Joint Submission to Members of the WA Legislative Council on the

Mental Health Bill 2013 as passed by the Legislative Assembly

Prepared by Martin Whitely, Senior Advocate, Health Consumers Council of WA[1]

This submission is endorsed by (in alphabetical order):

Consumers of Mental Health WA

Health Consumers Council WA

Mental Health Law Centre WA

Mental Health Matters 2

And has 'In Principle Support' from

Arafmi (WA)

Carers WA

Mental Illness Fellowship WA

Richmond Fellowship of WA

[1] Many of the issues in this paper are taken directly from submissions made by the Mental Health Law Centre and the Centre's Principal Solicitor has consented to the use of the Centre's words without each quote being individually identified.

Introduction – A good Bill that can be improved

The Minister for Mental Health the Hon. Helen Morton and the Mental Health Commission deserve congratulations for many of the improvements contained in the Mental Health Bill 2013 recently passed by the Legislative Assembly. The Members of the Legislative Assembly also deserve congratulations for some of the amendments made to the 2013 Bill during the debate. For example the amendment that removed the contempt provisions in respect of Mental Health Tribunal reviews is very welcome.

Despite these improvements over the current legislation there are problems with the Mental Health Bill 2013 (the Bill), and in one important area the bill represents a significant backwards step from the Mental Health Act 1996 (the Current Act). In particular the criteria for making patients involuntary have been broadened heightening the risk of unwarranted detention and involuntary treatment.

It must be remembered people who are believed to be mentally unwell and in need of urgent 'involuntary detention and treatment' have not committed a crime and that on many occasions throughout history the power to detain and treat those deemed to be 'mentally ill' has been abused in the guise of therapy or protecting the public. Although the majority of mental health practitioners are competent and responsible there are too many historical examples of mental health practitioners precipitating considerable harm, including avoidable deaths. And regrettably there is an unhappy local, national and international history of self-regulatory failure by some in the mental health professions.

Despite the improvements in the Bill it is interesting to note that the penalty for ill treatment or wilful neglect of a patient is a maximum penalty of $15,000 and/or 2 years imprisonment.[2] In contrast the maximum penalties for causing unnecessary harm to an animal under the *Animal Welfare Act 2002* (WA) are respectively $50,000 and/or 5 years imprisonment. Furthermore, the threshold for defining criminal behaviour in relation to the treatment of animals is much more rigorous than it is for involuntary mental health patients.

We therefore encourage Legislative Council Members to consider the following suggested amendments which are proposed having regard to Professor Stokes July 2012 Report[3] and our coal face experiences in working with the current Act.

Please Note: This submission is divided into three sections.

All references to clauses by number in this document relate to the Bill to be debated by the Legislative Council. Some number references are different to the Bill debated by the Legislative Assembly.

[2] Mental Health Bill 2013 clause 253 (Duty not to ill-treat or wilfully neglect patients)

[3] See http://www.health.wa.gov.au/publications/review/main_documents/mental_health_review_2012.pdf

MAJOR ISSUES

Clause 25 (Involuntary Detention Criteria)

Extract from the Mental Health Act 1996

26. Persons who should be involuntary patients
(1) A person should be an involuntary patient only…
(i) to protect the health or safety of that person or any other person;
(ii) to protect the person from self-inflicted harm of a kind described in subsection (2); or
(iii) to prevent the person doing serious damage to any property…

(2) The kinds of self-inflicted harm from which a person may be protected by making the person an involuntary patient are
(a) serious financial harm;
(b) lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships; and
(c) serious damage to the reputation of the person.

Extract from the Mental Health Bill 2013

25. Criteria for involuntary treatment order

(1) A person is in need of an inpatient treatment order…
(b) that, because of the mental illness, there is-
(i) a significant risk to the health or safety of the person or to the safety of another person; or
(ii) a significant risk of serious harm to the person or another person

Note : The Explanatory Memorandum (page 14) specifically highlights that the existing criteria of self-inflicted harm to 'property, finances, reputation or relationships' remain valid and are merely a subset of what may be deemed to constitute serious harm by a psychiatrist. It states:
The concept of 'serious harm' is not detailed in the Act itself because it must be determined by a psychiatrist on a case by case basis, using the appropriate clinical tools. As examples the harm may be to property, finances, reputation or relationships.

As demonstrated in the extract above, the Bill expands the criteria for detaining and/or treating patients without consent by substituting *'significant risk of serious harm'* for the narrower criteria in the Current Act. Specifically the Current Act limits 'risk' criteria by which a person can be made an involuntary patient to five risks (health and safety of self or others, property or financial, relationships and reputation). Although the Bill limits the number to two (health safety of self and others and unspecified serious harm), the term *'serious harm'* is so broad that the net effect is to make it likely that many more people will be involuntarily detained and treated. Furthermore clause 25(1)(b)(ii) of the Bill expands the criteria by applying it to unspecified harm to *'another person'*, not just 'self-inflicted' harm to the patient.

The issues sought to be covered by clause 25(b)(ii) could be resolved by other less restrictive, more dignified methods, such as guardianship and administration orders. Human dignity as a human right has been the subject of important recent international legal analysis,[4] and is contemplated by the objects of the Bill at clause 10(1). In addition a recent UN report on involuntary detention in Australia recommended the:

> *repeal of all legislation that authorizes medical intervention without free and informed consent, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.*[5]

The 1996 Act approach of specifying what constitutes *'harm'* is superior to the open definition approach in the new Bill. However, the wording of the 1996 ACT should be amended to remove the risk of damage to the '*reputation of the person'* and potential damage to an *'important personal relationship'*. These provisions are open to subjective interpretation, and even abuse; and should be removed. This would leave significant risk to health, safety and property of self and others, and significant risk of financial harm to the person, as grounds for making a person an involuntary patient.

Recommended Action - Amend the Bill to re-establish the effect of the 1996 Act but the terms 'significant' and 'serious' added with the following removed:

> ~~(b) lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships; and~~
> ~~(c) serious damage to the reputation of the person.~~

The new clause would therefore read

25. Criteria for involuntary treatment order

(1) A person is in need of an inpatient treatment order…

> (b) that, because of the mental illness, there is-
>
> > (i) a significant risk to the health or safety of the person or to the safety of another person; or
> > ~~(ii) a significant risk of serious harm to the person or another person~~ (deleted)
> > (ii) a significant risk of the person doing serious damage to any property (added)
> > (ii) a significant risk of serious financial harm to person (added)

Note: If this amendment fails, then the words 'or another person' should be deleted from 25 (1)(b)(ii). This would limit the criteria relating to another person as being a 'significant risk' to their 'health and safety'.

---

[4] Resta, Giorgio "the Law of Human Dignity" The Law Society of Western Australia Brief Vol 41 Number 11 February 2014, page 17-20.

[5] Paragraph 34 of the concluding observations on the initial report of Australia (CRPD/C/AUS/1), adopted by the Committee on the Rights of Person with Disabilities at its tenth session (2-13 September 2013) UN Convention on the Rights of Persons with Disabilities Distr.: General 21 October 2013 see http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCoQFjAA&url=http%3A%2F%2Fwww.ag.gov.au%2FRightsAndProtections%2FHumanRights%2FTreatyBodyReporting%2FDocuments%2FUN%2520Committee%2520on%2520the%2520Rights%2520of%2520Persons%2520with%2520Disabilities%2520Concluding%2520Observations.doc&ei=_lNgU6AnhaKIB7GJgIAN&usg=AFQjCNET9fLjJ1PRhZRo4s5X4UE88NpIIw&sig2=wCAPfIZoeUDnyLwGPm2sXQ&bvm=bv.65636070,d.aGc

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed an amendment that went further than the amendment recommended above in that it also removed the 'damage to property' criteria. Dr Buti's amendment was defeated in the Assembly. However the amendment proposed above leave the 'property' criteria unchanged and we urge Members of the Legislative Council to support it.

Powers of Authorised Mental Health Practitioners and Police

Oversight of powers of Medical Practitioners and Authorised Mental Health practitioners by the Mental Health and Chief Psychiatrist -The Bill gives Medical Practitioners (who are not psychiatrists), 'Authorised Mental Health Practitioners', and Police very significant powers to detain, restrain, seclude and search people they suspect of having a mental illness. The Chief Psychiatrist can designate social workers[6], occupational therapists, registered nurses, midwives and psychologists as *'Authorised Mental Health Practitioners'* (clauses 536-537).

A Medical Practitioner or an Authorised Mental Health Practitioner have the power to restrain (clause 230) and seclude patients (clause 214). In addition they may detain a person for up to 144 hours initially (clause 28(1)(2)(3)). When extended transportation orders (clauses 146-152) and delays for examination (see clauses 44,45 and 52) are taken into account, an individual could potentially be detained for up to seven days in the metro area and thirteen days outside the metro area (clauses 44-45) before being assessed by a psychiatrist.

Those suspected of having a mental illness should be given at least some of the same protections as those suspected of committing a crime. When the powers of detention or transportation are exercised by those who have limited mental health expertise, for example General Practitioners or Authorised Mental Health Practitioners, there needs to be an automatic process of timely independent review. This will at least ensure there is accountability after the event for the use of these extra-ordinary powers.

Recommended Action - Amend the bill to establish a requirement that any detention or transportation instigated by a Medical Practitioner or Authorised Mental Health Practitioner is reported to both the Chief Psychiatrist and the Chief Mental Health Advocate who may choose to initiate a visit to the detained person without being requested.

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed amendments that were in line with the above recommendation however they were defeated (see Hansard 13 March 2014 page 1227 and 18 March 2014 page 1361). However, we urge Members of the Legislative Council to support the proposed amendment and ensure appropriate oversight of the power to detain law abiding citizens.

Oversight of powers of the Police -There are very good reasons why police cannot detain someone whom they merely suspect may commit a crime. However, Police are empowered under clause 156 to apprehend any individual they suspect of having a mental illness and of being a danger to themselves, the public or property. Police officers are also empowered to enter any premises, conduct body searches and seize virtually any article from the individual suspected of having a mental illness (clause 162(2)(b)& 164(2)). Mandatory reporting to the Chief Mental Health Advocate of instances where the Police use these powers would help to ensure that these powers are used responsibly.

[6] 'Social Workers' being persons who are eligible for membership of the Australian Association of Social Workers (AASW)

Recommended Action – Amend the Bill to ensure that when the police powers granted under clause 156 and clause 162(2)(b)& 164(2) are used these actions are reported to both the Chief Psychiatrist and the Chief Mental Health Advocate.

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed amendments in line with the above recommendation that were defeated. (Hansard 18 March 2014 pages 1364 and 1367) However, we urge Members of the Legislative Council to support the proposed amendment and ensure appropriate oversight of the powers to bodily search and seize the property of law abiding citizens.

The use of Seclusion and Bodily and Chemical Restraint

There is a significant nationwide push to significantly decrease the use of seclusion and restraint in Australian Mental Health Services.[7] The Bill authorises psychiatrists and medical practitioners and mental health practitioners to (bodily, physically or mechanically) restrain or seclude patients but commendably seeks to restrict their use. The details of the restraint or seclusion are reported to the Chief Psychiatrist (restraint 240(2) and seclusion 224(2)). This is a worthwhile requirement. However, this information should also be forwarded to the Chief Mental Health Advocate. This will provide an added protection to ensure that the patient's rights are not unnecessarily violated.

The Bill should also apply the bodily restraint reporting protections (in clauses 226 – 240) to 'Chemical Restraint', especially for children because of the very significant risks to airways associated with this form of restraint. Without equal reporting requirements the incidence of chemical restraint may increase. The meaning of 'Chemical Restraint' as defined by the Office of the Public Advocate is

> *the intentional use of medication to control a person's behaviour when no medically identified condition is being treated; where the treatment is not necessary for the condition; or the intended effect of the drug is to sedate the person for convenience or for disciplinary purposes.* [8]

The reality of our coal face experience is that drugs with limited therapeutic effect are often intentionally over-utilised with the intent of sedating the patient to modify challenging, dangerous or difficult behaviours. We therefore believe the definition of 'Chemical Constraint' in the Bill should be expanded from that provided by the Office of the public Advocate to include the use of drugs with the intention of modifying behaviour even if the drugs are part of the patient's therapeutic treatment plan.

Recommended Action – Amend clauses 226 to 240 and 224(2) to expand the requirements to apply to chemical restraints in addition to bodily restraints and to include the requirement that the information provided to the Chief Psychiatrist regarding each incident of restraint and seclusion is also provided to the Chief Mental Health Advocate. The Bill should also state that use of all forms of restraint are to be measures of absolute 'last resort'.

---

[7] National Mental Health Consumer & Carer Forum 2009 Ending Seclusion and Restraint in Australian Mental Health Services ISBN : 978-0-9807007-0-1 available at www.nmhccf.org.au/documents/Seclusion%20&%20Restraint.pdf

[8] Office of the Public Advocate. 2013. Position Statement: Restraint. http://www.publicadvocate.wa.gov.au/_files/Position_statement_2.doc <05/05/14>

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed amendments in line with elements of the above recommendation that were defeated. (Hansard 20 March 2014 pages 1708 and 1724) However, we urge Members of the Legislative Council to support the proposed amendments and ensure appropriate oversight of these extremely invasive powers.

Interaction with *Advanced Health Care Planning Directive Act 2006*

There is a growing recognition that even persistent mental illness is often intermittent, with prolonged periods of wellness and periods of mental illness. When they are well people who later become mentally ill have the same capacity as all individuals to determine the treatments they find acceptable and effective. However, too often individuals who have become mentally unwell have been treated with medications that they know in the past have had serious adverse effects on them. When they are well they should have the ability to prohibit the use of these treatments.

Advanced Health Directives give patients the opportunity to determine what medical treatments they consent to in advance in the event they become unable to express their view at the time of the need for treatment. However, rather than giving an Advance Health Directive full force and effect, the Bill merely refers to an Advance Health Directive as a matter that must be regarded in ascertaining the wishes of a person where wishes have to be considered (see clause 8 and definition in clause 4).

This changes the nature of an Advanced Health Directive and reduces the effect set out in the *Guardianship and Administration Act* 1990. It also discriminates against mentally ill persons and is therefore contrary to Principle 1 of the Charter of Mental Health Care Principles in Schedule 1 to the Bill.

In rare cases it may be necessary to overturn their wishes as expressed in an Advanced Health Directive however, this should only occur after the need has been established via a rigorous independent process. Therefore a treating psychiatrist should be required to apply to the State Administrative Tribunal (SAT) before a patient's future health directive can be overturned. SAT should then follow the provisions of the *Guardianship and Administration Act* in exercising this jurisdiction.

Recommended Action - The Bill should provide that except in emergency situations the scheme of the *Guardianship and Administration Act* relating to advance health directives must be followed in its entirety in order to give them full force and effect. This means that in all cases of non- emergency treatment a treating psychiatrist should be required to apply to the SAT before a patient's future health directive can be overturned. The SAT should then follow the provisions of the *Guardianship and Administration Act* in exercising this jurisdiction.

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed an amendment in line with the above recommendation that was defeated. (Hansard 27 February 2014 pages 863) However, we urge Members of the Legislative Council to support the proposed amendment and respect the capacity of 'well' individuals to make decisions about their own future treatment.

Informed Consent about Treatment and the Disclosure of Financial Interests of Treating Doctors – Clause 19(1)

A 2011 draft of the Bill prepared for public comment contained rigorous clauses in relation to informed consent (see box below). Clause 14 of the 2011 draft required that *'consent must be in the*

approved form; and signed by the person.' The draft Bill also enabled the patient to request for *'another person'* to be present when information about the proposed treatment is provided and that *'information or advice…must be provided in a language, form of communication and terms the person is likely to understand 15(2).'* As demonstrated in the box below the *Mental Health Bill 2013* significantly waters down the requirements for informed consent that were in the 2011 draft of the Bill. There is no requirement for a signed consent form or any obligation to allow the patient to request another person is present or requirement that the information is provided in a manner comprehensible to the patient.

Informed Consent provisions ***Mental Health Bill 2011*** **-** (Earlier draft for public consultation)

15(1) Before a person is asked whether or not the person gives consent, the person must be provided with these things —

(a) a clear explanation of the nature, purpose and likely duration of the admission or treatment that includes sufficient information to enable the person to make a reasonable decision about whether or not to give consent to the admission or treatment;
(b) an adequate description (without exaggeration, concealment or distortion) of the expected benefits and possible discomforts and risks of the admission or treatment;
(c) an adequate description of the alternatives to the admission or treatment that are reasonably available;
(d) information about any financial advantage that may be gained by any medical practitioner or mental health service in respect of the admission or treatment, except information about the fees and charges payable by or on behalf of the person for the admission or treatment;
(e) information about any research relationship between any medical practitioner and any mental health service that may be relevant to the admission or treatment;
(f) advice that the person may obtain independent legal and medical advice about the admission or treatment before consent is given and that the person may request assistance to obtain that advice;
(g) if the person requests assistance to obtain legal or medical advice referred to in paragraph (f), reasonable assistance to obtain the advice;
(h) an opportunity to ask questions about the admission or treatment;
(i) clear answers that the person is likely to understand to all relevant questions the person asks;
(j) advice that the person may refuse to give consent to the admission or treatment and that, if the person does give consent, the person can withdraw consent at any time.

Informed Consent provisions ***Mental Health Bill 2013***

19 (1) Before a person is asked to make a treatment decision about the provision of treatment to a patient, the person must be provided with a clear explanation of the treatment —

(a) containing sufficient information to enable the person to make a balanced judgment about the treatment; and
(b) identifying and explaining any alternative treatment about which there is insufficient knowledge to justify it being recommended or to enable its effect to be predicted reliably; and
(c) warning the person of any risks inherent in the treatment.

(2) The extent of the information required under subsection (1) to be provided to a person is limited to information that a reasonable person in the person's position would be likely to consider significant to the treatment decision unless the person providing the information knows, or could reasonably have been *expected to know, that the person is likely to consider other information to be significant to the treatment decision.*

Information regarding treatment – The 2001 draft required a treating doctor to provide *'an adequate description of the alternatives to the admission or treatment that are reasonably available'* however the Bill only obliges doctors to provide 'sufficient information' about a single treatment. Patients have a right to know about all viable options in order to reach a guided decision

about their treatment rather than just be presented with a single treatment option chosen by the doctor, except of course where it is the only viable option.

Recommended Action - Amend the Bill at 19(1) to reflect the approach of the 2011 draft in regards to advice about treatment alternatives so that the patient is provided with *'an adequate description of the alternatives to the admission or treatment that are reasonably available'*.

It may be argued the 2011 draft of the Bill was overly prescriptive in terms of information provided to patients in regards to treatment risks and that the requirements of 19(1)(a)(b)(c) of the final Bill are adequate. It is however worth reinstating from the 2011 draft the clauses that requires treating doctors to provide '*advice that the person may refuse to give consent… {or] withdraw consent at any time … [and]… may obtain independent legal and medical advice… and that the person may request assistance to obtain that advice.'* These are not an onerous provision as competent practitioners will do this automatically.

Recommended Action - Amend the bill to insert the wording of the 2011 draft in regards to advice about refusal or withdrawal of consent. Specifically add the following:

19(1)… (e) advice that the person may refuse to give consent to the admission or treatment and that, if the person does give consent, the person can withdraw consent at any time.

(f) advice that the person may obtain independent legal and medical advice about the admission or treatment before consent is given and that the person may request assistance to obtain that advice.

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed amendments in line with aspects of the above recommendations that were defeated. (Hansard 13 March 2014 pages 1210 and 1214) However, we urge Members of the Legislative Council to support the proposed amendments and ensure that patients are provided with adequate information on which to base their treatment decisions.

Financial Disclosures – All references in the 2011 draft requiring disclosure of financial interests by treating doctors have been removed. This included the requirement to disclose any financial advantages which may be gained by the medical practitioner or mental health service in admitting a patient or administering a treatment. The 2011 draft also required disclosure of any relevant research relationships between the practitioner, the mental health service and third parties. The new bill offer patients no protection.

The AMA recognises the need for full disclosure of potential conflicts of interest. They advise their members in a document titled 'Medical Practitioners' Relationships with Industry 2010 Revised 2012' that doctors.

> should inform patients when having an interest that could affect, or be perceived to affect, patient care. This includes referring patients to a medical or other health care service in which the doctor has a financial or other material interest as well as recommending a product in which the doctor has a financial or other material interest (eg. a therapeutic device).'[9]

The important provisions in the 2011 draft that oblige full disclosure of financial interests need to be reinstated in the bill.

[9]Available at https://ama.com.au/position-statement/medical-practitioners-relationships-industry-2010-revised-2012

Recommended Action - Amend the bill to insert the wording of the 2011 draft in regards to financial disclosures. Specifically add the following:

19(1)… (f) information about any financial advantage that may be gained by any medical practitioner or mental health service in respect of the admission or treatment, except information about the fees and charges payable by or on behalf of the person for the admission or treatment;
(g) information about any research relationship between any medical practitioner and any mental health service that may be relevant to the admission or treatment.

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed amendments in line with the above recommendation that were defeated. (Hansard 13 March 2014 pages 1210 and 1214) A reason cited by the Parliamentary Secretary Andrea Mitchell MLA for opposing this amendment was that the AMA did not support it. If so the AMA appears to be unwilling to support legislation that would give legal effect to its own advice. We therefore urge Members of the Legislative Council to support the opposed amendments and guarantee patients are informed about potential conflicts of interest that may impact on their treatment.

The Use of 'Off Label' Treatments on Children

Reporting of Off Label Treatments - Although clauses 195(2)(b) and 208(2)(b) provide some protection by requiring the approval of the Mental Health Tribunal (MHT) for ECT and psychosurgery it is important to realise that many other far more common treatments like the use of SSRI Antidepressants and Antipsychotics are not approved for use by children (by the Therapeutic Goods Authority). These treatments carry warnings for significant risks, including increased suicidality in young people (up to age 24) for antidepressants[10] and significant weight gain, impotence and shortened life expectancy for antipsychotics.[11] Clinicians prescribing these controversial though common 'off label' treatments to children should be accountable for the long-term consequences of their actions.

By reporting these actions to the Chief Psychiatrist there will be the opportunity for external scrutiny of 'outlier' (unusually frequent) prescribers. It will also provide a central point where children who later find they have suffered long term iatrogenic harm (harm caused by treatment) can go for an accurate independent record of their past treatment.

Recommended Action - Amend the Bill to ensure that any 'off-label' (contrary to the manufacturer's prescribing information as approved by the Therapeutic Goods Authority) treatment of a child must be reported to the Chief Psychiatrist.

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed amendments that were in line with the above recommendation that were defeated. However, the Government successfully moved an amendment that required off label treatments for involuntary child patients to be reported to the Chief Psychiatrist (see Hansard 1 April 2014 page 30 to 39). This is a welcome amendment but it would be better if the Legislative Council extended this protection to all children. As the vast majority of treatment decisions are made by a child's parents or guardians in consultation with their doctors in reality most children are 'involuntary' patients and deserve the same protection.

[10] See http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM173233.pdf
[11] See http://benthamscience.com/open/toneuj/articles/V007/23TONEUJ.pdf

Parental Veto of Off Label Treatments - Under normal circumstances parents should have the capacity to veto 'off label' treatments of their children regardless of whether they are voluntary or involuntary patients. Although clauses 300 and 301 state that*; 'in performing a function under this act… a person or body must have regard to the views of a child and their parents or guardian'* these clauses are superseded by clause 299 which states that *the 'best interests of the child… [are the]… primary consideration'*. Therefore where the person or body responsible (often a treating psychiatrist) determines that a child would benefit from a treatment they can ignore the wishes of the child or the parents who oppose it.

There are circumstances in which it may be appropriate to exclude parents and guardians from decisions relating to their child's treatment particularly if they have abused or severely neglected the child. However, these decisions to exclude parents from controversial 'off label' treatment decisions must not be made unilaterally by the child's treating psychiatrist. Exclusions of parents and guardians from these decisions must be made by an independent third party on substantial grounds.

Recommended Action - Amend the Bill to ensure a parent or guardian's right to veto the use of 'off label' psychiatric treatments (treatment for purposes not approved by the TGA), including drug therapies, on their child unless it has been determined by the State Administrative Tribunal that this is not in the best interests of the child.

Debate in the Assembly - The Member for Armadale (Dr Tony Buti) proposed amendments in line with the above recommendation that were defeated. (Hansard 1 April 2014 page 30 to 39) However, we urge Members of the Legislative Council to support the proposed amendments and ensure that parent have the capacity to protect their children from potential harm from treatments that have not been approved for the purpose proposed.

Right to Legal Representation at MH Tribunal Reviews

Clause 447-450 (Subdivision 3 - Appearance and Representation)

The Bill dilutes the current implied (arguably express) right to legal advice for and representation of patients at Mental Health Review Board reviews of a patient's involuntary status. The right to a lawyer in the Current Act means that a lawyer has to be found by the government for a patient who wants a lawyer.[12] However permission to have a lawyer (as is in the Bill) means that the patient may have to find a lawyer and the funds to pay for one. The Bill would be improved by providing a clear right to legal advice and representation at Tribunal reviews.

Furthermore, particular circumstances should be prescribed where legal representation is required, such as for a child, a first time involuntary patient, a patient with comorbidity of mental illness and intellectual impairment, and where there are issues of procedural unfairness and/or invalidity of orders. In addition when a patient declines representation they must have the right to advocacy by a person of their choosing and they must continue to have the right to representation if their wishes change.

Of further concern is that 'representation' is broadened from the Current Act to include representation by non-legally trained advocates (Mental Health Advocate), a child's parent, guardian or some other person. 'Representation' should apply to lawyers and 'advocacy' should apply to non-lawyers, otherwise how will some patients be able to tell/understand the difference?

[12] Hence the funding by government of an independent Community Law Centre such as the MHLC to provide a lawyer

Clause 451 (Legal Representation of person with a mental illness) Clause 450 should be amended to make it clear that a lawyer can access all records of a patient before the Tribunal review and that this includes inspecting the records on the day of the hearing, given the difficulty lawyers presently have in viewing records when they have late instructions. It is not uncommon for a patient's solicitor to act for their client at a review without having reviewed the records. Delaying a review leads to an even greater injustice when the patient is detained and wants to leave hospital.

OTHER IMPROVEMENTS TO SPECIFIC CLAUSES

Clause 4 (Definitions)

'Psychiatrist' is defined in the Bill as 'a medical practitioner '—

(a) who is a fellow of the Royal Australian and New Zealand College of Psychiatrists; or
(b) who holds specialist registration under the Health Practitioner Regulation National Law (Western Australia) in the specialty of psychiatry; or
(c) who holds limited registration under the Health Practitioner Regulation National Law (Western Australia) that enables the medical practitioner to practise in the specialty of psychiatry.

Despite being described as having 'limited registration' there are no restrictions on those described at (c)

- making involuntary patient orders,
- being a clinical director of a psychiatric hospital to whom the Chief Psychiatrist can delegate his powers and therefore sign involuntary detention orders,
- becoming the Chief Psychiatrist or
- becoming the psychiatric member of the Mental Health Tribunal.

Broadening the definition of psychiatrists to include non-psychiatrists encourages stop gap measures, which diminish the standard of care of vulnerable involuntary patients. This is of particular concern for the vast areas of the state and the metropolitan area that are gazetted 'areas of need', meaning that clause 4 (c) psychiatrists can work in these areas.

Ideally only a psychiatrist who is a member of the Royal Australian New Zealand College of Psychiatrists - defined at (a) - should have the power to perform the functions listed above. However as a second best alternative, a medical practitioner with a recognised overseas psychiatric qualification could be registered to make involuntary orders provided that they become eligible for RANZCP registration within a specified period of time. However they should not be permitted to act under any delegated authority from the Chief Psychiatrist (who has wide powers to delegate his/her powers) or as work a clinical director.

Assessment & Examination Clause 4 (or elsewhere in the Bill) should define the minimum requirements for 'Assessment' and 'Examination' for the purpose of referrals and making involuntary orders. This is necessary in order to address the poor standards of care and governance identified by Professor Stokes in his July 2012 report.[13] This is especially important where non-

[13] See http://www.health.wa.gov.au/publications/review/main_documents/mental_health_review_2012.pdf

medical practitioners or medical practitioners without psychiatric qualifications are assessing or examining patients under the powers of the Bill: for example a nurse undertaking a monthly examination of patient on a Community Treatment Order under a power from cl 118(2)(b).

Care is used in the Bill in a number of places and should be defined to include attending to the welfare and protection of the patient and the patient's interests outside the hospital, while they are detained. At present no-one is made responsible in the Bill for preserving the detained patient's outside life, such as paying the rent, turning off the power, emptying our the 'fridge, getting the pets looked after etc., and this causes significant problems for patients who are detained suddenly.

Clauses 7 and 8 (Matters relevant to decision about person's best interests and wishes)

Where practical and where possible with the consent of the patient the patient's chosen practitioner (or current treating practitioner) should be included when in the process of ascertaining the person's 'wishes' and 'best interests'. They should also be involved in deciding who should also be consulted about the patient's 'wishes' and 'best interests.'

Clause 49 (Information to which practitioner must have regard)

Information to which the referrer must have regard should include comments and information from the patient's chosen practitioner (or current treating practitioner).

Clause 80 (Information to which examiner may have regard)

Information from the patient's choice of current treating practitioner must be included and considered by the referrer.

Clause 253 (Duty not to ill-treat or wilfully neglect patients)

There are few provisions and penalties directed to the treating practitioner and mental health services staff who breach standards set out in the Bill. However, there are many musts in the Bill that apply to Mental Health staff, which do not have express consequences for breach. The Bill would be improved by an overarching catch all provision for consequences for departures from the mandatory requirements of the Bill. As stated earlier the maximum penalty for ill treatment or wilful neglect of a patient is a fine $15,000 and/or 2 years imprisonment.[14] In contrast the maximum penalties for causing unnecessary harm to an animal under the *Animal Welfare Act 2002* (WA) are respectively $50,000 and/or 5 years imprisonment. Furthermore, the threshold for defining criminal behaviour in relation to the treatment of animals is much more rigorous than it is for involuntary mental health patients. This imbalance needs to be addressed.

Clause 275 to 277 (Role of Nominated Persons)

The role of a nominated person is to assist the person who made the nomination to ensure that other parties observe their rights and take their interests and wishes into account. Mental health patients have expressed concern that the restriction to one nominated person (clause 276) creates a conflict for the patient about who to involve, particularly where a person has additional requirements or multiple needs. As two examples, a person may wish to include an advocate and a cultural elder, or a disability advocate and their mental health treating practitioner, to receive key information about their care in the process of advocacy.

Further, while formal requirements for a nomination to be valid are prescribed and formalised (s275) no such requirements exist for revocation of nomination to ensure revocation is actually and

[14] Mental Health Bill 2013 clause 253 (Duty not to ill-treat or wilfully neglect patients)

deliberately sought by the person. This presents a risk that nominated persons are not included as a result of miscommunication between the patient and mental health practitioners.

Therefore we recommend clauses 276 and 277 are amended so that a person may choose to have more than one nominated person. Clause 275 should also be amended so that the revocation of a nomination requires a written 'revocation' signed by the person.

Clause 316 (Representative must not be paid) makes it a criminal offence to help someone with a complaint to the Health and Disability Services Complaint Office (HaDSCO) and be paid unless you are prescribed person.[15] Prescribed persons are Mental Health Advocates, person designated by the Director of HaDSCO or a person or class of person prescribed by regulations. As a result of amendment in the Legislative Assembly '*prescribed person*' now also includes the patient's lawyer. However, advocates from NGOs who are being paid through a funding arrangement with government to provide free advocacy, such as advocates from the Health Consumers Council, are arguably not included. At present anyone who is not prescribed person is at risk of criminal prosecution, including NGO paid staff, with fines up to $10,000 for a second offence. The clause needs to be amended to provide protection to professional advocates providing a free service to a patient.

Clause 322 should be amended so that the complainant's name and identifying details can be confidential to the Director alone, if the Director is satisfied that there could be repercussions for the complainant.

Clause 324 (2)(a) should be amended to provide that the Director can stop dealing with a complaint only if satisfied that the complaint has been withdrawn without duress on the complainant, given the patient's vulnerability.

Clause 385-386 (Initial Review after order made – periodic review while order in force) All reference to the requirement for continuity as a pre-requisite to reviews of involuntary treatment orders (see clauses 385(4) and 386(4)) should be removed from the Bill.

Clause 400 (Application for declaration) The list of people who can apply for a declaration that a treatment order is unlawful should apply expressly to a patient's lawyer. The declaration power should apply expressly to referrals and transport orders (which technically are not involuntary treatment orders orders).

Part 20 Division 4 – Mental Health Tribunal In making declarations as to validity of treatment orders under Part 20 Division 4, the Tribunal should have the same powers as in clause 406(1) for Part 20 Division 3 reviews, namely *'to make orders, and give directions, the Tribunal sees as appropriate'*. The Tribunal must be empowered to review past referrals and orders for invalidity/validity, as well as current orders whether or not the person the subject of the order is voluntary or not. This is an essential part of the oversight of the order making powers of treating psychiatrists.

Part 21 (Mental Health Tribunal) - Part 21 should prohibit the cancellation of hearings as a result of a request from Mental Health Service Staff, namely psychiatrists, without consent of patients, and where applicable a patient's lawyer.

[15] HaDSCO legislation has a similar provision about being remunerated for helping someone to make a complaint.

Clause 454 (Closed Hearings) The grounds on which the Tribunal can exclude persons from its hearings under clause 454(2)(b) should be set out in the Bill so that its decisions to do so can be assessed and where necessary, reviewed. **Clause 454(2)** If a patient or a patient's representative is ejected from the Tribunal under clause 454(2)(b), the Bill should provide that the Tribunal must appoint a suitable legal representative for the patient so that the patient's interests are protected during the hearing.

Clause 466 (Publication of information about proceedings) This clause should not apply to patients. That is patients should not be criminalised for showing a copy of the transcript of their review to other people.

Clause 535 (Delegation by Chief Psychiatrist)

- The setting of the standards of treatment and care under clause 543(2) should not be a matter that can be delegated by the Chief Psychiatrist.
- The delegation must be constrained by requiring the delegate to comply with any standards set by the Chief Psychiatrist.

Clause 581 (Protection from liability when detaining person with mental illness) This clause protects any member of the mental health service, or even the wider health service (public and private), in a charge of a person they reasonably suspect of having a mental illness to detain that person by using, for example locked doors or medication, without risk of liability. This clause subverts many of the protections in the Bill for a person who is proposed to be or is actually detained. This clause renders useless many of the protections of patient rights in the Bill. This clause could protect any nursing home or private hospital member of staff from action for unlawful detention by locking a person inside. Ideally this clause should be removed. Failing this the clause should be amended so as to protect only those acting in good faith and should not provide coverage for those persons utilising physical, chemical and bodily restraint.

OTHER IMPROVEMENTS BY SPECIFIC ADDITIONS

New Clause prohibiting unlawful detention and threatened detention, seclusion or restraint should be inserted The experience of those advocating for many nominally 'voluntary' mental health patients is that they are in effect involuntarily detained or threatened with formal involuntary detention and/or seclusion and restraint in order to achieve compliance. It is not uncommon for a threat to be made to control voluntary patients "If you do not do X, then we will make you an involuntary patient". There should be an offence in the Bill of detaining a person in the absence of a right to detain under the Act and also threatening such detention or seclusion or restraint, with an appropriate penalty for breach.

New Part: Appropriate Feedback Loop should be inserted The Bill (and the Current Act) do not include an effective feedback loop to remedy deficient or poor practice in the mental health service. The Bill could be improved by specifying possible consequences for departing from the mandatory provisions of the Bill. These consequences could include:

- Automatic Reports to HaDSCO, AHPRA or the Australian Association of Social Workers (AASW)
- Fines

- Statutory monetary compensation to voluntary patients detained unlawfully (there are precedents from Europe for this)
- Adding remedies to clauses 190 (Compliance with standards and guidelines) and 400 (failure to comply with the Act) of the Bill; and
- Suspension of registration/authority/licences/eligibility pending investigations.

Involuntary long term use of contraception Long term contraception without the consent of an involuntary patient should be required to be approved by the State Administrative Tribunal (as it is for applications for sterilisation).

Conclusion

As previously stated the Mental Health Bill 2013 is a significant improvement on the Mental Health Act 1996 and the signatory agencies encourage Members of the Legislative Council to support the Bill. However, despite the improvements there remain significant problems and in a few areas the bill represents a backwards step. In particular the criteria for making patients 'involuntary' must be significantly tightened. Accountability and oversight provisions should also be significantly strengthened. We therefore ask Members of the Legislative Council to give serious consideration to our recommendations.

Note: If you require any further information please contact Martin Whitely at the Health Consumer's Council of WA on 92213422 or via martin.whitely@hconc.org.au