularly with a new leader. The transitional challenges have been amplified by changing leadership of the Registry functions as well. The restructure process is always unsettling, and I am grateful for the Registry staff's continued cheerfulness and their rise to the challenges.

Finally, I am grateful to the Minister, The Honourable Roger Cook MLA, the Mental Health Commissioner, Mr Timothy Marney, and the Corporate Services team of the Mental Health Commission for their tireless ongoing support.



Karen Whitney  
President

## The Tribunal's Functions

The Tribunal's primary role is to safeguard the rights of involuntary patients in Western Australia. An involuntary patient is a person who receives psychiatric, medical, psychological or psychosocial treatment without informed consent. Such treatment requires an involuntary treatment order. An involuntary treatment order is made by a psychiatrist authorised under the Act. An involuntary treatment order may be either an inpatient treatment order (under which a person can be admitted to and detained by a hospital for treatment without consent) or a community treatment order (under which a person can be provided with treatment without consent in the community).

### Conducting hearings

The Tribunal conducts hearings for a range of matters detailed below. In all matters, the Tribunal must conduct the proceedings with as little formality and technicality, and as speedily as proper consideration of the matter permits. The Tribunal is bound by the rules of natural justice. The Tribunal's hearings are usually not open to the public, and there are statutory requirements about what information may be published. There are criminal penalties for non-compliance.

For the purposes of most proceedings, the Tribunal must be constituted by three members: a legal member, a psychiatrist member, and a community member. For the purposes of psychosurgical matters, the Tribunal must be constituted by five members: a legal member, two psychiatrist members, a neurosurgeon member, and a community member.

The legal member is always the presiding member. Questions of law (including questions of mixed law and fact) must be resolved according to the opinion of the presiding member. Questions other than questions of law must be resolved according to the majority of the members constituting the Tribunal for the proceeding.

No fees are payable for Tribunal proceedings and each party must bear the party's own costs.

The Tribunal must notify relevant parties of hearings. The relevant parties include the patient, any carer, close family member or other personal representative, as well as any legal or other representative. For matters involving children, the child's parent or guardian also receives notice, as does the Chief Mental Health Advocate. Representatives of the patient's treating team also attend the hearing, including the patient's psychiatrist or a psychiatric registrar. Most hearings are conducted on site at hospitals or clinics for the convenience of the participants. Some hearings are conducted by videoconference from the Tribunal's videoconference room. Where required, the Tribunal provides the services of interpreters.

Every party must have a reasonable opportunity to call evidence, examine or cross-examine witnesses, and make submissions. The Tribunal is not bound by the rules of evidence but may inform itself of relevant matters in any manner the Tribunal considers appropriate, within the bounds of procedural fairness.

In conducting every proceeding, the Tribunal must have regard to the objects set out in the Act, including:

- ensuring that people who have a mental illness are provided the best possible treatment and care:
  - with the least possible restriction of their freedom; and
  - with the least possible interference with their rights; and
  - with respect for their dignity;
- recognising the role of carers and families in the treatment, care and support of people who have a mental illness;
- recognising and facilitating the involvement of people who have a mental illness, their nominated persons and their carers and families in the consideration of the options that are available for their treatment and care;
- helping to minimise the effect of mental illness on family life;
- ensuring the protection of people who have or may have a mental illness; and
- ensuring the protection of the community.

The Tribunal also must have regard to the principles set out in the Charter of Mental Health Care Principles. The Charter is reproduced at Appendix Three.

## **Types of hearings**

### **Initial and periodic reviews**

Most of the Tribunal's work involves reviewing involuntary treatment orders. To ensure that every involuntary treatment order is necessary and issued in accordance with the Act, the Tribunal conducts an initial review of each involuntary treatment order made in Western Australia within 35 days of the order being made (s 386) and then a periodic review every three months thereafter (s 387). Where the involuntary patient is a child under 18 years of age, the Tribunal conducts an initial review within ten days of the order being made and then a periodic review every 28 days thereafter. For certain long-term patients under a community treatment order, the Tribunal conducts a periodic review every six months.

### **Requested reviews**

In addition to conducting initial and periodic reviews, the Tribunal also hears applications for review of orders on the request of patients, carers, close family members or other personal support persons, mental health advocates, or any other person who, in the Tribunal's opinion, has a sufficient interest in the matter. The Tribunal reviews a range of different types of orders, including:

- involuntary treatment orders, to decide whether or not the involuntary patient is still in need of an involuntary treatment order (s 390(1)(a));
- inpatient treatment orders, to decide whether or not the involuntary inpatient is still in need of an inpatient treatment order (s 390(1)(b));
- community treatment orders, to decide whether or not the terms of the order are appropriate (s 390(1)(c));
- transfer orders authorising transfer of patients to or between authorised hospitals (s 390(1)(d));

- orders transferring responsibility for the patient between supervising psychiatrists (s 390(1)(e));
- orders transferring responsibility for the patient between treating practitioners (s 390(1)(f)); and
- orders transferring certain inpatients interstate (s 390(1)(g)).

Whenever the Tribunal considers it appropriate, it may also review such matters on its own initiative (s 391).

### **Review orders**

On completing a review, the Tribunal may make any orders, and give any directions, the Tribunal considers appropriate, including:

- an order revoking an involuntary treatment order;
- a direction to the psychiatrist named in the order to make a community treatment order; and
- an order varying the terms of a community treatment order (s 395).

Additionally, the Tribunal may make limited recommendations concerning the patient's treatment, support or discharge plan. Psychiatrists directed by the Tribunal to make a community treatment order also have a right of review to the Tribunal (s 396).

The Tribunal may also suspend the operation of orders or restrain treatment pending review, where appropriate.

### **Applications for declaration about the validity of treatment orders**

The Tribunal may also be asked to make declarations concerning the validity of:

- an involuntary treatment order;
- a continuation order made by a psychiatrist in respect of an involuntary treatment order; or
- an order made by a psychiatrist varying a community treatment order (s 397).

Declarations concerning the validity of orders must be by application to the Tribunal by either:

- the involuntary patient or the person who was the subject of the treatment order;
- the psychiatrist who made the treatment order;
- a carer, close family member or other personal support person of the involuntary patient or the person who was the subject of the treatment order;
- a mental health advocate; or
- any other person who, in the Tribunal's opinion, has a sufficient interest in the matter (s 400).

Where the order in question is no longer in force, the Tribunal has the discretion to consider the matter if satisfied the matter raises a question of law or a matter of public interest (s 403).



## **Applications to review admission of long-term voluntary inpatients**

The Tribunal has limited powers to review the admission of long-term voluntary inpatients. A long-term voluntary inpatient is:

- an adult who has been a voluntary inpatient at an authorised hospital for a continuous period of more than six months; or
- a child who has been a voluntary inpatient at an authorised hospital for a continuous period of more than three months (s 404).

The Tribunal may receive an application to review a long-term voluntary inpatient's admission to an authorised hospital to decide whether or not there is still a need for the admission (s 405(1)). The application may be made by:

- the long-term voluntary inpatient;
- a carer, close family member or other personal support person of the long-term voluntary inpatient;
- a mental health advocate; or
- any other person who, in the opinion of the Tribunal, has a sufficient interest in the matter (s 405(2)).

Upon completing such a review, the Tribunal may recommend that:

- the treating psychiatrist consider whether or not there is still a need for the admission;
- a treatment, support and discharge plan for the inpatient be prepared and be reviewed regularly;
- the inpatient be discharged (s 408).

The Tribunal's powers are recommendatory only.

## **Applications to approve electroconvulsive therapy**

The Tribunal determines applications to authorise the use of electroconvulsive therapy (ECT) on certain patients, including:

- a child who has reached 14 years of age but is under 18 years of age and is a voluntary patient;
- a child who has reached 14 years of age but is under 18 years of age and is an involuntary patient or mentally impaired accused detained at an authorised hospital; or
- an adult who is an involuntary patient or mentally impaired accused required to be detained at an authorised hospital (s 409).

In such circumstances, where a patient's psychiatrist recommends ECT be performed, the psychiatrist must apply in writing for the Tribunal's approval to perform ECT (s 410). The application must identify the reasons why the patient's psychiatrist is recommending that ECT be performed, and provide a treatment plan which includes:

- the mental health service at which it is proposed to perform ECT; and
- the maximum number of treatments with ECT that it is proposed will be performed; and
- the maximum period over which it is proposed to perform that number of treatments; and
- the minimum period that it is proposed will elapse between any two treatments.

The parties to a proceeding in relation to the application are the patient, the applicant, and any other person who, in the Tribunal's opinion, has a sufficient interest in the matter (s 411).

The Tribunal cannot approve ECT being performed on a patient unless satisfied that the mental health service at which it is proposed to perform ECT is approved for that purpose. Likewise, the Tribunal cannot approve ECT being performed on a child who has reached 14 years of age but is under 18 years of age and is a voluntary patient unless satisfied that informed consent to it being performed on the patient has been given as required by the Act (s 412). In deciding whether or not to approve ECT being performed on a patient, the Tribunal must have regard to the *Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia* (s 413). The Tribunal must also have regard to the factors enumerated in section 414 of the Act, including:

- the patient's wishes, to the extent that it is practicable to ascertain those wishes;
- if the patient is a child — the views of the child's parent or guardian;
- the views of the patient's close family member, carer, and nominated person;
- the reasons why the patient's psychiatrist is recommending that ECT be performed;
- the consequences for the treatment and care of the patient of not performing ECT;
- the nature and degree of any significant risk of performing ECT;
- whether ECT 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;
- any other things that the Tribunal considers relevant to making the decision.

The Tribunal may decide the application by:

- approving ECT being performed in accordance with the treatment plan set out in the application; or
- approving ECT being performed in accordance with the treatment plan set out in the application subject to the maximum number of treatments with ECT to be performed being reduced to the number specified by the Tribunal; or
- refusing to approve ECT being performed (s 415).

### **Applications to approve psychosurgery**

The Tribunal also determines applications to approve psychosurgery. With the Tribunal's approval, psychosurgery may be performed on adults or children between the ages of 16 and 18 who consent to the treatment (s 208).

An application for psychosurgery must be made in writing by a patient's psychiatrist, setting out the reasons why the patient's psychiatrist is recommending that the psychosurgery be performed and including a treatment plan in relation to the psychosurgery which sets out:

- a detailed description of the psychosurgery proposed to be performed; and
- the name, qualifications and experience of the neurosurgeon who it is proposed will perform the psychosurgery; and
- the name and address of the place where it is proposed to perform the psychosurgery (s 417).

The parties to a proceeding in relation to the application are the patient, the applicant, and any other person who, in the Tribunal's opinion, has a sufficient interest in the matter (s 418).

The Tribunal cannot approve the psychosurgery being performed on the patient unless satisfied that:

- the patient gives informed consent to the psychosurgery being performed;
- performing the psychosurgery has clinical merit and is appropriate in the circumstances;
- all alternatives to performing psychosurgery that are reasonably available and likely to be of a sufficient and lasting benefit to the patient have been appropriately trialled with the patient but have not resulted in a sufficient and lasting benefit to the patient;
- the neurosurgeon who it is proposed will perform the psychosurgery is suitably qualified and experienced;
- the place where it is proposed to perform the psychosurgery is a suitable place.

In deciding whether or not to approve the psychosurgery being performed on the patient, the Tribunal must have regard to:

- the views of any carer, close family member or other personal support person of the patient;
- the consequences for the treatment and care of the patient of not performing the psychosurgery;
- the nature and degree of any significant risk of performing the psychosurgery;
- whether the psychosurgery is likely to promote and maintain the health and wellbeing of the patient;
- any other things that the Tribunal considers relevant to making the decision.

The Tribunal has not yet considered an application for psychosurgery.

### **Applications to issue compliance notices**

The Tribunal also has powers to consider applications to issue a service provider with a compliance notice in respect of non-compliance with prescribed requirements under the Act.

A 'prescribed requirement' means a requirement under the Act to:

- give a document, or provide other information, to a patient or another person; or to include a document or other information on a patient's medical record; or to comply with a request made by a patient or other person; or

- to ensure that one of the above things is done; or
- to ensure that a treatment, support and discharge plan for a patient is prepared, reviewed or revised (s 422).

The service provider, in relation to a prescribed requirement, includes the person in charge of a mental health service, the medical practitioner, or the mental health practitioner required under this Act to comply with, or to ensure compliance with, the requirement (s 422).

Where, on considering the application it appears to the Tribunal that the service provider has not complied with a prescribed requirement, the Tribunal may issue a compliance notice directing the service provider:

- to take specified action within the specified period for the purpose of complying with the prescribed requirement; and
- to report to the Tribunal in the specified manner within the specified period that —
  - the service provider has taken the action specified within the specified time period; or
  - if the service provider has not taken the action specified within the specified time period — the reasons for not doing so.

Before deciding whether or not to issue a compliance notice with a service provider, the Tribunal must consider whether it would be appropriate to refer the matter to one or more of the following:

- the Commissioner of the Mental Health Commission;
- the Director General of the Health Department;
- the Chief Psychiatrist;
- a registration board (s 423).

The parties to a proceeding under section 423 are:

- the patient or other person to whom the prescribed requirement relates; and
- the service provider on whom the prescribed requirement is imposed; and
- if the proceeding relates to an application made under section 424 and the applicant is not the patient or other person to whom the prescribed requirement relates — the applicant; and
- any other person who, in the opinion of the Tribunal, has a sufficient interest in the matter.

The President of the Tribunal must include in the Annual Report the name of each service provider issued with a compliance notice during that year; and the number of compliance notices with which each of those service providers was issued during that year.

Section 423 arises most frequently in the context of treatment support and discharge plans (TSDPs). To date, no compliance notices have been issued. This is not to suggest that there has been complete compliance with the Act, however. For example, the March 2018 report arising from the Mental Health Advocacy Service's Treatment Support and Discharge Plans Inquiry (TSDP Report) notes at page four that 'no health service provider (HSP) was fully compliant with the Act [in respect of preparing TSDPs]. That remains the cases for most HSPs which means that patient and carer rights under the Act are being breached daily.'

To issue a compliance notice, procedural fairness requires the Tribunal to conduct a hearing on the issue, commenced either by an individual specified above or on the Tribunal's own initiative. Concerned parties must be notified and offered the opportunity to attend and make submissions. Until 2018, the Tribunal had neither application form nor procedures in place to list such applications. Issues may have been raised *ad hoc* in the context of other hearings, but there is no comprehensive record of any orders made arising from such hearings.

In 2018, the President requested that prior to issuing a compliance notice, Tribunal members consider whether it would be appropriate to order instead that the matter be referred to the Chief Psychiatrist, the Mental Health Commissioner, and or the Director General of Health as provided for in section 423(3) of the Act. This occurred twice prior to the end of the financial year. Both matters pertained to TSD planning.

Through this process, it became apparent that the Tribunal is rarely provided with a copy of the TSDP for its hearings, despite regard to the TSDP being a mandatory consideration in most matters.

In response to recommendations 5.1 and 5.2 of the TSDP Report, the Tribunal has agreed to:

- amend its correspondence to the treating team to request a copy of the TSDP for every hearing; and
- where there is no TSDP compliant with the Act, to consider an order under s423 of the Act to refer the matter to the CEO of the Health Department, the Chief Psychiatrist and/or CEO under the Act (the Commissioner for Mental Health).

In due course, once these changes are fully operational, the Tribunal will likely move to issuing section 423 referrals in addition to issuing the service provider with a compliance notice, as provided for in section 423(4) of the Act.

### **Applications to review orders restricting a patient's freedom of communication**

Section 261 of the Act provides that patients have the right of freedom of lawful communication, including the freedom to:

- see and speak with other people in the hospital to the extent that is reasonable;
- have uncensored communications with people, including receiving visits, sending and receiving telephone calls, and sending and receiving mail and electronic communications;
- receive visits from, and otherwise have contact with, the patient's legal practitioner at all reasonable times;
- receive visits from, and otherwise have contact with, a mental health advocate at any time;
- receive visits from, and be otherwise contacted by, other people at all reasonable times.

Nevertheless, in certain circumstances a psychiatrist may make an order prohibiting a patient from exercising one of these rights, or limiting the extent to which a patient can exercise one of these rights. Such orders must be in the approved form and must include the date and time when it is made, the reasons for making it, and the name, qualifications and signature of the psychiatrist. The order must be filed, and a

copy given to the patient and any carer, close family member or other personal support person of the patient.

Orders restricting a patient's freedom of communication may be reviewed by the Tribunal upon application by:

- the patient;
- a carer, close family member or other personal support person of the patient;
- a mental health advocate; or
- any other person who, in the opinion of the Tribunal, has a sufficient interest in the matter (s 427, 428). The Tribunal may decide the application by confirming the order, amending the order, or revoking the order.

### **Applications to resolve certain questions arising in respect of nominated persons**

The Act provides for patients to nominate another person to assist them by ensuring that their rights are observed and their wishes and interests are considered in the performance of functions under the Act. The Tribunal is empowered with jurisdiction to make declarations about the validity of a nomination, or to revoke a nomination, upon the application of:

- the person who made the nomination;
- the nominated person;
- a carer, close family member or other personal support person of the patient;
- a mental health advocate; or
- any other person who, in the opinion of the Tribunal, has a sufficient interest in the matter (s 430).

On an application for a declaration about validity, the Tribunal may declare that a nomination is valid or invalid. Furthermore, instead of declaring that a nomination is invalid because of a failure to comply with the formal requirements for the nomination, the Tribunal may declare the nomination to be valid; and may make an order varying the terms of the nomination in the manner the Tribunal considers most likely to give effect to the intention of the person who made the nomination (s 431).

On an application to revoke the nomination, the Tribunal may revoke a nomination if satisfied that the nominated person is not an appropriate person to perform the role of the nominated person because:

- the person is likely, in performing that role, to adversely affect to a significant degree the interests of the person who made the nomination; or
- the person is not capable of performing that role because of mental or physical incapacity; or
- the person is not willing, or is not reasonably able, to perform that role (s 432).

### **Applications to review any other decision affecting a patient's rights**

Finally, the Tribunal has a general power to review a decision made under the Act affecting a person's rights under the Act which cannot be heard and determined by the Tribunal under another provision.

An application may be made by:

- the person whose right is affected;
- a carer, close family member or other personal support person of the person whose right is affected;
- a mental health advocate; or
- any other person who, in the opinion of the Tribunal, has a sufficient interest in the matter.

The parties to a proceeding in relation to the application include the person whose rights it is alleged are affected, the applicant, and any other person who, in the opinion of the Tribunal, has a sufficient interest in the matter.

On completing the review, the Tribunal may make any orders, and give any directions, the Tribunal considers appropriate.

### **Determinations, orders and reasons for decision**

After conducting a hearing, the Tribunal members deliberate privately and inform the parties of their decision. The Tribunal makes appropriate orders, and delivers oral reasons for decision. This is done at the end of the hearing, so parties are aware of the outcome and the reasons before leaving the hearing venue.

Tribunal members provide parties with oral reasons which contain sufficient information for the parties to understand (although not necessarily accept) the outcome, and which are extensive enough for the State Administrative Tribunal to understand the factual and legal bases of the decision and the Tribunal's reasoning processes.

The Act also provides that a party may request, within 28 days of the Tribunal's decision, that the Tribunal provide reasons for decision. The Tribunal does so by providing the party with a transcript of the oral reasons provided at the hearing. The Tribunal does not otherwise provide formal written reasons for decision unless the member does not provide adequate reasons at the hearing. Such matters are referred to the President for further action.

A written copy of the Tribunal's order is provided to the parties either at the hearing itself or by post or email shortly thereafter. The Tribunal's order contains a notice informing that the party may apply to the State Administrative Tribunal for a review of the decision.

### **Review by the State Administrative Tribunal**

Decisions of the Tribunal are reviewable by the State Administrative Tribunal (SAT). Such matters fall within the SAT's review jurisdiction, and are conducted by way of a hearing de novo. In other words, the SAT is not confined to matters that were before the Tribunal and may consider new material whether or not it existed at the time of the Tribunal hearing. The purpose of the SAT's review is to produce the correct and preferable decision at the time of the decision upon review.

The SAT may affirm the Tribunal's decision, vary the Tribunal's decision, or set aside the Tribunal's decision, and either substitute its own decision or send the matter back to the Tribunal for reconsideration.



## Performance and Statistics

The statistics reported in this year's annual report differ considerably from those produced in previous years. This is because a close examination of the Tribunal's data collection and data entry methodologies has revealed concerns about the accuracy of some statistics reported in previous years.

As mentioned above, because the Tribunal's case management system has not been updated to reflect the current legislation, there is a range of data which cannot be accurately collected or entered into the case management system. For example; there are approximately 20 types of applications to the Tribunal for which accurate data concerning application type and outcome cannot be entered into the case management system because it lacks the necessary classifications. All of these other applications are classified as 'requested reviews' with outcome classifications which do not reflect the orders made.

For this reason, the Tribunal cannot report on matters such as the number of ECT applications, the number of patient initiated requests for the six different types of review hearings pursuant to section 390 of the Act, or any other hearing type falling outside initial and periodic review hearings.

Even where it is possible to accurately record data, it appears that some data has been inconsistently recorded because of confusion about how it should be classified.

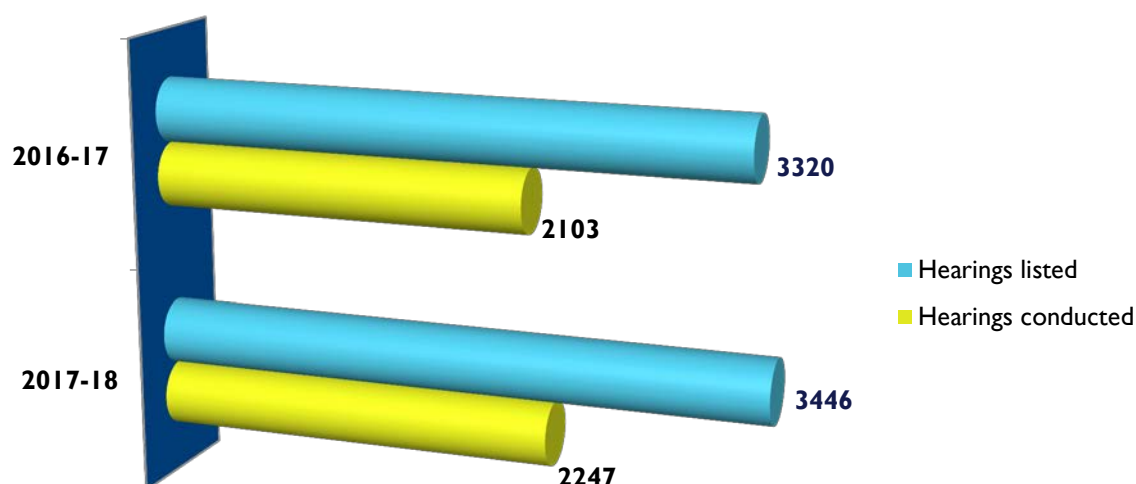
In the circumstances, the President has limited the reporting of statistics in the annual report to those statistics for which a high level of accuracy can be assured. Furthermore, because of the significant change to the Tribunal's operations since commencement of the new Act, the Tribunal will no longer continue to report comparison statistics for financial years earlier than 2016-17.

### Hearings conducted

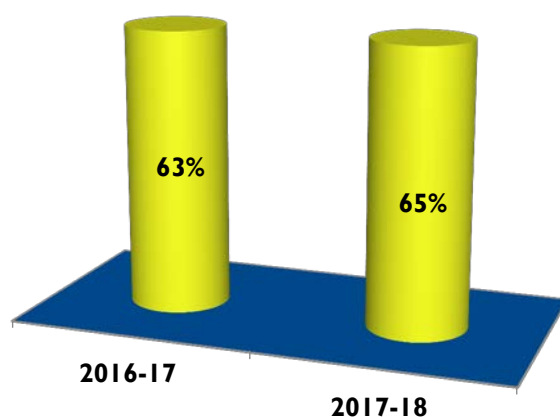
In 2017-18, the Tribunal listed 3446 hearings, an increase of 126 (4%) from 2016-17. Of these 3446 hearings, only 2247 (65%) proceeded to a hearing. This is relatively consistent with the 2016-17 financial year, where about 63% of listings proceeded to hearing. The Tribunal has a statutory obligation to list every involuntary patient for review hearing within a prescribed timeframe. The process of preparing for the review usually involves the patient being reviewed by the treating team to prepare an updated report for the Tribunal.

During this process, it is common for the involuntary order to be revoked, meaning that the patient no longer requires Tribunal review and the hearing is discontinued. Often this occurs within days or hours of the scheduled hearing, and the spot cannot be filled with another hearing. In such cases, Registry staff and Tribunal members have undertaken all of the necessary work to list and conduct the hearing. Registry and Tribunal staffing establishments must be calculated using the number of hearings listed, rather than the number of hearings conducted given the unpredictability of this process. As part of the Tribunal's strategic objective to make best use of our resources, the President is currently considering ways to manage this issue to achieve greater efficiency.

### Comparison of number of hearings listed to number of hearings conducted



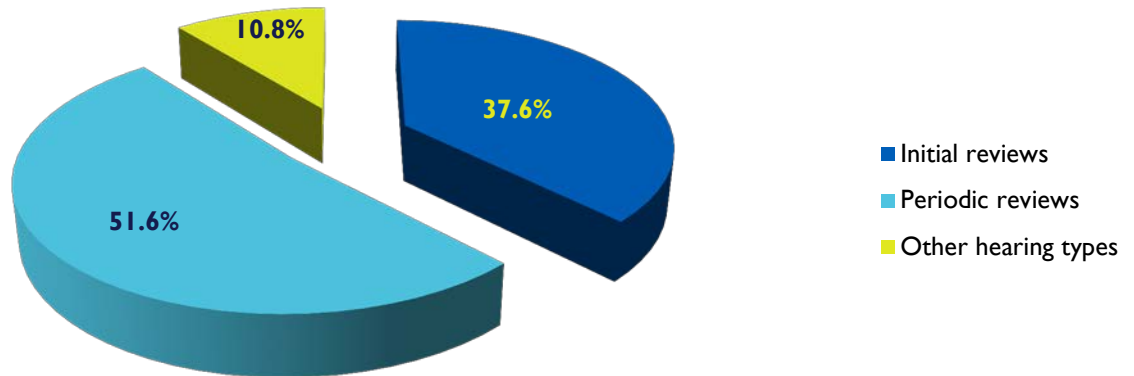
### Percentages of listings proceeding to hearing by year



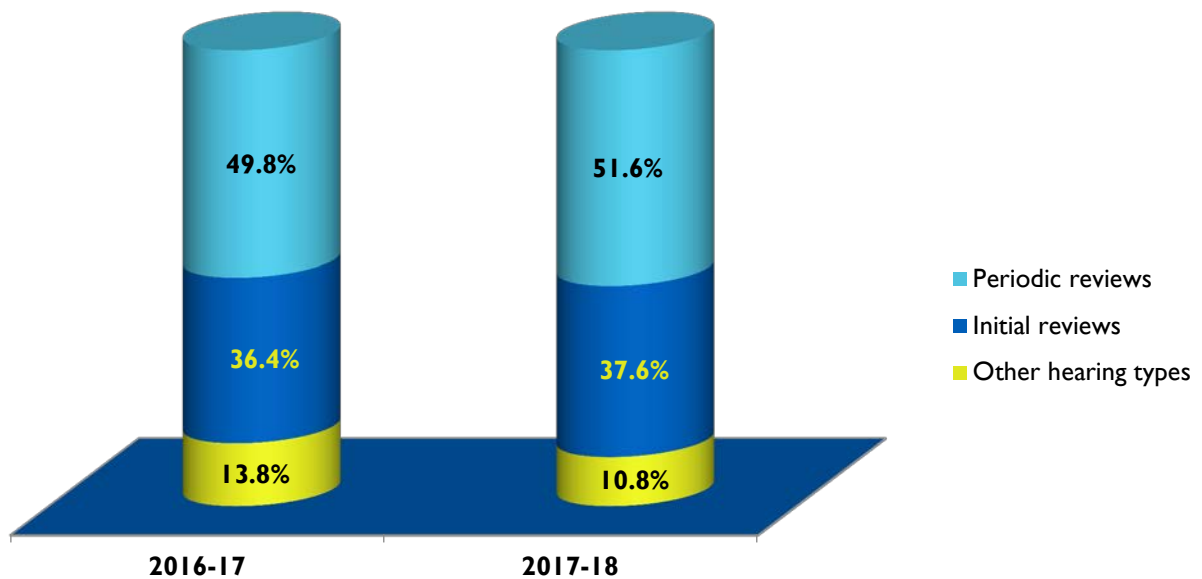
### Hearings conducted by matter types

In 2017-18, the Tribunal conducted 2247 hearings. Of these 2247 hearings, 845 (37.6%) were initial review hearings conducted pursuant to section 386 of the Act. A further 1160 (51.6%) were periodic review hearings conducted pursuant to section 387 of the Act. The balance of 242 (10.8%) were classified by our case management system as 'requested reviews', which represents approximately 20 different types of hearing, for which statistics cannot be recorded because of the current configuration of our case management system.

### 2017-18 hearings conducted by matter type



### Comparison 2016-2017 and 2017-18 hearings conducted by matter type



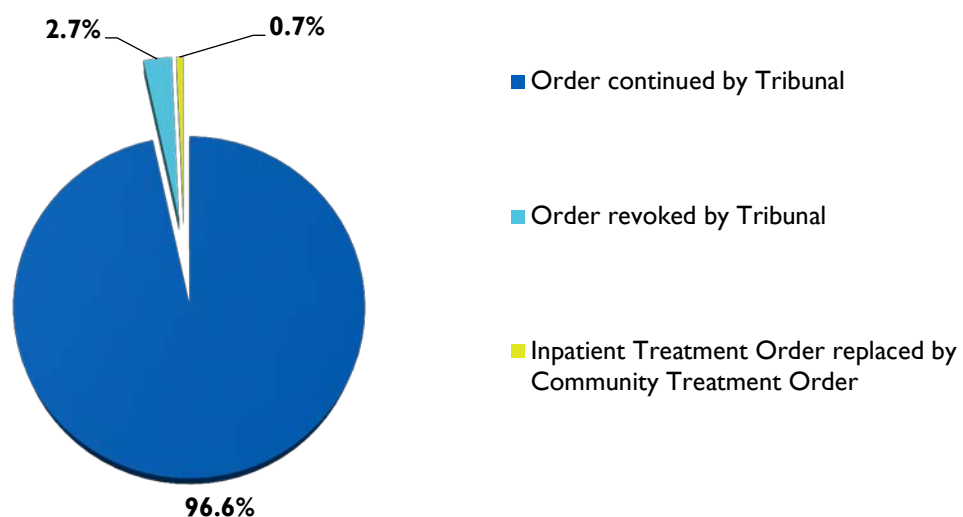
### Hearings conducted by outcome

There were 2247 hearings conducted in 2017-18. In ten matters the outcome is unknown as it was not recorded in the case management database. Of the 2237 hearings for which the outcome is known, 2161

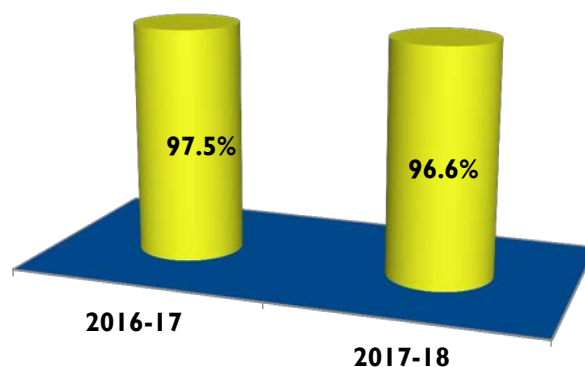
(96.6%) the Tribunal agreed with the treating psychiatrist that the involuntary patient was still in need of the involuntary treatment order and continued the order. In 60 (2.7%) of hearings conducted, the Tribunal disagreed with the treating psychiatrist that the involuntary patient was still in need of the involuntary treatment order and revoked the order. In 16 (.7%) of hearings conducted, the Tribunal disagreed with the treating psychiatrist that the involuntary patient needed an inpatient treatment order, and directed the psychiatrist to issue a community treatment order instead.

In 2016-17, the Tribunal agreed with the treating psychiatrist that the involuntary patient was still in need of the involuntary treatment order and continued the order in 97.5%.

### 2017-18 hearing outcomes



### Percentages of orders continued by Tribunal by year

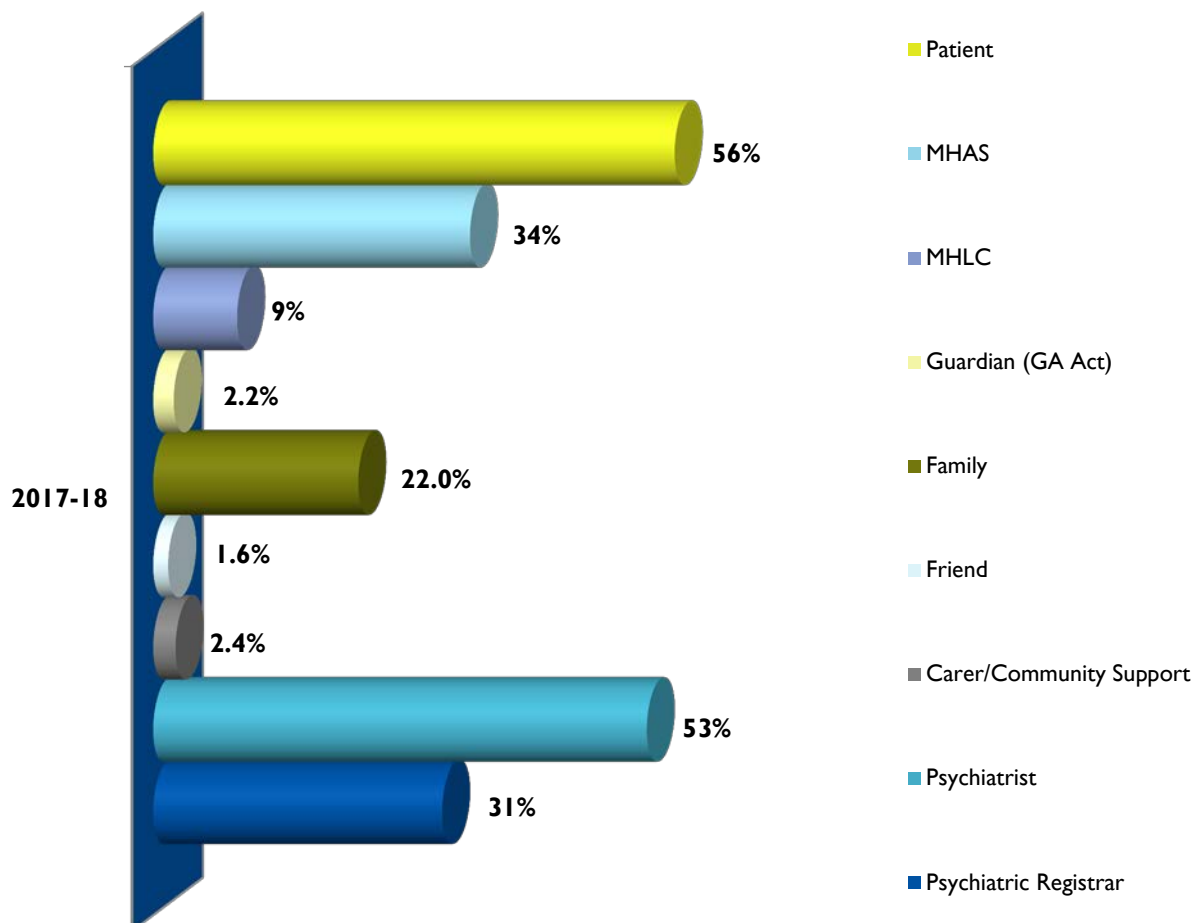


## Attendance at hearings

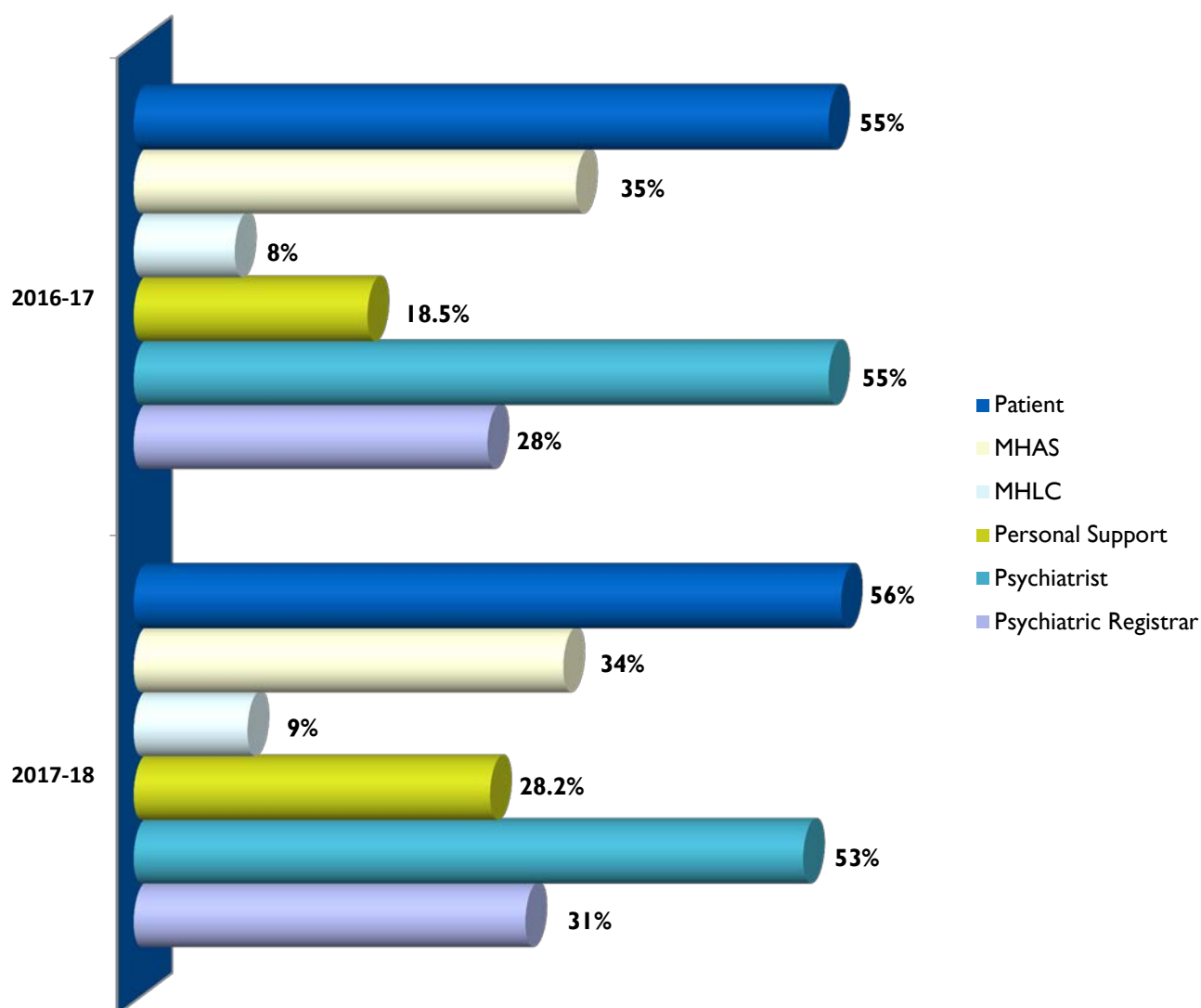
In 2017-18, the Tribunal conducted 2247 hearings. Patients attended their own hearings 56% of the time. Patients were represented by the Mental Health Advocacy Service (MHAS) at 34% of hearings. Patients were represented by the Mental Health Law Centre (MHLC) at 9% of hearings. Patients had Guardians (appointed under the *Guardianship and Administration Act 1990* (WA) (GA Act)) present at 2.2% of hearings, and family members present at 22% of hearings. Patients attended the hearing with a friend or carer at 4% of hearings. Psychiatrists attended 53% of hearings, and psychiatric registrars attended at 31% of hearings (either with a psychiatrist or alone).

*Note: multiple parties attend most hearings, so total attendees will exceed the number of hearings.*

### 2017-18 percentage of parties attending hearings



## Comparison of percentage of parties attending hearings by year

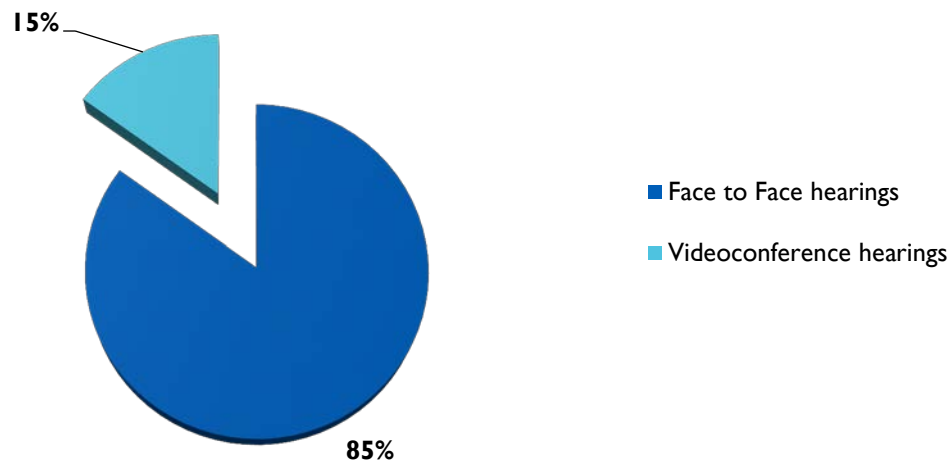


*Note: In 2016-17, separate figures for attendance by Guardians, Family, Friends, and Carer/Community support were not reported. All four categories were combined, so direct comparisons with 2017-18 are not available for these categories. For the purposes of comparison between 2016-17 and 2017-18, a combined category of 'Personal Support' has been used.*

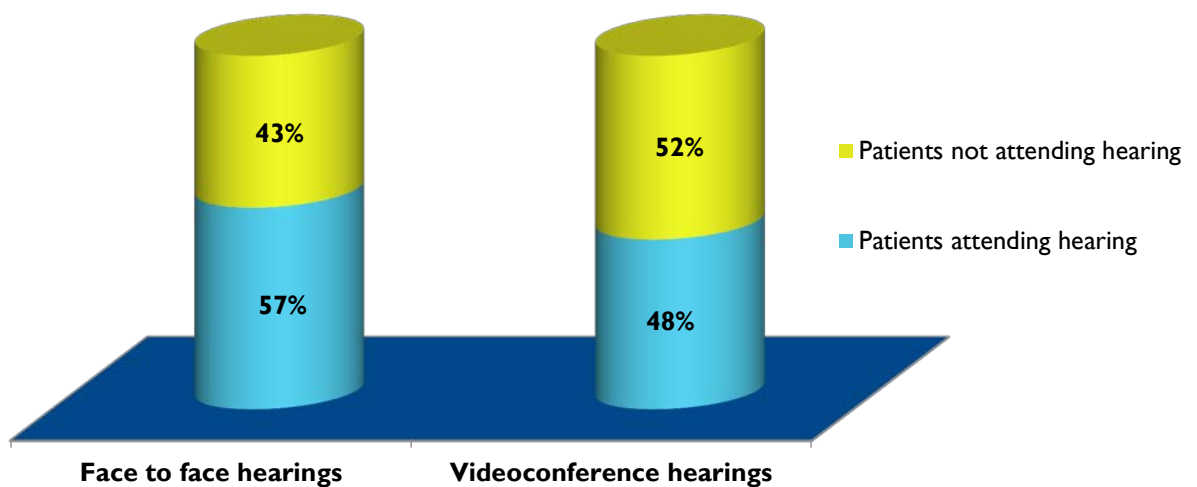
## Mode by which hearing conducted

In 2017-18, the Tribunal conducted 1918 of its 2247 hearings (85%) in-person at a hospital or clinic. The Tribunal conducted 329 hearings by videoconference (15%). Patients attend in-person hearings at a rate of 57% and attend videoconference hearings at a rate of 48%.

## 2017-18 hearing mode



## 2017-18 Patient attendance at hearings by hearing mode



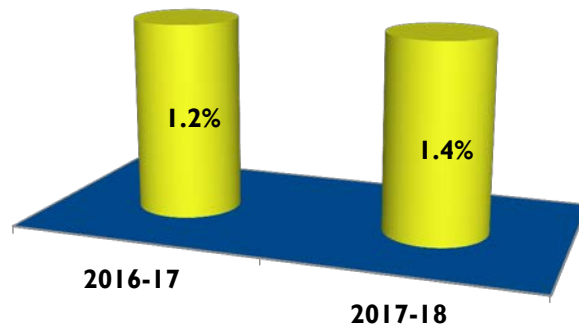
*Note: In 2017-18, most videoconferences involved patients living in remote locations. Often there are significant distances between the patient's residence and the location of the videoconference, which may impact on the attendance rate.*

## Requests for written reasons for decisions

Patients request written reasons for the Tribunal's decision in only a very small percentage of hearings. Tribunal members provide oral reasons for decision at the end of every hearing, but in 2017-18 this was

followed up with written reasons in 33 out of 2247 hearings (1.4% of hearings). In 2016-17, the Tribunal provided written reasons in 26 out of 2103 hearings (1.2% of hearings).

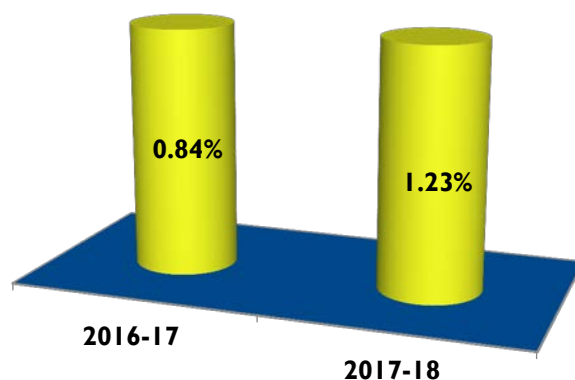
#### 2017-18 requests for written reasons for decision



#### Applications to the State Administrative Tribunal for review

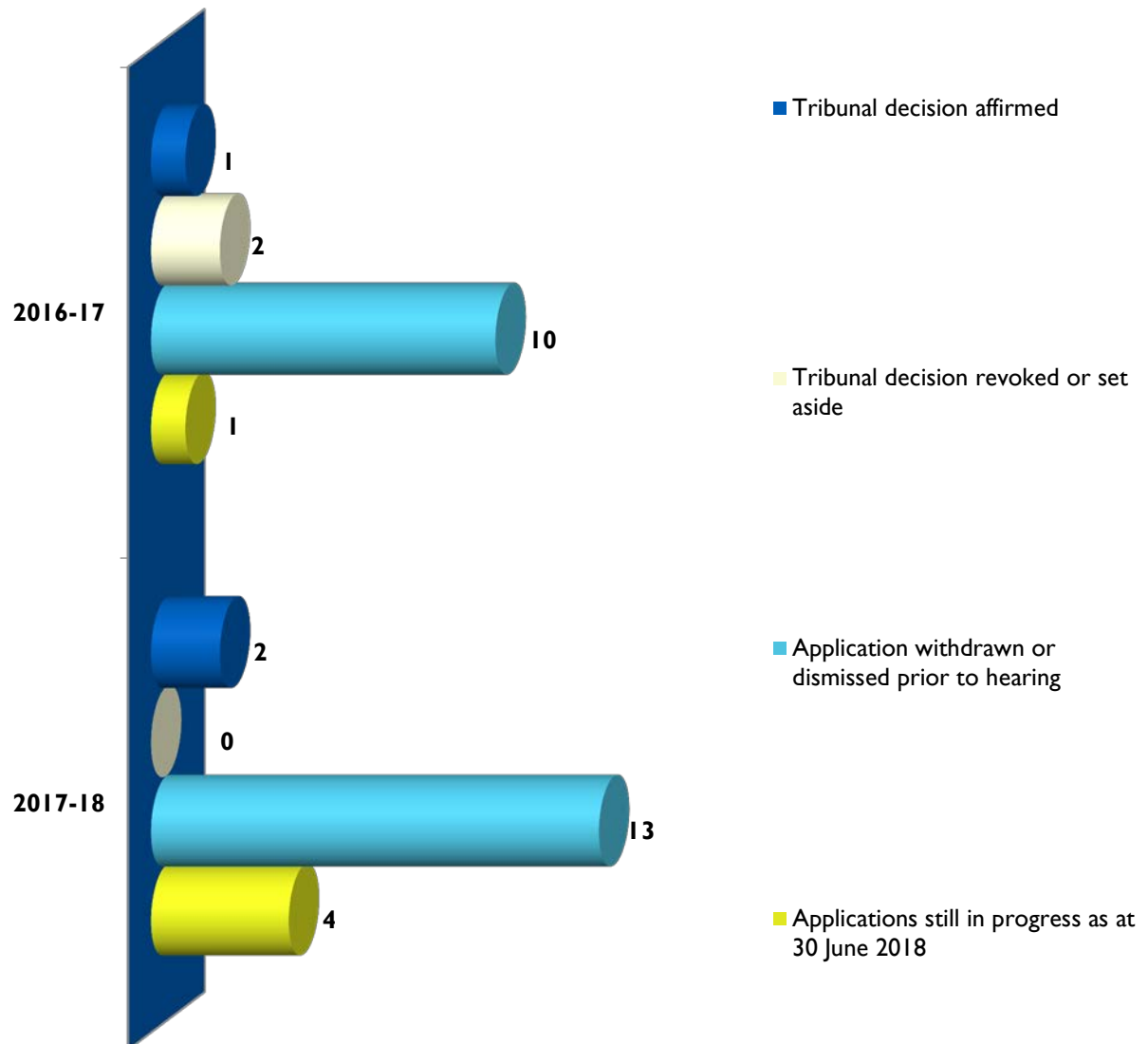
Only a very small percentage of the Tribunal's hearings are the subject of an application to the SAT for review pursuant to section 494 of the Act (19 out of 2247 hearings in 2017-18 and 26 out of 2103 hearings in 2016-17). Of these, even fewer proceed to a hearing on the merits at the SAT, with most applications either falling away because the involuntary treatment order has been revoked by the psychiatrist whilst awaiting hearing, or because the application is abandoned by the applicant. As the SAT determines matters based on the evidence available at the date of its hearing, rather than the materials before the Tribunal at the original hearing, the revocation or setting aside of a decision of the Tribunal does not necessarily indicate an error on the part of the Tribunal in deciding the matter.

#### Comparison of percentage of review applications to the State Administrative Tribunal by year





## Comparison outcomes of review applications to the State Administrative Tribunal by year



## Financial Report

In 2017-18, the Tribunal was funded by Parliamentary appropriation of \$2,653,000.

The Tribunal is an affiliated body of the Mental Health Commission within the meaning of section 60(1)(b) of the *Financial Management Act 2006* (WA) and its funding is administered by the Mental Health Commission. The Mental Health Commission includes in its annual report a financial statement for the Tribunal detailing the amount or value of financial assistance provided by the Mental Health Commission during the financial year.

## Appendix One: Tribunal Members at 30 June 2018

### Legal Members

Tribunal Member Name	Commencement of Current Term	Expiry of Current Term
Geoffrey Abbott	20 December 2016	19 December 2021
Ryan Arndt	2 May 2017	1 May 2022
Kathryn Barker	2 May 2017	1 May 2022
Harriette Benz	2 May 2017	1 May 2022
Peter Curry	2 May 2017	1 May 2022
Jeanette De Klerk	2 May 2017	1 May 2022
Andrea McCallum	2 May 2017	1 May 2022
Dr Hannah McGlade	2 May 2017	1 May 2022
Michael Nicholls QC	2 May 2017	1 May 2022
Anne Seghezzi	2 May 2017	1 May 2022
Merranie Strauss	2 May 2017	1 May 2022
Jennifer Wall	2 May 2017	1 May 2022
Karen Whitney	30 December 2017	29 December 2022
Rachel Yates	2 May 2017	1 May 2022

### Psychiatrist Members

Tribunal Member Name	Commencement of Current Term	Expiry of Current Term
Dr Dawn Barker	1 May 2018	30 April 2023
Dr Ann Bell	1 May 2018	30 April 2023
Dr Adam Brett	2 May 2017	1 May 2022
Dr Jacques Classen	13 September 2017	12 September 2018
Dr Hugh Cook AM	2 May 2017	1 May 2022
Dr Emma Crampin	1 May 2018	30 April 2023
Dr Russell Date	20 December 2016	19 December 2021
Dr Rowan Davidson	20 December 2016	19 December 2021
Dr Daniel De Klerk	1 May 2018	30 April 2023
Dr Kevin Dodd	2 May 2017	1 May 2022
Dr Larissa Harding	13 September 2017	12 September 2018
Dr Aleksandra Jaworska	20 December 2016	19 December 2021
Dr Fiona Krantz	1 May 2018	30 April 2023

Dr David Lord	20 December 2016	19 December 2021
Dr Roland Main	20 December 2016	19 December 2021
Dr Elizabeth Moore	1 May 2018	30 April 2023
Dr Ahmed Munib	1 May 2018	30 April 2023
Dr Steven Patchett	2 May 2017	1 May 2022
Dr Nada Raich	2 May 2017	1 May 2022
Dr Mircea Schineanu	1 May 2018	30 April 2023
Dr Gordon Shymko	20 December 2016	19 December 2021
Dr Helen Slattery	20 December 2016	19 December 2021
Dr Alexander Tait	20 December 2016	19 December 2021
Dr Bryan Tanney	2 May 2017	1 May 2022
Dr Gabor Ungvari	20 December 2016	19 December 2021
Dr Helen Ward	1 May 2018	30 April 2023
Dr Caroline Zanetti	13 September 2017	12 September 2018
Dr Anthony Zorbas	2 May 2017	1 May 2022

## Community Members

Tribunal Member Name	Commencement of Current Term	Expiry of Current Term
Alan Alford	2 May 2017	1 May 2022
Jennifer Bridge-Wright	2 May 2017	1 May 2022
Reverend Rodger Bull	2 May 2017	1 May 2022
Donna Dean	2 May 2017	1 May 2022
Stuart Flynn	2 May 2017	1 May 2022
John Gardiner	2 May 2017	1 May 2022
Susan Grace	2 May 2017	1 May 2022
Emeritus Prof. David Hawks AM	2 May 2017	1 May 2022
John James	2 May 2017	1 May 2022
Manjit Kaur	2 May 2017	1 May 2022
Lorrae Loud	20 December 2016	19 December 2021
Dr David Rowell	2 May 2017	1 May 2022
Maxinne Sclanders	2 May 2017	1 May 2022
Leone Shiels	2 May 2017	1 May 2022
Anthony Warner AM LVO	2 May 2017	1 May 2022
Ann White	2 May 2017	1 May 2022
The Hon. Keith Wilson AM	2 May 2017	1 May 2022

## Appendix Two: Strategic Plan 2018 – 2020

### our vision

Accessible justice for those whose rights are affected by decisions made under the *Mental Health Act 2014*.

### our mission

Safeguarding rights and promoting compliance and accountability under the *Mental Health Act 2014* by:

- Ensuring involuntary treatment authorised under the Act strictly complies with the provisions and objects of the Act;
- Determining applications for treatment by electroconvulsive therapy and psychosurgery;
- Addressing non-compliance with prescribed requirements under the Act; and
- Providing independent review of the validity of involuntary treatment orders, the admission of long-term voluntary patients, the validity and appropriateness of nominated persons, and the reasonableness of certain decisions under the Act restricting freedoms and affecting rights.

### our values

- |                           |                |                  |              |
|---------------------------|----------------|------------------|--------------|
| ▪ Respect for the law     | ▪ Fairness     | ▪ Accessibility  | ▪ Competence |
| ▪ Equality before the law | ▪ Impartiality | ▪ Efficiency     | ▪ Integrity  |
|                           | ▪ Independence | ▪ Accountability |              |

strategic objectives	action plan
<b>We will achieve high quality patient-centred outcomes in every matter.</b>	<ul style="list-style-type: none"><li>▪ The Tribunal will conduct a respectful, fair hearing resulting in a consistent, just decision in every matter by:<ul style="list-style-type: none"><li>✓ conducting hearings in accordance with the principles of procedural fairness;</li><li>✓ deciding matters solely on the application of the relevant law to the facts of the case;</li><li>✓ making factual findings based on an independent assessment of the quality and weight of the evidence presented, including the expert evidence;</li><li>✓ interpreting the law consistently, impartially and independently;</li><li>✓ treating everyone with fairness, courtesy, tolerance and compassion.</li></ul></li><li>▪ The Tribunal will meet statutory objects, functions, obligations and timeframes in every matter by:<ul style="list-style-type: none"><li>✓ ensuring the Tribunal is validly constituted in every matter;</li><li>✓ conducting every matter in accordance with the timeframes set out in the Act;</li><li>✓ ensuring Tribunal proceedings, notices, orders and reasons are consistent with the Act;</li><li>✓ having regard to the mandatory statutory factors required for each matter type;</li><li>✓ ensuring Registry functions comply with the Act.</li></ul></li></ul>

<b>We will support stakeholder participation in the hearing process.</b>	<ul style="list-style-type: none"> <li>▪ The Tribunal will provide patients, carers, families and supporters with the information they need to actively participate in hearings.</li> <li>▪ The President will make rules and or publish practice directions to ensure that hearing materials (including medical reports) are available to participants sufficiently in advance of hearings to facilitate proper consideration.</li> <li>▪ The Tribunal will provide a range of convenient participation options (including telephone, videoconference, or in-person).</li> <li>▪ The Tribunal will ensure participants know their participation at hearings is valuable and contributes to the outcome.</li> <li>▪ The Tribunal will make information about the Tribunal's processes publically available and will refer participants to these sources of information.</li> </ul>
<b>We will improve how we work and maximise our use of technology.</b>	<ul style="list-style-type: none"> <li>▪ The Tribunal will implement a case management system which facilitates, monitors, and reports on compliance with statutory functions and statutory timeframes and supports the transition to electronic delivery of hearing materials.</li> <li>▪ The Tribunal will enhance its website to provide greater access to information and Tribunal forms.</li> <li>▪ The Tribunal will conduct video/tele-conference hearings as required to meet urgent timeframes and maximise Tribunal efficiency.</li> <li>▪ The Tribunal will transition to an electronic records management system to comply with its statutory record-keeping obligations.</li> </ul>
<b>We will build our capacity and make best use of our resources.</b>	<ul style="list-style-type: none"> <li>▪ The Tribunal will recruit and reappoint members solely on the basis of merit through an open recruitment process.</li> <li>▪ The President will develop and implement a mandatory continuing professional development program for members.</li> <li>▪ The Tribunal will appoint members on a full time, part time, or sessional basis as required to ensure availability and to maximise Tribunal efficiency.</li> <li>▪ Tribunal members will demonstrate mastery of the core competencies identified in the COAT Tribunal Competency Framework, conduct themselves in accordance with relevant Codes of Conduct, and demonstrate commitment to ongoing development.</li> <li>▪ The Tribunal Registry will utilise best practice in case flow management.</li> <li>▪ The Tribunal Registry will articulate its administrative processes in a manual which will be publically available</li> <li>▪ The President will commence implementation of the COAT Tribunal Excellence Framework.</li> <li>▪ The President will maintain links and exchange ideas with Mental Health Tribunals and other Tribunals throughout Australia.</li> <li>▪ All members and staff will demonstrate a commitment to best practice and maximising Tribunal efficiency.</li> </ul>

# Appendix Three: Charter of Mental Health Care Principles

## **Purpose**

The Charter of Mental Health Care Principles is a rights-based set of principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness.

The Charter is intended to influence the interconnected factors that facilitate recovery from mental illness.

## **Principle 1: Attitude towards people experiencing mental illness**

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.

## **Principle 2: Human rights**

A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

## **Principle 3: Person-centred approach**

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

A mental health service must promote positive and encouraging recovery focused attitudes towards mental illness, including that people can and do recover, lead full and productive lives and make meaningful contributions to the community.

## **Principle 4: Delivery of treatment, care and support**

A mental health service must be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is consistent with their needs.

## **Principle 5: Choice and self-determination**

A mental health service must involve people in decision-making and encourage self-determination, cooperation and choice, including by recognising people's capacity to make their own decisions.

### **Principle 6: Diversity**

A mental health service must recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

### **Principle 7: People of Aboriginal or Torres Strait Islander descent**

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

### **Principle 8: Co-occurring needs**

A mental health service must address physical, medical and dental health needs of people experiencing mental illness and other co-occurring health issues, including physical and intellectual disability and alcohol and other drug problems.

### **Principle 9: Factors influencing mental health and wellbeing**

A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, accommodation, recreation, education, financial circumstances and employment.

### **Principle 10: Privacy and confidentiality**

A mental health service must respect and maintain privacy and confidentiality.

### **Principle 11: Responsibilities and dependants**

A mental health service must acknowledge the responsibilities and commitments of people experiencing mental illness, particularly the needs of their children and other dependants.

### **Principle 12: Provision of information about mental illness and treatment**

A mental health service must provide, and clearly explain, information about the nature of the mental illness and about treatment (including any risks, side effects and alternatives) to people experiencing mental illness in a way that will help them to understand and to express views or make decisions.

### **Principle 13: Provision of information about rights**

A mental health service must provide, and clearly explain, information about legal rights, including those relating to representation, advocacy, complaints procedures, services and access to personal information, in a way that will help people experiencing mental illness to understand, obtain assistance and uphold their rights.



**Principle 14: Involvement of other people**

A mental health service must take a collaborative approach to decision making, including respecting and facilitating the right of people experiencing mental illness to involve their family members, carers and other personal support persons in planning, undertaking, evaluating and improving their treatment, care and support.

**Principle 15: Accountability and improvement**

A mental health service must be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the treatment, care and support of people experiencing mental illness, including their family members, carers and other personal and professional support persons.

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West Perth WA 6872

