



Government of **Western Australia**
Mental Health Commission

Post-Implementation Review of the *Mental Health Act 2014*

March 2018

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Disclaimer

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The Mental Health Commission would like to thank all individuals, groups and organisations that provided submission or feedback for the Post-Implementation Review of the *Mental Health Act 2014*.

Acronyms

- Aboriginal Cultural eLearning (ACeL)
- Advance Health Directive (AHD)
- Australian College of Mental Health Nurses (ACMHN)
- Australian Institute of Health and Welfare (AIHW)
- Authorised Mental Health Practitioners (AMHPs)
- Better Regulation Unit (BRU), formerly the Regulatory Gatekeeping Unit
- Clinicians' eLearning Package (CeLP)
- Collaborative Action Plan (CAP)
- Compulsory Treatment Order (CTO)
- Consumers of Mental Health WA (CoMHW)
- Council of Official Visitors (CoOV)
- Department of Health (DoH)
- East Metropolitan Health Service (EMHS)
- Electroconvulsive therapy (ECT)
- Guardianship and Administration Act 1990 (GAA Act)
- Health and Disability Services Complaints Office (HaDSCO)
- Health Consumers Council (HCC)
- Health Service Providers (HSPs)
- Lived Experience Advisory Group (LEAG)
- *Mental Health Act 1996* (the 1996 Act)
- *Mental Health Act 2014* (the Act)
- Mental Health Act Response Group (MHARG)
- Mental Health Advisory Council (MHAC)
- Mental Health Advocacy Service (MHAS)
- Mental Health Bill 2013 (the Bill)
- Mental Health Bill Implementation Reference Group (MHBIRG)
- Mental Health Commission (MHC)
- Mental Health Co-Response Trial (MH CRT)
- Mental Health Law Centre (MHLC)
- Mental Health Regulations 2015 (Regulations)
- Mental Health Review Board (MHRB)

- Mental Health Tribunal (MHT)
- Non-government organisations (NGOs)
- North Metropolitan Health Service (NMHS)
- Office of the Chief Psychiatrist (OCP)
- Post-Implementation Review (PIR)
- Psychiatric Services Online Information System (PSOLIS)
- Query Reference Group (QRG)
- Regulatory Impact Assessment (RIA)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Royal Flying Doctor Service (RFDS)
- South Metropolitan Health Service (SMHS)
- Statewide Specialist Aboriginal Mental Health Service (SSAMHS)
- Statewide Standardised Clinical Documentation (SSCD)
- Treatment Support and Discharge (TSD) plan
- Western Australia Police (WA Police)
- Western Australian Association for Mental Health (WAAMH)

1. Executive Summary

Mental health legislation has existed in various forms in Western Australia since the 19th Century¹. Following an extensive consultation process and statutory review undertaken by Professor D'Arcy Holman (Holman Review²), the *Mental Health Act 2014* (the Act) repealed and replaced the *Mental Health Act 1996* (the 1996 Act) on 30 November 2015.

The Act reflects the key findings of the Holman Review and in particular, the recommendation to address the advancement of the human rights of persons with mental illness, their families and carers. Specifically, the Act provides for: the treatment, care, support and protection of people who have a mental illness; the protection of the rights of people who have a mental illness; and the recognition of the role of families and carers in providing the best possible care and support to people who have a mental illness, in the least restrictive environment³. The Objects, set out in Part 3 of the Act, detail these requirements, providing clarity of the rights, interest and importance of families and carers, versus the previous emphasis on confidentiality under the 1996 Act.

Prior to proclamation of the Act on 30 November 2015, an extensive 12 month implementation process was led by the Mental Health Commission (MHC). A number of working groups were established to oversee implementation involving a range of key government and non-government agencies, in addition to consumers, families and carers. Guiding documentation and online training modules were developed for mental health staff and the community, and public presentations were provided.

The MHC was required by State Government regulatory requirements to undertake a two year Post-Implementation Review (PIR) of the Act, with a focus on the regulatory impact of the Act and whether the Objects are being achieved. The PIR was required to be submitted to the Department of Treasury's Better Regulation Unit (BRU) (formerly the Regulatory Gatekeeping Unit) on 30 November 2017. Following a request from the MHC, the BRU approved a four month extension to this date for the purposes of incorporating additional contemporary data and to allow further consultation with stakeholders impacted by the recommendations. The MHC has consulted with the BRU to determine the scope and requirements for the PIR, and also throughout the drafting and finalisation of the PIR.

The MHC initially advised stakeholders of the purpose and process for the PIR in August and September 2016. This was followed by research into data requirements and possible data sources. In March and April 2017, information was requested from stakeholders, including anecdotal information and data relating to the Objects of the Act and specific to each agency. During the following months, meetings were held with a number of stakeholders and written submissions were received. **Appendix 1** details the stakeholders contacted and the types of information received.

¹ Western Australia was initially governed by the English *Lunacy Act 1845*. The first local Act was the Western Australian *Lunacy Act 1871*, which was repealed and replaced by the *Lunacy Act 1903*. The *Lunacy Act 1903* was repealed by the *Mental Health Act 1962* in 1966, which was subsequently repealed by the *Mental Health Act 1996* when it came into force on 13 November 1997.

² Holman CDJ. *The Way Forward. Recommendations of the Review of the Mental Health Act 1996*. Perth: Government of Western Australia. 2003.

³ *Mental Health Act 2014*. Long title.

There were a number of limitations relating to the quality of the data provided by stakeholders as a result of variations in reporting periods, data validity and inconsistent formatting. Additionally, data was not available in many instances. Due to the limitations in the quantitative data provided, the PIR primarily references anecdotal information. This is supported by data, where available, from stakeholder submissions and 2015-16 and 2016-17 Annual Reports.

With the assistance of organisations representing consumers, families and carers, an online survey (MHA Survey) was also developed and distributed, in order to seek direct feedback from those who had experienced care from mental health services, since the commencement of the Act. The survey was open to respondents for three weeks from 26 June 2017 and a total of 83 valid responses were received⁴.

Findings of the PIR identified many positive outcomes regarding achievements towards the Objects of the Act, while a number of issues and areas for improvement and development have also been identified. Two consistent themes have emerged regarding future improvements which may assist further in achieving the Objects. These are training and education for those working within mental health services, both around compliance with and in relation to the 'spirit' (or intention) of the Act, and improved data collation and reporting. It is noted that the issues identified may be best addressed through a variety of responses, including legislative, operational, administrative and educational. Details regarding these findings are provided in the Summary section of this report (Section 6).

Appendix 4 provides an overview of the 48 recommendations that have been made within the PIR that aim to enhance the effectiveness of the Act in meeting its Objects, identify opportunities for improvement, and assist in preparing for the Act's statutory review. The majority of the recommendations relate to improved data collection and reporting, and the need for further education and training for mental health staff working under the Act. In addition, a range of broader issues covering operational, administrative, educational and legislative issues were identified for further consideration.

The Department of Health (DoH) has noted its involvement in a significant number of these recommendations and confirmed that the DoH "will consider with the MHC, the feasibility of the implementation of the recommendations subject to resourcing, systems and business process development requirements and DoH priorities"⁵.

The MHC is committed to working with stakeholders⁶ to implement the recommendations of the PIR and to assist in identifying, collecting and refining data required for the more comprehensive statutory review of the Act. The statutory review is to be commenced as soon as practicable after 30 November 2020, and will evaluate the overarching operation and effectiveness of the Act and the *Mental Health Regulations 2015* (Regulations).

⁴ A valid response is one that provided response(s) to questions in addition to demographic information, and identified as either a consumer or personal support person with experience under the Act.

⁵ DoH's response to the MHC regarding the PIR (unpublished), February 2018.

⁶ Section 3.3 of the PIR sets out the governance structure under the Act, setting out those stakeholders who have roles and responsibilities under the Act and who will have a role to play in implementing the recommendations of this report.

2. Introduction

2.1 Requirement for a Post-Implementation Review

The Department of Treasury's BRU is responsible for administering the Regulatory Impact Assessment (RIA) program. The RIA program aims to assist agencies to develop effective and efficient regulation that addresses a clear need in the community, and provides assurance to the Government and stakeholders that a proper assessment of options, including consultation with stakeholders, has occurred. In most cases, a RIA is required to be undertaken prior to the introduction of legislation into Parliament. However, on 10 January 2012, a Treasurer's exemption from RIA was granted in relation to the proposed Mental Health Bill, as introduction of the Bill to Parliament was necessary to ensure adequate rights and protections were afforded to consumers of mental health services, along with their families and carers. As a condition of the exemption, the MHC was required to undertake a two year PIR of the Act, due to be submitted to the BRU by 30 November 2017. On 16 November 2017, the BRU granted an extension to 30 March 2018, to enable the incorporation of additional up-to-date data and further consultation with stakeholders impacted by the recommendations.

The aim of the PIR is to determine the effectiveness of the Act in meeting the Objects set out in Part 3, identify opportunities for improvement, and assist in preparing for the Act's statutory review. Benefits of undertaking a PIR of the Act include:

- identifying what issues or concerns were intended to be addressed by the Act and how these have been addressed through its implementation and operation;
- how effective and efficient the Act has been in meeting its objectives, and whether the intended benefits outweigh the regulatory burden;
- identifying opportunities for enhancement of the legislation and its operation; and
- assisting the ongoing monitoring and evaluation, and the preparation and planning for a statutory review, due to commence after five years of operation of the Act.

3. Background

3.1 Mental Health Legislation

Mental health legislation exists in every Australian jurisdiction. In Western Australia, mental health legislation has existed in various forms since 1903⁷. On 30 November 2015, the Act repealed and replaced the 1996 Act.

The purpose of the 1996 Act was to provide for the treatment, care and protection of persons who have a mental illness⁸. In 2001, a statutory review of the operation and effectiveness of the 1996 Act was undertaken by Professor D'Arcy Holman. The review was based on an extensive consultation process that involved a number of working groups, and public and targeted consultation with community groups across Western Australia. The Holman Review⁹, was provided to the then Minister for Health, Mr Jim McGinty AM, in December 2003. The recommendations of the Holman Review primarily focused on two key areas: the advancement of human rights of persons with mental illness, their families and carers; and the clarification of the intent of the legislation, with the aim of making the Act more practical in its implementation. The Government accepted the majority of the recommendations in the Holman Review, including that the 1996 Act be repealed and replaced.

The publication of the Holman Review was followed by a change of Government in 2008, the appointment of the first Western Australian Minister for Mental Health, and the establishment of the MHC. The MHC sought advice from stakeholders, and national and international experts, and finalised an Exposure Draft Mental Health Bill 2011. The draft Bill was refined following public consultation throughout Western Australia, comprising over 40 information sessions and receiving approximately 1,200 written submissions.

In November 2013, the Green Mental Health Bill 2012 was tabled in Parliament. During further public consultation, the MHC received 100 written submissions and over 500 issues were raised by consumers, families and carers, clinicians, Government and Non-Government agencies, advocacy bodies, and the wider community. Advice was also sought from Mr Gregor Henderson, an internationally respected mental health advisor, in relation to the issues raised. Consumers, families and carers expressed concern about being disempowered and ignored by the mental health system, specifically in relation to the lack of focus on the rights, protection and needs of persons subject to the 1996 Act and their families and carers. Mental health clinicians and services raised similar concerns and called for greater flexibility and improved quality of treatment and care.

The subsequent Mental Health Bill 2013 (the Bill) was introduced into Western Australian Parliament on 23 October 2013, passed by Parliament on 14 October 2014, and received Royal Assent on 3 November 2014. Following proclamation on 30 November 2015, the 1996 Act was repealed and replaced by the *Mental Health Act 2014*. The Act brought the State's mental health legislation in line with community expectations and good practice

⁷ The *Lunacy Act 1903* was repealed by the *Mental Health Act 1962* in 1966, which was subsequently repealed by the *Mental Health Act 1996* when it came into force on 13 November 1997.

⁸ *Mental Health Act 1996* (repealed). Long title.

⁹ Holman CDJ. *The Way Forward. Recommendations of the Review of the Mental Health Act 1996*. Perth: Government of Western Australia. 2003.

from Australian and international perspectives¹⁰. The Act ensured that a human rights approach was at the forefront of the State's mental health legislation, which was in line with the United Nations Convention on the Rights of Persons with Disabilities¹¹. The Act includes Objects (Part 3) detailing the treatment, care, support and protection of people who have a mental illness; the protection of the rights of people who have a mental illness; and the recognition of the role of families and carers in providing the best possible care and support to people who have a mental illness, in the least restrictive environment¹².

The legislative improvements introduced in support of the Objects of the Act, are explored throughout the Post-Implementation Review section of the PIR (Section 5).

3.2 Implementation of the Act

Implementation of the Act was representative of a reform agenda within the mental health sector and underpinned a broader cultural shift in the management of mental health problems and the treatment of people with mental illness.

As the agency responsible for administration and monitoring of the Act, the MHC developed and led the implementation planning process in collaboration with other relevant stakeholders and with input and oversight from a Mental Health Bill Implementation Reference Group (MHBIRG). **Appendix 2** sets out the structure and organisation of the respective groups and stakeholders involved in the implementation process, and the working groups established to inform and develop required processes and documentation to support implementation.

A 12 month implementation period prior to the commencement of the Act, from November 2014 to November 2015, enabled the preparation of the Regulations, training of relevant stakeholders and implementation of other transitional arrangements. All individual projects and strategies were endorsed by the MHBIRG.

The implementation process included the following:

- development of legislative Approved Forms;
- replacement of data systems to enable the Mental Health Tribunal (MHT) and the Mental Health Advocacy Service (MHAS) to collect appropriate data;
- establishment of a clinical helpdesk by the Office of the Chief Psychiatrist (OCP), available 24 hours a day, seven days a week, for the first six months of the operation of the Act;
- development of four eLearning packages for specific target groups:
 - consumers, families and carers;
 - mental health clinicians;
 - referring practitioners, including general practitioners; and
 - transport officers.
- drafting and publishing of brochures (in 20 languages, including English) and fact sheets for consumers, families and carers, which were distributed to service providers and continue to be available online;

¹⁰ Mental Health Bill 2013: Explanatory Memorandum page 1.

¹¹ Australia signed the United Nations Convention on the Rights of Persons with Disabilities in 2007, and ratified the Convention in 2008.

¹² *Mental Health Act 2014*. Long title.

- drafting and publishing of other materials to assist in implementation, including posters, flowcharts and checklists;
- drafting and publishing of both a consumer handbook and a carer handbook, written by consumers and carers for consumers and carers;
- publication of a Clinicians' Practice Guide;
- publication of Chief Psychiatrist's Standards;
- provision of training for clinicians and Authorised Mental Health Practitioners¹³ (AMHPs) by the OCP; and
- continued access to legal and legislative services by the OCP through the DoH.

More information relating to some of the key groups and processes established for the implementation of the Act is provided below.

a. Mental Health Bill Implementation Reference Group

From October 2013, the MHBIRG was chaired by Dr Judy Edwards and, from October 2014, by Mr Eric Ripper. Members included Lived Experience Advisory Group (LEAG) representatives, the Chief Psychiatrist, the Head of the former Council of Official Visitors (CoOV) (now the Mental Health Advisory Service (MHAS)), the President of the former Mental Health Review Board (MHRB) (now the MHT), and representatives from the DoH (Mental Health Unit and Area Health Services), the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Australian College of Mental Health Nurses (ACMHN), the Aboriginal Advisory Group, and non-government organisations (NGOs).

Numerous working groups reported to the MHBIRG, including the LEAG, an NGO Roundtable, an Aboriginal Advisory Group (formerly called the Cultural and Clinical Reference Group), and the Approved Forms Working Group, amongst others.

b. Lived Experience Advisory Group

Establishment of the LEAG involved a comprehensive recruitment process to select people who had lived experience of being an involuntary patient under the 1996 Act, or as a family member and/or carer of someone who was an involuntary patient under the 1996 Act. Equal numbers of both consumer and family/carer representatives were sought for the LEAG, and meetings were co-chaired by a person with lived experience and an Assistant Director of the MHC. The purpose of the LEAG was to provide consumer, family and carer perspective to the MHBIRG regarding strategies and priorities to optimise the implementation of the Act¹⁴. The Terms of Reference, developed and approved by LEAG members, identify the role of the LEAG being to:

“liaise within their network of people who experience mental illness and their families and carers who have had experience of involuntary treatment, and use this liaison to inform the consumer, family, carer perspective brought to the work of the advisory group”.

Two consumer and two carer LEAG members were also members of the MHBIRG. In addition, the members of the LEAG met every two months to review documentation

¹³ An AMHP is defined in s539 as a designated mental health practitioner (psychologist, registered nurse, occupational therapist or social worker) who has at least three years' experience in the management of people who have a mental illness, and has been authorised as an AMHP by the Chief Psychiatrist.

¹⁴ LEAG Terms of Reference – Mental Health Act Implementation (unpublished).

associated with the implementation of the Act, such as the Clinicians' Practice Guide to the *Mental Health Act 2014* (Clinicians' Practice Guide)¹⁵ and the eLearning materials. LEAG also wrote the content of a Consumer Handbook¹⁶ and a Family and Carer Handbook¹⁷.

LEAG members also had the opportunity to express their interest in other working groups, based on their skills and experience, and a selection process was also applied to these additional roles. As a result, most other Bill Implementation Working Groups included two LEAG representatives, being one consumer and one carer representative. Through their involvement in other working groups, the LEAG members also assisted with such things as the establishment of the MHAS and the content of the Act's brochures.

c. Education and training

To support the implementation of the Act, the MHC developed an online training package, with separate modules for clinicians, referring practitioners, consumers and carers, and transport officers. The MHC rolled out a comprehensive Clinicians' eLearning Package (CeLP) in August 2015. Content was prepared by the MHC, in collaboration with the OCP, a small group of mental health clinicians and LEAG members. All mental health clinicians across the State were required to complete the CeLP prior to commencement of the Act. As at 1 December 2015, almost all mental health clinicians had completed this training. The CeLP was supplemented by face-to-face training conducted throughout the State, using a 'train the trainer' model, facilitated by the OCP and DoH. As at 1 December 2015, the vast majority of clinicians had received face-to-face training, with the remainder being on long-term leave and required to complete the CeLP upon their return. The CeLP continues to be available to all new mental health staff as they join the DoH and Health Service Providers (HSPs), as part of their induction to the provision of mental health treatment, care and support.

Further, the CeLP was available to all interested parties to complete and everyone, including consumers, families and carers, was encouraged to complete the CeLP in addition to the more specific training packages, to inform themselves of all requirements under the Act. This transparency of access to the CeLP was requested by LEAG members and agreed to by the MHC and the Chief Psychiatrist, to further support the Objects of the Act.

The MHC also developed three shorter eLearning modules. One module was prepared for referring practitioners, such as general practitioners and other doctors who may need to refer a person for examination by a psychiatrist. Another module was prepared for transport officers, who transfer some of the people who are within the scope of the Act.

¹⁵ The Clinicians' Practice Guide to the *Mental Health Act 2014* (Clinicians' Practice Guide) Edition 3, current as of 25 November 2015, is available on the Chief Psychiatrist's website – http://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/11/CPG_Edition-3_25112015.pdf, last accessed 20 November 2017.

¹⁶ The Consumer Handbook to the *Mental Health Act 2014*, Version 2, updated 9 December 2015, is available on the MHC website – <https://www.mhc.wa.gov.au/media/1437/consumer-handbook-to-the-mental-health-act-2014-version-2-1.pdf>, last accessed 20 November 2017.

¹⁷ The Family and Carer Handbook to the *Mental Health Act 2014*, Version 2, 12/9/2015, is available on the MHC website – <https://www.mhc.wa.gov.au/media/1436/family-and-carer-handbook-to-the-mental-health-act-2014-version-2-1.pdf>, last accessed 20 November 2017.

The MHC, in collaboration with the LEAG, also developed a module targeted at consumers and carers.

In addition to the eLearning training packages, the MHC developed an extensive range of educational materials and resources to inform and educate mental health services, consumers, families and carers, and the general public in relation to the new legislative requirements. These included a number of brochures, published in multiple languages, information and fact sheets, flowcharts, checklists and posters. Access to all of these educational materials, resources and eLearning training modules were, and continue to be, available on the MHC website, with links available on other stakeholder websites. **Appendix 3** provides a list of all resources developed to support implementation of the Act, including a list of the 15 modules contained within the CeLP.

The MHC facilitated public presentations in a number of regional locations. These provided: information and facilitated discussion regarding the comprehensive changes under the Act; information brochures; and contact details on where additional information could be accessed. These information sessions were open to all people, and were frequently attended by mental health staff, ambulance and other transport officers, police officers, NGO workers, consumers, families, carers and members of the general public. The DoH and the OCP provided face-to-face education and training to mental health staff.

d. Mental Health Act Response Group, Clinical Helpdesk and Query Reference Group

As part of the implementation process, the MHC also established and chaired a Mental Health Act Response Group (MHARG) and a Query Reference Group (QRG) to respond to questions and concerns raised by mental health clinical and operational staff immediately before and following commencement of the Act.

The MHARG was comprised of representatives of the MHC, the OCP, the DoH and area health services, with the MHT and MHAS conscripted where required. The MHARG had an operational focus aimed at monitoring implementation initiatives across the mental health sector, identifying systemic concerns and providing a timely response to issues as they arose. This group met daily upon commencement of the Act, then less frequently as required, until six months following commencement when group members deemed that the MHARG had performed well in addressing the immediate needs associated with the new legislation and that health services had ably demonstrated their adaption to the new requirements.

The QRG comprised representatives of the MHC, the OCP, as well as two clinicians. The QRG addressed specific legislative queries that were not immediately resolved through the telephone and email Clinical Helpdesk established by the OCP for the purposes of implementation. The Clinical Helpdesk was available 24 hours a day, seven days a week during the first six months of the operation of the Act. The OCP reports that, in the seven months of operation of the Act from 30 November 2015 to 30 June 2016, the Clinical Helpdesk received 257 calls and emails during the first month, 123 in the following two months, and 180 over the last four months¹⁸. Some of the common inquiries during

¹⁸ OCP presentation to the 2017 Rural and Remote Mental Health Conference, Broome, 25-27 October 2017 (unpublished).

this time related to: transitional arrangements for consumers who were under the 1996 Act; leave of absence requirements for involuntary patients; requests for amendments to Approved Forms; timeframes; and notifiable events – informing a personal support person.

The QRG initially met daily from commencement of the Act to consider and respond to queries raised, meeting less frequently as the number of queries lessened. Contentious issues or those requiring a systemic response, were referred to the MHARG for consideration, and then collated into a Frequently Asked Questions (FAQ) document which was located on the MHC website and updated regularly. The link to the FAQ document was then circulated widely through various networks to provide consistent messages to those responsible for implementing, and those impacted by, the legislation.

3.3 Governance structure under the Act

The stakeholders described below are considered to be key stakeholders given their specific role and defined responsibilities under the Act. Therefore, many of the recommendations set out in this report refer to actions to be undertaken by those key stakeholders, given their responsibility for the operation of the Act and the provision of mental health services.

The MHC acknowledges that consumers, families and carers are also key stakeholders, in relation to their experience of the provision of mental health services under the Act.

a. Mental Health Commission

As at December 2017, the MHC is responsible to the Minister for Mental Health, the Hon Roger Cook, MLA, and is primarily responsible for the administration and monitoring of the Act. Administration of the Act includes implementation and monitoring of the Act and its application to operational services, undertaking reviews and progressing legislative amendments as required from time to time. The MHC does not directly provide mental health services, instead it commissions a range of inpatient and community based mental health services from the DoH and HSPs. In addition to the commissioning of mental health services, the MHC is also responsible for the provision of drug and alcohol treatment services and programs formerly provided or purchased by the Drug and Alcohol Office.

b. Department of Health and Health Service Providers

On 1 July 2016, with the commencement of the *Health Services Act 2016*, the health system's centralised governance structure was abolished and a new, devolved structure consisting of HSPs was introduced.¹⁹ The HSPs operate as separate statutory authorities, governed by Boards, legally responsible and accountable for the oversight of hospital and health service delivery, including the delivery of mental health services.

In its role as System Manager, the DoH is responsible for the strategic direction, oversight and management of the Western Australian health system, which is comprised of the DoH and five HSPs – North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), East Metropolitan Health Service (EMHS), Child and Adolescent Health

¹⁹ Department of Health Annual Report 2016-17.

Service (CAHS) and WA Country Health Service (WACHS). The DoH and each of the HSPs are responsible for the delivery of mental health services in Western Australia.

c. Chief Psychiatrist

The introduction of the Act also resulted in the establishment of three independent statutory entities, each with separate roles and responsibilities under the Act, being the Chief Psychiatrist, the MHT and the MHAS.

The Chief Psychiatrist has statutory responsibility for overseeing the treatment and care of all voluntary patients being provided with treatment by a mental health service, all involuntary patients, all mentally impaired accused detained in an authorised hospital, and all persons referred under certain provisions of the Act for examination by a psychiatrist. The Chief Psychiatrist discharges these responsibilities by publishing standards for the treatment and care to be provided, and overseeing compliance with those standards.

Additionally, the Chief Psychiatrist has statutory responsibility for:

- making recommendations to the Governor of Western Australia regarding the authorisation of psychiatric hospitals²⁰;
- training and credentialing AMHPs²¹;
- approving those mental health services where electroconvulsive therapy (ECT) can be performed²²; and
- approving Forms for use under the Act²³.

The Chief Psychiatrist has a responsibility for a range of statutory reporting parameters²⁴, which must be tabled in Parliament. In addition, the Chief Psychiatrist continues to operate a Clinical Helpdesk providing direct operational translation advice in relation to the Act.

d. Mental Health Tribunal

The MHT is an independent quasi-judicial tribunal, whose role is to safeguard the rights of people subject to involuntary treatment orders, either in hospital or in the community. The Act requires the MHT to conduct regular reviews, within certain timeframes, of all involuntary patients in Western Australia. In addition, the MHT is responsible for approving restricted treatments such as ECT and psychosurgery.

e. Mental Health Advocacy Service

The MHAS has responsibilities for safeguarding the rights of people under the Act, through providing advocacy services to 'identified persons'²⁵. These include involuntary patients, either in hospital or in the community, persons referred for examination by a psychiatrist, some voluntary patients, mentally impaired accused persons and psychiatric hostel residents. The MHAS must contact all identified persons within certain timeframes to

²⁰ *Mental Health Act 2014*, s542.

²¹ *Mental Health Act 2014*, s539.

²² *Mental Health Act 2014*, s544.

²³ *Mental Health Act 2014*, s545.

²⁴ The Chief Psychiatrist, as part of the requirement under s533 of the Act to report annually to the Minister, must include statistics relating to ECT, emergency psychiatric treatment, psychosurgery, seclusion, bodily restraint, urgent non-psychiatric treatment, off-label treatment and notifiable incidents.

²⁵ *Mental Health Act 2014*, s348.

ensure that their rights have been explained, assist them exercise those rights or resolve complaints, inquire into and investigate the extent to which their rights are being observed, advocate for and facilitate access to other services, and assist them in MHT hearings.

f. Health and Disability Services Complaints Office

The Health and Disability Services Complaints Office (HaDSCO) is an independent Statutory Authority offering an impartial resolution service for complaints relating to health, disability and mental health services in Western Australia and the Indian Ocean Territories. The HaDSCO supports improvements to health, disability and mental health services through complaint resolution. The HaDSCO has two service areas:

- Service One, covering the assessment, negotiated settlement, conciliation and investigation of complaints; and
- Service Two, covering the education and training in the prevention and resolution of complaints.

The HaDSCO has an important role in safeguarding the rights of persons under the Act by investigating complaints by consumers and carers in relation to the provision of mental health services.

4. Scope of the Post-Implementation Review

4.1 Objects of the Act

This PIR focuses on the regulatory impact of the Act, in particular, whether the Objects set out in Part 3 of the Act are being achieved. The Objects are as follows:

- (1) The Objects of this Act are as follows —
 - (a) to ensure people who have a mental illness are provided the best possible treatment and care —
 - (i) with the least possible restriction of their freedom; and
 - (ii) with the least possible interference with their rights; and
 - (iii) with respect for their dignity;
 - (b) to recognise the role of carers and families in the treatment, care and support of people who have a mental illness;
 - (c) to recognise and facilitate 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;
 - (d) to help minimise the effect of mental illness on family life;
 - (e) to ensure the protection of people who have or may have a mental illness;
 - (f) to ensure the protection of the community.
- (2) A person or body performing a function under this Act must have regard to those Objects.

The more comprehensive statutory review of the Act (s587), to be commenced as soon as practicable after 30 November 2020, will evaluate the overarching operation and effectiveness of the Act and Regulations.

4.2 Consultation

The MHC worked with the former Regulatory Gatekeeping Unit (now the BRU), Department of Treasury, to determine the scope of, and requirements for, the PIR. Consultation and engagement with the BRU has been ongoing throughout the PIR process and drafting of the final report.

The MHC initially wrote to a number of stakeholders in August and September 2016, informing them of the purpose of, and process for, the PIR. **Appendix 1** provides a list of stakeholders consulted and information received. Following this initial communication, the MHC conducted research into data requirements and possible data sources required for the PIR.

In March 2017, the MHC advised stakeholders of the aims of the PIR and requested them to provide data and information relating to the Objects. The MHC met with a number of stakeholders to discuss the specific issues relating to the information required from their agency. Submissions were received from 23 stakeholders, inclusive of formal written submissions and email information. Many provided a combination of written submission and email information. Additionally, 2015-16 and 2016-17 Annual Reports for the

Chief Psychiatrist, MHAS and HaDSCO have been reviewed for relevant comparative data.

Information and data were sought for the PIR from all five HSPs – NMHS, SMHS, EMHS, CAHS and WACHS. Data and some additional information were received from all HSPs, however, in many cases limitations with the data meant that not all of it was able to be included in the PIR. Where appropriate, additional information and commentary provided by HSPs has been included in relevant topics in the PIR.

An online survey (MHA Survey) was also developed by the MHC to seek direct feedback from consumers, families and carers who had experienced care and treatment under the Act. The MHA Survey was developed in consultation with organisations representing consumers, families and carers to ensure it was relevant and appropriate. The MHA Survey was promoted by a number of representative organisations, through different mailing lists, and on the MHC website to ensure wide distribution. The MHA Survey was open from 26 June 2017 to 17 July 2017. A total of 83 valid responses were received²⁶. Limitations exist with the results of the MHA Survey, with the questions focusing on the processes and requirements of the Act, and asking respondents for additional comments in relation to those questions. Consumers, families and carers were not specifically asked about the positive aspects of the operation of the Act, and this oversight may have impacted on the results, potentially skewing the results to the more negative aspects of their experience.

The PIR was due to be submitted to the BRU by 30 November 2017. On 16 November 2017, the BRU agreed to extend the due date to 30 March 2018. This extension was granted to allow for the incorporation of data from the 2016-17 financial year, therefore providing a full year of operation of the Act for review. It also enabled the MHC to undertake further consultation with those stakeholders who have roles and responsibilities under the Act and who will be directly impacted by the recommendations in the PIR report.

The MHC notified stakeholders of the extension to the due date for submission of the PIR. In addition, on 14 December 2017, those stakeholders with roles and responsibilities under the Act were provided with a confidential draft PIR report to give them an opportunity to provide feedback and input on the content and recommendations. Additional information and data was also requested from stakeholders, with meetings occurring with some stakeholders, where necessary, to clarify information and data provided. The majority of stakeholders responded to this final round of consultation, with the incorporation of additional feedback and up-to-date data and information resulting in a more informed and comprehensive PIR report.

²⁶ A valid response is one that provided response(s) to questions in addition to demographic information, and identified as either a consumer or personal support person with experience under the Act.

4.3 Data Limitations

Given that the Act commenced on 30 November 2015, and information for the PIR was being sought from stakeholders from March 2017, there were a number of limitations in the quality of the data provided by stakeholders relating to variations in reporting periods, data validity and inconsistent format. Additionally, data were not available in many instances. Therefore, access to supporting data was limited. As such, the PIR primarily references anecdotal information, with supporting data included where available from stakeholder submissions and from 2015-16 and 2016-17 Annual Reports. The majority of stakeholder Annual Reports for 2016-17 were tabled in Parliament during October 2017, becoming publically available at that time.

Consequently, the data used for the PIR covers a 19 month period, from commencement of the Act on 30 November 2015 to 30 June 2017. Given the vast changes from the 1996 Act, many services continue to implement and/or amend their reporting methods and data collection systems.

Throughout the PIR, there are references to data regarding the provision of services required under the Act. It is important to remember that, in some cases, the data refer to a small number of people only, when taken in the context of the overall mental health service provision across the State. DoH data²⁷ (**Table 1**) provides some perspective regarding the overall provision of mental health services and the information contained within the PIR.

Table 1: DoH 2016-17 financial year data for involuntary treatment orders and voluntary admissions.

Admission type	Adults (18 – 65+ years)	Children (0 – 17 years)	Female	Male	Total number (statewide)
Inpatient treatment orders	4,416	81	2,004	2,493	4,497
Community treatment orders	1,457	13	496	974	1,470
Voluntary admissions ²⁸	11,226	951	6,919	5,258	12,177

The data in **Table 1** highlights the extremely small percentage of comparative data referenced in some areas within the PIR. As a result of these data limitations, caution must be applied regarding the interpretation of the results contained within the report. Regardless, the findings can reasonably assist by providing a foundation for recommendations regarding issues to be further explored and developed, particularly within the context of the longer term statutory review.

²⁷ DoH submission to MHC for the PIR (unpublished), February 2018.

²⁸ The DoH advise that data for voluntary admissions are based on each admission, whereas data for inpatient and community treatment orders are based on each legal order. Therefore, although the numbers of voluntary admissions may appear much higher than for inpatient and community treatment orders, these data are not comparable.

5. Post-Implementation Review

The Post-Implementation Review section highlights the key areas of change from the 1996 Act to the Act that are relevant to achieving the Objects. Rights for consumers, rights for personal support persons and options for recourse are some of the most significant inclusions in the Act, which are all in support of the recommendations of the Holman Review. Other significant advancements are also discussed, such as changes to the referral and detention timeframes, audiovisual communication, transportation, matters pertaining to children, ECT, seclusion and restraint, and interstate arrangements.

Each of these key areas identifies the associated Object(s), key issues raised by stakeholders (inclusive of consumers and personal support persons), whether or not the Object(s) is/are currently being met, available data supporting this, and recommendations or opportunities for future improvement. Unintended consequences of the Act are also identified within this section through the exploration of the reported administrative burden, in addition to matters relating to training and education.

5.1 Rights for consumers

The advancement of the human rights of people with mental illness is a core principle underpinning the recommendations of the Holman Review. The Objects of the Act were aligned with international human rights instruments which require treatment and care to be provided in the least restrictive environment, consistent with the consumer's circumstances at the time of their treatment.

Historically under the 1996 Act, in a July 2015 inspection²⁹, the CoOV reported that Official Visitors did not find evidence that consumers were consistently given an explanation of their rights or a copy of their Form 6³⁰ inpatient treatment order; or that a copy of the Form 6 was given to a relative, guardian or friend as required by the Act. In addition, the CoOV raised concerns about inconsistencies in recording when consumers had been informed of their rights.

Despite the 1996 Act containing provisions regarding the protection of patients' rights (Part 7), this was considered limited, particularly with regard to the explanation of rights. The 1996 Act also made no reference to families or carers. Recommended improvements relating to the rights of families and carers are further detailed in Section 5.2 of the PIR.

a. Importance of explaining rights

In accordance with Objects 1(a)(ii) and (c), the Act and the Regulations emphasise the importance of explaining consumers' rights orally and in writing (s244 and regulation 10). Furthermore, the explanation must also be provided to the carer, family member or other support person (s245 and regulation 10). Rights must be explained in a language, form of communication and terms familiar to the recipient of the information (s9). The MHC has facilitated these functions with the publication of a range of brochures, produced in English and 19 other languages, available on the MHC website.

²⁹ The CoOV Annual Report July to November 2015 is located at – <https://mhas.wa.gov.au/assets/documents/COV-Annual-Report-2015.pdf>, last accessed 20 November 2017.

³⁰ Under the Act, a Form 6 relates to an inpatient treatment order, either in an authorised hospital (Form 6A) or in a general hospital (Form 6B).

Key Issues Raised:

Feedback received from stakeholders and from respondents to the MHA Survey identified instances where rights were not explained or were being poorly communicated. Ten out of 24 (42%) consumer responses advised that they did not have their rights explained to them in a form, language and terms they understood. Thirty out of 49 (61%) responses from personal support persons stated they were not advised of the consumer's legal rights, in a form, language and terms they understood.

- Information relating to rights was “in styles & jargon my dyslexic self and i couldn't digest or comprehend. Layman language needed” [consumer].
- “No I felt that the hospital did a very poor job of explaining the rights of the patient and my own as a personal support person” [personal support person].

Another consumer stated they were not in a fit state to read the information pertaining to their rights, due to being too upset.

Way Forward:

While the requirement in the Act for the explanation of rights to consumers improves on the 1996 Act, many of the consumers, families, carers and support persons responding to the MHA Survey believed that their rights were not always explained in accordance with the requirements of the Act.

The Western Australian Association for Mental Health's (WAAMH) consultation with their members and other sector organisations identified that more could be done by way of education and training of staff to ensure better support for consumers, families, carers and support persons, particularly with regard to the provision of rights. A NGO mental health support service echoed similar sentiments with a suggestion to develop further resources to assist clinicians and other mental health services staff to better communicate with carers and other personal support persons.

The Chief Psychiatrist advised that the OCP regularly provides training for AMHPs regarding the explanation of rights to consumers, and that tailored training provided to non-mental health clinicians also includes training regarding an explanation of rights to consumers. Non-mental health clinicians include general hospital staff, NGOs, St John Ambulance and Mental Health Law Centre (MHLC) staff³¹.

The MHAS informed that, in accordance with their role in promoting compliance with the Charter of Mental Health Care Principles, including Principle 13 (Provision of information about rights), the MHAS provides presentations to mental health staff regarding the importance of explaining rights to consumers. However, the MHAS acknowledges the frequency of these presentations could be increased³².

Aligned to feedback, further improvements can be made to increase the explanation of rights to consumers in a suitable form or language.

³¹ Chief Psychiatrist's submission to the MHC for the PIR (unpublished), January 2018.

³² MHAS submission to the MHC for the PIR (unpublished), January 2018.

Recommendations:

1. Greater promotion by the MHC of the existing eLearning and other resource materials regarding the explanation of rights to consumers, which are currently available online.
2. The DoH and HSPs to provide an operational response to the issue of consumers not consistently having their rights explained, including potential further education and training of mental health staff.
3. The OCP, as part of their role in the education of relevant staff, including AMHPs, to continue to provide education and training regarding the explanation of rights to consumers.
4. The MHAS, as part of their role in promoting compliance with the Charter of Mental Health Care Principles, specifically Principle 13 (Provision of information about rights), continue to provide education to mental health staff regarding the explanation of rights to consumers.
5. The DoH to ensure appropriate data collection regarding the explanation of rights to consumers, to identify compliance and to inform the statutory review of the Act.

b. Social and Emotional Wellbeing of Aboriginal people

In accordance with Objects 1(a), (b) and (c), the Act emphasises that people have a right to be treated in a culturally appropriate way. Various provisions are included regarding the assessment and care of people of Aboriginal and Torres Strait Islander descent. Specifically, the Charter of Mental Health Care Principles requires that a mental health service must make every effort to comply with the following Principle, among others:

Principle 7: People of Aboriginal or Torres Strait Islander descent³³

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.

The Act requires that the assessment, examination and treatment of a person who is of Aboriginal or Torres Strait Islander descent be conducted, where appropriate and practicable, in collaboration with an Aboriginal or Torres Strait Islander mental health worker, and significant members of the person's community, including elders and traditional healers.

³³ *Mental Health Act 2014*, Schedule 1 – Charter of Mental Health Care Principles.

During the implementation of the Act, the Aboriginal Advisory Group provided input and advice into the development of the Clinicians' Practice Guide, including Addendum 5, Working with people of Aboriginal and Torres Strait Islander Descent³⁴.

In support of Principle 7, in 2015-16 the MHAS engaged a specialist Aboriginal Advocate to assist Aboriginal consumers and provide culturally appropriate advice to other Advocates³⁵. Further, the MHAS advised that it would be useful to inquire into the extent to which the Act is being complied with, and has considered developing a list of all Aboriginal mental health workers and services available at, or to, each authorised hospital, to help advocate for compliance with the Act and facilitate access to such services³⁶.

On 6 September 2017, the DoH issued the Aboriginal Cultural eLearning (ACeL) Policy³⁷ (MP0065/17), its stated purpose being 'to build the cultural knowledge of the WA health system workforce and strengthen its capacity to provide health care that is culturally respectful and non-discriminatory'. All DoH and HSP staff are required to complete ACeL training within six months of their commencement date. On 4 October 2017, the DoH advised that the ACeL training is a single online training package, designed to provide consistent training content to all WA health system employees and covering a broad range of historical and social issues impacting on health generally, not just mental health.

The DoH also issued the Aboriginal Health and Wellbeing Policy³⁸ (MP 0071/17) on 4 October 2017. This Policy applies across all areas of health services, including mental health services, and requires all HSPs to address the DoH's WA Aboriginal Health and Wellbeing Framework 2015-2030³⁹. Further, HSPs are required to develop an Action Plan for 2017-2020 using meaningful and measureable actions towards improvements in Aboriginal health and wellbeing outcomes.

Data:

In their submissions, HSPs provided data indicating that engagement is occurring with Aboriginal mental health workers, elders and traditional healers. NMHS provided detailed commentary⁴⁰ that engagement by mental health services with these key roles had increased prior to the commencement of the Act and remained elevated over the six month period post-implementation of the Act (December 2015 – June 2016). NMHS advised that this engagement appeared to reduce gradually after this time up until December 2016. However, NMHS notes this cannot be attributed to a reduction in provision of care given the unreliability of the data, which is dependent on the list of staff members who self-identify as Aboriginal being updated, and movement of these staff into other roles.

³⁴ Chief Psychiatrist's Clinicians' Practice Guide to the *Mental Health Act 2014*, Edition 3 (current as of 25 November 2015). Located at – http://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/11/CPG_Edition-3_25112015.pdf, last accessed 20 November 2017.

³⁵ MHAS 2015-16 Annual Report, page 28.

³⁶ MHAS submission to the MHC for the PIR (unpublished), January 2018.

³⁷ Aboriginal Cultural eLearning (ACeL) Policy (MP0065/17). Located at – http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13373, last accessed 20 November 2017.

³⁸ Aboriginal Health and Wellbeing Policy (MP 0071/17). Located at – http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13379, last accessed 20 November 2017.

³⁹ DoH WA Aboriginal Health and Wellbeing Framework 2015-2030 Strategic Directions. Located at – http://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Aboriginal%20health/PDF/12853_WA_Aboriginal_Health_and_Wellbeing_Framework.pdf, last accessed 20 November 2017.

⁴⁰ NMHS submission to the MHC for the PIR (unpublished), July 2017.

Given the lack of data consistency and validation, it is not possible to ascertain the statewide extent to which engagement is occurring and whether it is occurring in all cases, where required. Additionally, there is currently no way to understand if treatment was provided in consultation or collaboration with people from the consumer's own community as this might not be systematically recorded or captured on the relevant database.

Key Issues Raised:

Examination and treatment in collaboration with Aboriginal mental health workers

In their 2015-2016 Annual Report, MHAS noted that mental health services are not consistently undertaking examinations and providing treatment to Aboriginal consumers in collaboration with Aboriginal mental health workers and/or significant members of the person's community⁴¹.

Lack of culturally appropriate MHT hearings

A lack of Aboriginal and Torres Strait Islander representation at MHT hearings was noted by the MHAS in their 2015-16 Annual Report. The MHAS Aboriginal Advocate reports there is a need for more culturally appropriate MHT hearings for Aboriginal and Torres Strait Islander consumers, with particular attention being drawn to consumers who are regularly placed on inpatient treatment orders. The MHAS Aboriginal Advocate subsequently recommends that members of the Aboriginal and Torres Strait Islander community should be encouraged to apply to sit on the MHT as community members⁴².

The President of the MHT acknowledged the need to increase the diversity and geographic representation of MHT members. As MHT members are appointed by the Governor on the recommendation of the Minister, the President advised she will seek Ministerial approval to recruit more MHT members to address this identified need⁴³.

The Statewide Specialist Aboriginal Mental Health Service (SSAMHS) provides a service that supports Aboriginal consumers and carers in accessing mainstream mental health services, and in better meeting the needs of Aboriginal people. The SSAMHS "operates with cultural integrity using strategies which include brokering of elders, and traditional healers to participate in particular clinical cases"⁴⁴. This directly relates to the Act and specifically, Principle 7 of the Charter of Mental Health Care Principles. The 2017 evaluation of the SSAMHS⁴⁵ found that SSAMHS promotes a culturally secure environment by involving Aboriginal mental health workers. A snapshot survey of patients who engaged with the service in 2017 indicated that they were satisfied with the level of cultural security, with many patients agreeing that the Aboriginal mental health worker was an important factor in their decision to engage with the service. Although the SSAMHS has been in operation from 2011 and pre-dates the commencement of the Act, it is expected that the benefits derived from the service continue to be experienced under the Act.

⁴¹ MHAS 2015-16 Annual Report, page 29.

⁴² MHAS 2016-17 Annual Report, page 21.

⁴³ MHT submission to the MHC for the PIR (unpublished), January 2018.

⁴⁴ Information is located at – http://www.nmahsmh.health.wa.gov.au/services/statewide_simhs.cfm, last accessed 20 November 2017.

⁴⁵ The evaluation of the Statewide Specialist Aboriginal Mental Health Service was undertaken by the MHC in 2017 (unpublished).

MHA Survey Results:

There was minimal feedback with regard to the social and emotional wellbeing of Aboriginal people as part of the MHA Survey, due to the very small number of Aboriginal respondents⁴⁶. Two Aboriginal personal support persons advised that the consumers' rights were explained to them. In contrast, one Aboriginal personal support person commented that rights were not explained, as "it was assumed by staff that we had been through the process previously."

Way Forward:

Improving access to Aboriginal mental health workers and/or significant members of the Aboriginal consumer's community is required in order to better address the Objects of the Act.

Additionally, improved recording and reporting of all relevant data will assist in ascertaining gaps and areas for improvement in cultural engagement and collaboration by mental health services in accordance with the Act. This will assist in determining whether the Objects are being met with regard to consumers' right to be treated in a culturally appropriate way, in addition to informing the statutory review of the Act.

The promotion of the CeLP training package, specifically the requirements in the Act for the assessment, examination and treatment of persons of Aboriginal or Torres Strait Islander descent, may also assist in ensuring those requirements are met and there is appropriate consultation and collaboration with the Aboriginal community.

Recommendations:

6. The DoH to work with the HSPs in their provision of the SSAMHS, to improve access to Aboriginal mental health workers and/or significant members of the person's community for Aboriginal consumers, and consider options for increasing the provision of mental health services in regional/remote communities.
7. The MHT to develop ways of increasing representation of Aboriginal and Torres Strait Islander peoples in tribunal membership.
8. The MHAS to conduct an inquiry into and prepare a report on services available to assist in the assessment, examination and treatment of Aboriginal people, in accordance with the requirements in the Act.
9. Through the Mental Health Data Management Group, the DoH and HSPs to assess and improve where necessary, the requirements and appropriate data capture for improved recording and reporting of data relating to collaboration with Aboriginal mental health workers and/or significant members of the person's community.
10. The MHC to promote the CeLP training package, particularly with regard to the specific requirements in the Act for the assessment, examination and treatment of persons of Aboriginal or Torres Strait Islander descent.

⁴⁶ Five valid respondents to the MHA Survey identified as being Aboriginal or Torres Strait Islander.

c. Use of interpreters

Section 9 of the Act provides for the use of interpreters if necessary and practicable. Any communication with a person, such as the provision of any advice, explanation, information, notification or reasons, must be in a language that the person understands, which is in support of Objects 1(a)(ii), (iii), (c) and (e). The option to use an interpreter is not a new initiative, as the 1996 Act provided for an interpreter to be used for obtaining informed consent for treatment. However, the Act strengthens this by stating ‘any’ communication with a person under the Act ‘must’ be in a language they understand.

The DoH policy, WA Health System Language Services Policy⁴⁷ (MP0051/17) and supporting Guidelines⁴⁸, outline the need for health services staff to promote the availability of language services to consumers. The Policy applies to those who cannot effectively communicate in English, and ensures the provision of interpreting and translating services to facilitate effective and consumer-focussed communication between consumers, carers and health services staff. The Policy also supports the engagement of the Kimberley Interpreting Service interpreters for Aboriginal consumers.

As part of the implementation of the Act, the MHC, in consultation with stakeholders, developed and distributed throughout the State a range of brochures regarding the provisions of the Act in 20 different languages. In selecting languages other than English, the MHC sought the advice of the WA Transcultural Mental Health Service regarding the most common non-English languages spoken by inpatients. From the information received, the MHC collated and developed brochures for the 19 most commonly spoken non-English languages in mental health services. The brochures continue to be available on the MHC website and are printable.

The MHAS has a policy outlining that anyone who “does not speak English as their first language, no matter how good their English is said to be, will be offered an interpreter and an interpreter will be used where there is any doubt about the consumer’s understanding”⁴⁹. In addition, the MHAS employ several Advocates from culturally and linguistically diverse backgrounds and/or who have some training in working with people from culturally and linguistically diverse backgrounds.

The President of the MHT advised that when the MHT becomes aware that a consumer has requested or is due for a periodic review by the Tribunal, all parties receive a ‘Notice of Review’ two weeks prior to the hearing⁵⁰. This Notice is sent to:

- the relevant mental health service;
- the treating team; and
- any nominated support person or organisation (including the MHLC, MHAS, the Public Advocate and/or family members/carers).

The Notice includes a request that the party inform the MHT if the patient requires an interpreter to attend the hearing. The President notes that the MHT is not always advised

⁴⁷ WA Health System Language Services Policy is located at – www.health.wa.gov.au/circularsnew/pdfs/13359.pdf, last accessed 20 November 2017.

⁴⁸ WA Health System Language Services Policy Guidelines are located at – www.health.wa.gov.au/circularsnew/attachments/1220.pdf, last accessed 20 November 2017.

⁴⁹ MHAS 2015-16 Annual Report, page 28.

⁵⁰ MHT submission to the MHC for the PIR (unpublished), January 2018.

of the need for an interpreter. When the MHT is aware that an interpreter is required, this will be recorded electronically and on the consumer's hardcopy files to ensure an interpreter will be arranged for future hearings. The President advised that she will confer with the Chief Psychiatrist and explore ways to improve the identification of the need for interpreters⁵¹.

Data:

The President of the MHT reported⁵² that during the 2016-17 financial year, the MHT conducted 44 hearings with professional interpreters present. This involved 29 patients, from the following language groups:

Language Group	Number	Language Group	Number	Language Group	Number
Arabic	4	Farsi	4	Macedonian	1
Bengali	1	French	2	Mandarin	3
Burmese	1	French Based Creole	1	Swahili	2
Cantonese	3	Greek	3	Thai	2
Croatian	3	Indonesian	1	Urdu	1
Dari	5	Java East Indonesian	1	Vietnamese	4
Auslan	2				

The HSPs provided data on the use of official paid interpreters, however, this information is inconsistently recorded across HSPs and significant data limitations are noted.

Key Issues Raised:

Lack of interpreters being offered

The MHAS reported that their Advocates received 12 complaints relating to lack of interpreters being offered during the 2015-16 financial year⁵³. The MHAS also reported that mental health staff, have on occasion, asked to use the Advocate's interpreter while they were on the ward. The MHAS provides an example of inappropriate methods for interpretation as follows:

“In one case a consumer who spoke little or no English was made involuntary without access to an interpreter and the ward was using a staff member who was also the consumer's cousin to interpret”⁵⁴.

⁵¹ MHT submission to the MHC for the PIR (unpublished), February 2018.

⁵² MHT submission to the MHC for the PIR (unpublished), January 2018.

⁵³ Data in the MHAS 2015-16 Annual Report relates only to the period 30 November 2015 to 30 June 2016, to coincide with the commencement of the Act and the establishment of the MHAS.

⁵⁴ MHAS 2015-16 Annual Report, page 28.

Anecdotal feedback received from a consumers, families and carers support group identified an issue where consumers, families or carers with limited language skills often do not attempt to speak to mental health services about their concerns.

NMHS reported issues with the way in which data are currently captured regarding the use of interpreters⁵⁵. The method relates to an invoicing financial database which does not provide the ability to link the provisioning to an individual consumer. As such, it is difficult to assess the provision of interpreters specifically to consumers under the Act.

Although it is evident that interpreters are being used for consumers in some cases where required, the limited data available makes it difficult to assess whether the Objects of the Act are being met with regard to the use of interpreters.

Way Forward:

A review of the way in which data are currently being collected and a move toward a more effective and consistent system across all HSPs is required to ensure valid and reliable data regarding the use of interpreters. The MHC, as a member of the Mental Health Data Management Group⁵⁶, will continue to work with the DoH and HSPs to assess the requirements for improved recording and reporting. Consultation with other stakeholders will be undertaken as required as part of that process.

Improved recording, monitoring, and reporting of all relevant data will assist in ascertaining gaps and areas for improvement, which will assist in informing the statutory review of the Act.

Further education and training is required for mental health services staff engaged with the assessment of consumers on admission, in order to identify the need for an interpreter, promote this option as being available and improve knowledge on the processes required to engage an interpreter. To address this issue, it is recommended that the DoH and the HSPs determine the most effective solutions for implementation at an operational level.

Recommendations:

11. The MHC to further promote the online availability of Act related brochures in languages other than English to improve communication with non-English speaking persons under the Act.
12. The MHT to consult with other stakeholders to determine ways to improve the identification of the need for interpreters at MHT hearings.
13. DoH and the HSPs to determine the most effective solution(s) at an operational level, including provision of education and training for mental health services staff engaged with assessment of consumers on admission, in order to identify the need for an interpreter, promote this option being available and raise awareness of the processes required to engage an interpreter.
14. Through the Mental Health Data Management Group, the DoH and HSPs to develop requirements and appropriate data capture for improved recording and reporting of relevant data pertaining to the use of interpreters, to identify areas for improvement and to support the statutory review of the Act.

⁵⁵ NMHS submission to the MHC for the PIR (unpublished), July 2017.

⁵⁶ The Mental Health Data Management Group, attended by the MHC, the DoH and HSPs, provides advisory support and recommendations to improve the quality of mental health data collections and management.

d. Capacity and informed consent

Section 13 of the Act presumes that adults have the capacity to make decisions (including treatment decisions), unless demonstrated that they do not have capacity (Objects 1(a) and (c)). Assumed capacity also includes decisions that may relate to admission and discharge, involvement of families and carers, or seeking a further opinion. The position on capacity under the Act differs from the 1996 Act, where the presumption was that an adult did not have capacity, unless proven otherwise.

With regard to children, the Act (s14) presumes that children (persons under the age of 18 years) do not have capacity to make decisions (including treatment decisions), unless demonstrated that they do have that capacity. This takes account different levels of maturity and developmental stages, and reflects the common law mature minor principle⁵⁷.

Key Issues Raised:

Assessing the impact of the definition of capacity

While the Chief Psychiatrist supports the enhancement of capacity as a defining characteristic for involuntary care, feedback provided indicates that there have been no measurable indices to identify whether the definition of capacity is impacting the number and nature of the cohort subject to involuntary treatment orders⁵⁸.

Definition of capacity

The Mental Health Law Centre (MHLC) also raised an issue with determining capacity as per s18 of the Act.

“...the contemporaneous examination of capacity is difficult when capacity may be waxing and waning. In our view, section 18 does not provide a clear definition of capacity, and thereby allows the definition to be skewed. One regular obstacle resulting from section 18 arises when a psychiatrist claims that because the patient did not previously have capacity, they therefore would not have capacity in future. We dispute this conclusion, but we are limited by the parochial nature of section 18”⁵⁹.

Way Forward:

The Chief Psychiatrist acknowledged the complexities related to assessing how the Act’s definition of capacity impacts on the application of involuntary treatment orders. While capacity is not a static state and can change over time, the intent of the Act is that clinicians assess capacity at a particular point in time. The MHC acknowledges that the change in the definition of capacity from the 1996 Act may impact on the number and nature of the cohort subject to involuntary treatment orders. However, assessing capacity is a fundamental requirement of the current Act, determining those who will be subject to

⁵⁷ The Australian Law Reform Commission website (www.alrc.gov.au) provides the following explanation of the common law mature minor principle – the capacity of ‘mature minors’ to make their own decisions about medical treatment without parental involvement and reflect the concept of evolving capacities.

⁵⁸ Chief Psychiatrist’s submission to the MHC for the PIR (unpublished), August 2017.

⁵⁹ MHLC submission to the MHC for the PIR (unpublished), June 2017.

involuntary treatment and therefore require the additional safeguards and protection offered by the Objects of the Act.

e. Advance Health Directives

As detailed by the DoH⁶⁰, an Advance Health Directive (AHD) is a formal document that contains decisions about a consumer's future medical, surgical and dental treatment and other health care. In making an AHD, the consumer may provide or refuse consent for future treatment. Additionally, the AHD will only come into effect if the consumer is unable to make reasonable judgements about a treatment decision at the time the treatment is required.

Under the 1996 Act, there was no requirement to have regard to a consumer's wishes, and no reference to AHDs. In contrast, the Act states that a person's wishes must be taken into account, including in an AHD. This initiative is in support of Objects 1(a), (c) and (e).

Since 2008, Part 9B of the *Guardianship and Administration Act 1990* (GAA Act) provides for the making of an AHD by a person regarding treatment decisions in respect of the person's future treatment. The GAA Act requires that, for an AHD to be valid, it must be completed, or substantially completed, on a prescribed legal form. However, regarding mental health consumers, s4 of the Act additionally allows for an AHD to be a directive given by a patient under the common law containing treatment decisions in respect of the patient's future wishes.

The Act stipulates that clinicians must have regard to AHDs in certain situations, such as the medical treatment of the person for whom the AHD is in place.

Data:

Data were requested from HSPs in relation to the use of AHDs but limitations were identified by the HSPs in relation to the data provided and therefore it was not included in the PIR.

NMHS advised that a clinical record audit was conducted in March 2017 and identified that AHDs are not routinely completed. Of the 341 adult mental health consumer files randomly audited, none had evidence of an AHD being completed. However, it was not possible to identify whether this was due to the consumers not having an AHD in place or whether the AHD had not been filed in the consumer's clinical record⁶¹.

In February 2018, NMHS further detailed that the AHD document is generally used in situations where there is significant physical health morbidity, whereas a Collaborative Action Plan (CAP) has been adopted for use as a collaborative planning document with patients related specifically to their mental health needs when in crisis⁶². The CAP can be filed on PSOLIS⁶³, whereas the AHD is only in the clinical file of the

⁶⁰ A booklet was prepared by the Office of the Chief Medical Officer, DoH in 2016 titled *Preparing an Advance Health Directive* to assist people in deciding whether they wish to make an AHD. Located at – http://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Advance%20care%20planning/PDF/preparing_an_advance_health_directive.ashx, last accessed 20 November 2017.

⁶¹ NMHS submission to the MHC for the PIR (unpublished), July 2017.

⁶² NMHS submission to the MHC for the PIR (unpublished), February 2018.

⁶³ PSOLIS is the Psychiatric Services Online Information System which is the mental health services information system.

facility where the clinical staff have completed it. Therefore, if the consumer attends another facility, the instructions provided in the AHD may not be known to exist.

This alternative document is reported by NMHS to have had a wider clinical uptake and satisfies the requirement of having the consumer note their wishes, in a format which can be understood and reviewed by the clinical team.

EMHS⁶⁴ and SMHS⁶⁵ advised that AHDs may be collected in various forms, which provides contemporaneous time specific data and are subject to manual count.

The Chief Psychiatrist identified the importance of distinguishing between an AHD for end-of-life decisions and an AHD to address a period of non-terminal loss of capacity, as the nature of these situations differs greatly. The Chief Psychiatrist informed that while the DoH has a number of resources available to assist clinicians with preparing AHDs, these are primarily aimed at assisting clinicians who are working with consumers considering end-of-life decisions⁶⁶.

Way Forward:

The lack of information and data available on the use of AHDs makes it problematic to comment on whether the Objects are being met in this regard.

The Chief Psychiatrist identified that the lack of guidance around preparing AHDs for temporary loss of capacity may potentially be contributing to a lack of uptake and issues such as the development and use of alternative forms. As such, it may be beneficial to improve clarity around the interface between AHDs and other proactive planning, such as crisis plans⁶⁷. The Chief Psychiatrist noted that mental health standards dictate that consumers must be centrally involved in the development of Care Plans and Crisis intervention/Crisis Action Plans, and therefore AHD planning must consider the existence of these other mandated and consumer-driven planning processes.

Recommendation:

15. The DoH to work with HSPs and other relevant stakeholders to improve data collection and processes regarding AHDs, including identifying how the use of AHDs interacts with other forms of consumer-collaborative planning.

f. Further opinions

Section 182 of the Act stipulates further opinions may be requested by a consumer, a personal support person or an advocate on behalf of the consumer. Requests can be made to the mental health service or the Chief Psychiatrist. When the further opinion is requested via the Chief Psychiatrist, the Chief Psychiatrist liaises with the consumer, carer or advocate to determine the preferred pathway. The Chief Psychiatrist facilitates the provision of the further opinion in a timely manner and is objectively independent.

⁶⁴ EMHS submission to the MHC for the PIR (unpublished), June 2017.

⁶⁵ SMHS submission to the MHC for the PIR (unpublished), June 2017.

⁶⁶ Chief Psychiatrist's submission to the MHC for the PIR (unpublished), January 2018.

⁶⁷ Chief Psychiatrist's submission to the MHC for the PIR (unpublished), January 2018.

The Chief Psychiatrist also reviews any refusals to provide a further opinion. In requesting a further opinion, a consumer may request the opinion from a psychiatrist at the same health service, from a psychiatrist at a different health service, or from a private psychiatrist at the consumer's own cost⁶⁸.

When obtaining a further opinion, the person's psychiatrist or the Chief Psychiatrist must have regard to the Chief Psychiatrist guidelines⁶⁹ about the independence of psychiatrists providing the further opinion. The intention is to allow the consumer the opportunity to express any concerns in relation to their treatment and care to an independent psychiatrist; and to be given confidence in relation to treatment, or to be given treatment options to find the treatment most conducive to their recovery, or both. The very nature of having the option to request a further opinion is in line with Objects 1(a), (c), (d) and (e).

The DoH's Operational Directive, Further Opinions under the *Mental Health Act 2014*⁷⁰ (OD 0637/15), developed as part of the implementation of the Act, states that the provision of further opinions is to be based on the following principles:

- Independence
- Timeliness
- Flexibility and choice
- Consumer and carer rights
- Clear accountability and documentation
- Collaboration and access to information.

Data:

The Chief Psychiatrist's 2015-16 Annual Report outlines that the majority of further opinions are primarily facilitated by mental health services directly. From 30 November 2015 to 30 June 2016 the Chief Psychiatrist received six requests to facilitate a further opinion. All requests were received in writing, with three received from consumers and three from the MHAS⁷¹.

In the 2016-17 full reporting period, the OCP received a total of 18 requests for further opinions, with 10 from the MHAS, six from consumers and two from the MHLC⁷². An increase in requests for a further opinion may be considered a positive outcome whereby consumers are utilising their rights in keeping with the intent of the Objects of the Act.

Between 1 July 2016 and 30 June 2017, the MHAS reports that Advocates were involved in making 330 requests for further opinions⁷³. The number of requests for further opinions

⁶⁸ The Chief Psychiatrist's 2016-17 Annual Report, page 38.

⁶⁹ The Chief Psychiatrist Guidelines: as required under Section 547 of the *Mental Health Act 2014* (December 2015) are located at – https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/12/CP_Guidelines_December_20151.pdf, last accessed 7 December 2018.

⁷⁰ OD 0637/15 is located at – www.health.wa.gov.au/circularsnew/pdfs/13271.pdf, last accessed 20 November 2017.

⁷¹ The Chief Psychiatrist's 2015-16 Annual Report, page 23.

⁷² The Chief Psychiatrist's 2016-17 Annual Report, page 38.

⁷³ The MHAS: Further Opinions Report and Survey of Advocates July 2016/June 2017 report, dated 18 August 2017 is located at – <https://mhas.wa.gov.au/assets/documents/Final-Further-Opinions-Report-and-Survey-by-MHAS-July-2016-to-June-2017.PDF>, last accessed 20 November 2017.

in which Advocates were involved was 9.2% of all inpatient treatment orders and 4.0% of community treatment orders.

The MHAS Further Opinions Report states there is currently no system for collecting total numbers of further opinion requests across the system, particularly if the request is made directly to the mental health service. EMHS⁷⁴ notes that a database was introduced in 2016 to collect information on further opinions; however, this is not consistently used to record the information.

Key Issues Raised:

Availability of psychiatrists

The Chief Psychiatrist's 2015-16 Annual Report raises concerns around the availability of psychiatrists to provide further opinions, particularly when the request is for a psychiatrist from a different mental health service⁷⁵. The Chief Psychiatrist advised that he had recommended a mandated formal roster system to ensure timely further opinions; however, this was not accepted by the DoH due to concerns that clinician availability would be overwhelmed by requests for further opinions. A list of private psychiatrists available for the provision of further opinions is collated and updated by the RANZCP, which has been an important improvement. However, the Chief Psychiatrist considers that, in practice, negligible numbers of further opinions are provided by private psychiatrists due to cost implications, as the consumer is responsible for the cost in these cases⁷⁶.

The Chief Psychiatrist acknowledges that there is a lack of data on further opinion numbers and considers that a comprehensive data collection process is required. This may assist in reassuring clinicians' concerns in this regard. The Chief Psychiatrist further acknowledges that the current unstructured system does not provide a timely response to consumer needs and considers a more formal, agreed system is required⁷⁷.

MHAS further opinions review

The MHAS Further Opinions Report⁷⁸ states that although "it might be expected that there would be more requests for further opinions made in those hospitals where there were more involuntary inpatients...the data collected by MHAS does not reflect this". Possible reasons cited are the:

- length of stay of consumers, alternatively the length of time consumers are kept on involuntary orders;
- ability of treating teams to engage with and gain the trust of involuntary consumers
- approach of the Advocates; and
- approach of Advocates combined with the experience of the Advocates and consumers in relation to getting a further opinion and the value of the further opinion.

⁷⁴ EMHS submission to the MHC for the PIR (unpublished), June 2017.

⁷⁵ Chief Psychiatrist's 2015-16 Annual Report.

⁷⁶ Chief Psychiatrist submission to the MHC for the PIR (unpublished), January 2018.

⁷⁷ Ibid.

⁷⁸ The MHAS: Further Opinions Report and Survey of Advocates July 2016/June 2017 report dated 18 August 2017 is located at – <https://mhas.wa.gov.au/assets/documents/Final-Further-Opinions-Report-and-Survey-by-MHAS-July-2016-to-June-2017.PDF> (page 2), last accessed 20 November 2017.

The MHAS Further Opinions Report suggests that the Act and DoH's mandatory Operational Directive 0637/15⁷⁹ "are not being complied with even though the number of requests for further opinions in which Advocates are involved is relatively low".

MHA Survey Results:

Twenty one of 44 (48%) personal support persons who completed the further opinions section of the MHA Survey advised they have, on behalf of the consumer, requested a further opinion regarding the consumer's treatment. Fourteen of the 21 (67%) personal support persons advised they received a further opinion, and six (29%) of these felt the opinion was provided in a reasonable timeframe.

However, with regard to being provided with the option of a further opinion, one consumer commented:

- "it was not really made clear to me at the time that this was an option" [consumer].

Eighteen (41%) personal support persons provided a comment regarding their experiences with further opinions, such as:

- "Asked for review of treatment/ further opinion. took over a year to get, was not informed that it was a legal right.. had to send many emails and follow up" [personal support person].
- "... We were told that my son had asked for a second opinion, and so they had gotten another one of the doctors in the hospital to look at him and that the doctor agreed with them. That is all we were told. So they may say they got a second opinion. We never saw a copy, and we certainly didn't think another of their colleagues would disagree with them anyway..." [personal support person].

Way Forward:

The information received from stakeholders, consumers and personal support persons indicates there are issues regarding further opinions, inclusive of the lack of reliable data collation⁸⁰. Anecdotal evidence indicates that in some instances the Objects are not always being met, however, until reliable data are available, firm conclusions cannot be drawn.

It is possible that mental health services staff are not consistently advising consumers and personal support persons of the option of obtaining a further opinion. Further training and education on this requirement and process under the Act may assist.

To address the issue of psychiatrists' availability, the Chief Psychiatrist⁸¹ and the MHAS⁸² both suggest the DoH set up a formal arrangement for reciprocal provisions of further opinions between services in order to improve the ability to service patients' requests.

⁷⁹ The DoH Operational Directive, Further Opinions under the *Mental Health Act 2014* (OD 0637/15) is located at – www.health.wa.gov.au/circularsnew/pdfs/13271.pdf, last accessed 20 November 2017.

⁸⁰ NMHS has identified that although data are captured on the number of further opinions furnished to a consumer/requestor, the consumer perception of the HSP adhering to the requirements regarding further opinions would need to be assessed from the perspective of the requestor.

⁸¹ The Chief Psychiatrist's 2015-16 Annual Report, page 23.

⁸² The MHAS: Further Opinions Report and Survey of Advocates July 2016/June 2017 report dated 18 August 2017 is located at – <https://mhas.wa.gov.au/assets/documents/Final-Further-Opinions-Report-and-Survey-by-MHAS-July-2016-to-June-2017.PDF>, last accessed 20 November 2017.

It has been suggested that a roster system between hospitals and community health services could be established to ensure consumers have a choice of external psychiatrists to provide the further opinion, which may need to include external psychiatrists paid by the HSP.

The RANZCP strongly support independent further opinions; however, they believe that facilitating access to these has diverted time from clinical care. The RANZCP recommend a government-funded further opinions panel to ensure appropriate and timely responses⁸³. It is also recommended that in cases where the further opinion relates to a specialist area of psychiatry, the expertise of an appropriately qualified subspecialist is sought.

The DoH commenced the Further Opinions Impact Study (Impact Study) on 1 August 2017 to measure the operational impact of further opinions on HSPs. The Impact Study will gather both quantitative and qualitative data. This includes an online survey of psychiatrists working within the public health system, and assist in determining compliance with the Act and Operational Directive 0637/15. The DoH advised that while the report of the Impact Study is not intended to be released publicly, the DoH will work collaboratively with all relevant stakeholders, including HSPs, the MHAS, the MHC and the Chief Psychiatrist, to ensure compliance with s182 of the Act and Operational Directive 0637/15. The Impact Study is expected to be completed in February 2018.

In August 2017, the DoH's Mental Health Unit, in consultation with the RANZCP, updated and released the list of private psychiatrists available for further opinions and this was circulated to mental health services, the MHAS and the OCP. The list has also been published on the DoH intranet. The RANZCP intends to review and update the list annually and advise the DoH's Mental Health Unit accordingly.

Recommendations:

16. The DoH to complete the Further Opinions Impact Study and coordinate the implementation of outcomes from this review across all relevant stakeholders, including consideration of formal reciprocal arrangements between services for the provision of further opinions.
17. The DoH to work with all relevant stakeholders to improve access to further opinions under the Act, to ensure compliance and inform the statutory review of the Act.
18. The DoH to review the current database in place for recording further opinions, with a view to ensure more consistent recording and reporting of data, to ensure compliance and inform the statutory review of the Act.

g. Treatment Support and Discharge planning

Treatment, Support and Discharge (TSD) plans are a requirement under the Act and are more comprehensive than those under the 1996 Act, which were undertaken operationally as good practice, rather than being mandated by legislation. A TSD plan recognises and facilitates the involvement of consumers, along with their personal support persons, in consideration of options for treatment and care. Involvement of personal support persons

⁸³ RANZCP submission to the MHC for the PIR (unpublished), July 2017.

in TSD planning is subject to the consent of the consumer and may also be limited by the psychiatrist's consideration that it is not in the best interest of the consumer for the personal support person to be involved⁸⁴. Given the holistic and throughcare focus of a TSD plan, this process is in accordance with all Objects of the Act.

The DoH developed a TSD plan as part of the Statewide Standardised Clinical Documentation (SSCD)⁸⁵, for use by HSPs. The SSCD TSD plan is completed with the patient and support person/s, with a copy placed in the patient's clinical record and provided to the patient and support person. As the SSCD TSD plan is not yet available in PSOLIS, Operational Directive 0526/14 mandates the use of a Management Plan instead. The Management Plan is available in PSOLIS and can be used to document clinical care requirements relating to treatment. Having the Management Plan available on PSOLIS enables mental health clinicians, who have the appropriate access in PSOLIS⁸⁶, to review the patient's treatment no matter which mental health service they present to.

While the Management Plan is an important aspect of clinical care, it appears to be more limited in its purpose than a TSD plan, encompassing only the treatment aspects of a person's care. It does not appear to fulfil the broader purpose of a TSD plan, which includes treatment and support following discharge. Advice from the DoH indicates that different plans on PSOLIS are used to record different aspects of a person's treatment and care, including their treatment and support following discharge. However, as the more comprehensive SSCD TSD plan is not accessible electronically through PSOLIS, and its completion is not mandated by Operational Directive 0526/14, its use by clinicians is limited. Therefore, current policy requirements within the DoH and HSPs do not appear to provide the holistic and throughcare focus of a TSD plan, in accordance with the Objects of the Act.

The MHC eLearning training modules for clinicians and consumers and carers, developed during the implementation of the Act, highlight the importance of TSD planning and how consumers, families and carers can be involved. Brochures for personal support persons, available on the MHC website, also inform of their rights to be involved in TSD planning.

Key Issues Raised:

Lack of TSD plans

The MHAS states that Advocates have frequently reported not being able to find a TSD plan, or if there was one, it is primarily a nursing management plan, and in some cases was not made available to the consumer because it gave the full names of the treating team⁸⁷.

⁸⁴ *Mental Health Act 2014*, Part 17, Division 2.

⁸⁵ Statewide Standardised Clinical Documentation (SSCD) for Mental Health Services (OD 0526/14) is located at – http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13105, last accessed 20 November 2017.

⁸⁶ Email advice from the DoH in February 2018 informed that, for security reasons given the sensitive nature of information recorded in PSOLIS, not all mental health staff have full access to PSOLIS information, with the level and range of access being restricted, dependent on the role and location of staff.

⁸⁷ MHAS 2015-16 Annual Report, page 21.

Feedback from the MHA Survey supports these views:

- “I have never been given any information about a discharge plan” [consumer].
- “I am rarely involved in decision making about my care” [consumer].

Twenty eight (28) of the 45 (62%) personal support persons who responded to this question of the MHA Survey stated that a TSD plan had not been prepared, or they were not aware that one had been prepared.

Lack of standardised TSD plan document

A DoH Operational Directive (OD 0526/14)⁸⁸ currently in place requires that all health services staff use the SSCDs to document care provided to a consumer. OD 0526/14 highlights the benefits of the SSCD to enable consistent recording, retrieval and sharing of medical record information at all points of care from triage through to discharge. The primary goal is to improve consumer health outcomes by enhancing the clinical information available to inform care decisions.

NMHS has advised that as a result of this, the completion of the TSD plan is of secondary importance due to the OD 0526/14 clearly stating that the requirement is to comply with the electronic information systems and instead complete the alternative plan in the DoH database⁸⁹.

OD 0526/14 also states that a copy of the TSD plan must be given to the consumer. An annual clinical record audit undertaken by NMHS (unpublished) found that, in a number of cases, the alternative plans were completed electronically, but not printed and placed on the hardcopy clinical record. A total of 119 records were audited from inpatient services associated with NMHS⁹⁰, with 112 (94%) of these records found to contain a ‘management plan’ (not a TSD plan). Only twenty two (18%) audited records contained TSD documentation, of which 21 (95%) were from one specific service location⁹¹.

Lack of involvement of personal support persons

With regard to TSD plans, 33 of the 44 (75%) personal support persons who responded to the MHA Survey stated they were not provided with a copy of the TSD plan.

Personal support persons responding to the MHA Survey stated:

- “The person did not see their doctor for 2 weeks. Discharge came in the form of a nurse saying “you’re out of here”, one morning. There was no follow up” [personal support person].
- “This was not willingly discussed by hospital” [personal support person].
- “I sometimes feel that the familiarity of support persons with the case history of the patient - what has worked in the past, what hasn’t etc - is not given sufficient weight by treatment teams when considering TSDs etc” [personal support person].

⁸⁸ Statewide Standardised Clinical Documentation (SSCD) for Mental Health Services (OD 0526/14) is located at – http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13105, last accessed 20 November 2017.

⁸⁹ NMHS submission to the MHC for the PIR (unpublished), July 2017.

⁹⁰ Note: NMHS has advised that the records provided cover all aspects of the inpatient services, not only involuntary patients.

⁹¹ NMHS submission to the MHC for the PIR (unpublished), July 2017.

A NGO mental health support service reported that carers are frequently unable to obtain a family meeting, despite a number of requests to the hospital, with a common response being 'someone will call you back'.

Terminology of TSD Plans

The Chief Psychiatrist raised concerns regarding the TSD terminology, suggesting that this has resulted in a confusing paradigm for clinical settings by attempting to include all aspects of treatment and care in one document. The Chief Psychiatrist advised the TSD plan does not account for the consumer journey through the stages of illness, where in practice a range of documents may capture the process of care.

Discharge stage of TSD planning

Regarding discharge more generally, both the Royal Flying Doctor Service (RFDS) and the ACMHN have raised concerns about consumers being released from hospitals too soon after being transferred to the new location (for examination or treatment) and/or without any prior notification to the relevant community health services. The RFDS highlight the strain this places on both mental health services affected by the transfer, along with the RFDS' aeromedical resources⁹².

The ACMHN cites that timely notifications to local health service staff is essential to coordinate appropriate follow-up for those at risk of self-harm and suicide attempts following discharge. WAAMH has raised similar concerns and highlights that consumers may be discharged with a sense of institutionalisation, which needs to be taken into account in provision of community supports.

Additionally, the DoH's 2016 Patient Safety Surveillance Unit's Your safety in our hands in hospital report⁹³ also identified a number of discharge related issues. The review examined and documented the contributory factors in 39 confirmed clinical incidents resulting in the unexpected death of a mental health consumer. The most common themes relating to health care contributory factors were identified and included:

- A lack of, or inadequate, management plan, lack of communication with family members, delays in sending discharge documentation and referrals to other care providers (for example, general practitioner, drug and alcohol services) and lack of follow-up post-discharge.
- Communication issues between the multi-disciplinary team treating the patient, including a lack of discussion at the point of discharge, unstructured clinical handovers and handover policies not being followed.
- Inadequate clinical documentation, including variable adoption of the SSCDs for mental health services.

On 4 October 2017, the DoH issued the Mental Health Emergency and Follow Up Information on Discharge from Hospital Emergency Departments Policy (MP 0070/17)⁹⁴.

⁹² RFDS submission to the MHC for the PIR (unpublished), July 2017.

⁹³ Your safety in our hands in hospital; and Integrated Approach to Patient Safety Surveillance in WA Hospitals, Health Services and the Community: 2016, located at – http://ww2.health.wa.gov.au/~media/Files/Corporate/Reports%20and%20publications/Patient%20Safety/Your_Safety_In_Our_Hands_Report_2016.pdf, last accessed 20 November 2017.

⁹⁴ The Mental Health Emergency and Follow Up Information on Discharge from Hospital Emergency Departments Policy (MP 0070/17) is located at – http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13378, last accessed 20 November 2017.

This Policy requires that consumers who present to emergency departments for mental health reasons are offered written mental health emergency and follow up information on discharge. This information must include:

- the contact numbers for 24 hour specialised mental health emergency response services;
- if the individual is being referred to another service for mental health care, the name and contact details of that service and, if possible, written information regarding an appointment date and time;
- if an appointment with the referred service for mental health care cannot be made at discharge, the name, contact number, address and normal opening hours of that service; and
- a space for a health professional or consumer to record a future appointment date and time.

The Policy applies to HSP emergency departments and a brief summary of the actions taken must be documented on the consumer's record. This information is also required to be provided to the consumer's family member or carer if they present to the emergency department with the consumer, with the consent of the consumer and in accordance with legal requirements regarding sharing of information. The development and implementation of this Policy assists in meeting the Objects of the Act.

The MHAS is undertaking a TSD plan inquiry⁹⁵. As part of the inquiry, Advocates are working with three consumers, their personal support persons and treating teams, to produce TSD plans that comply with the Act. Advocates are also working with the treating teams to educate them on the requirements under the Act and to ensure the TSD plans are easy to use. Ongoing and follow-up work by the MHAS is planned, subject to funding.

Way Forward:

Given the inability to obtain data on the completion of TSD plans and the feedback received, it could be asserted that the intention of the Objects are not being met in all cases. Education and training of mental health services staff, along with a requirement to complete a standardised TSD plan document, and reliable data collation and reporting may assist with this.

Additionally, clarification and direction is required regarding the current use of an alternative plan available electronically, as per OD 0526/14.

The Chief Psychiatrist recommends a change of terminology from TSD plan to "Care Plan", which has greater international recognition, is understood by clinicians, does not create administrative duplication and the terminology is already used in primary health care settings where the majority of mental health care occurs. This may be further explored by the relevant stakeholders for consideration of achieving greater clarity in this regard.

The Chief Psychiatrist advised⁹⁶ that his office was in the process of undertaking the first series of clinical monitoring reviews against the Chief Psychiatrist's Standards for Clinical Care. This series of reviews is expected to be completed by mid-2018. Dependant on the

⁹⁵ The TSD plan inquiry is expected to be completed early 2018.

⁹⁶ Chief Psychiatrist's submission to the MHC for the PIR (unpublished), January 2018.

outcome of these reviews and identified trends, the Chief Psychiatrist may consider a Thematic Review of Treatment, Support and Discharge Plans as they exist in their various forms, such as Care Plans, Management Plans, Risk Management Plans, Crisis Plans, Relapse Prevention Plans and Discharge/Follow-up Plans.

There is a need to improve the timeliness of referrals to primary and community care services upon a consumer's discharge from hospital. The ACMHN recommends that a discharge checklist be developed and that potential barriers to primary and community care teams receiving timely discharge advice be identified and addressed. The WAAMH and the ACMHN both identified the need to improve community based linkages and supports for consumers when discharged, rather than being required to seek their own assistance and support. This is supported by the anecdotal information received in the MHA Survey from personal support persons, indicating a lack of support upon discharge.

Recommendation:

19. The DoH to collaborate with the HSPs and other relevant stakeholders in order to identify the specific issues relating to TSD planning and determine appropriate solutions for implementation, including training and education requirements, adding the SSCD TSD plan on PSOLIS, and monitoring and reporting on compliance with the requirements of the Act relating to TSD planning (ss186-188).

h. Physical health assessment

People with mental illness have more physical illness than the general population, yet are less likely to be diagnosed with physical illnesses, and therefore less likely to receive the required medical treatment⁹⁷. In line with Objects 1(a)(ii), (ii), (d) and (e), and as a result of concerns about the physical health of people with mental illness, the Act (s241) stipulates voluntary and involuntary inpatients, and people detained for examination on referral must be offered a physical examination within 12 hours of admission. Under the 1996 Act, there were no rights or processes for the assessment of a consumer's physical health.

The physical health assessment initiative is intended as a preventive measure to ensure there are no health related issues that may impact on a consumer's overall recovery and thereby offering a service in adherence to their rights, dignity and protection.

MHA Survey Results:

Responses to the MHA Survey indicate that physical health assessments were undertaken in the majority of cases, with 14 out of 24 (58%) consumers advising they were offered a physical health assessment on admission. Additional comments from consumers who did receive a physical health assessment include:

- "Not within 12 hrs" [consumer].
- "Blood pressure, blood tests with a complete lack of empathy from that dr and nurses" [consumer].
- "I wasn't offered. I was forced" [consumer].

⁹⁷ Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001) *Duty to Care: Physical Illness in People with Mental Illness*. Perth: The University of Western Australia.

- “Mainly because they wanted to do drug testing. Wasn't really about my health” [consumer].

Way Forward:

The Chief Psychiatrist's Standards for Clinical Care include a Physical Health Care of Mental Health Consumers Standard, which was developed to improve the physical health of consumers who experience mental illness⁹⁸. The Standard provides systemic criteria that must be adhered to by the mental health service and staff, along with personal criteria that outlines what must be addressed or considered for consumers.

Recommendations:

20. The DoH to collaborate with the HSPs and other relevant stakeholders to identify potential barriers at an operational level to undertaking physical health assessments, and assist the DoH and HSPs develop and implement strategies to increase compliance with the Chief Psychiatrist's Standards.
21. Through the Mental Health Data Management Group, the DoH and HSPs to identify opportunities to assist with appropriate data collection, monitoring and reporting regarding consumers being offered and receiving physical health assessments.

i. Statutory Bodies

MHAS – expanded scope and reduced timeframes

Under the 1996 Act, the CoOV were only required to make contact with consumers (involuntary, mentally impaired accused in an authorised hospital, a consumer in a private psychiatric hostel, or other institution⁹⁹) upon request.¹⁰⁰ Under the Act, the MHAS has specific timeframes to make contact with all involuntary consumers (within seven days for adults or 24 hours for children). The Act also provides for other groups who have the right to access the MHAS, for example referred persons and voluntary inpatients admitted for examination by a psychiatrist. The expanded scope and reduced timeframes for the MHAS contact is in support of Objects 1(a), (b), (c), (d) and (e).

Data:

From July 2015 to November 2015, prior to the commencement of the Act, the CoOV assisted 867 consumers for individual advocacy.¹⁰¹ In the first seven months of the Act's operation, the MHAS has made statutory contact with adult and child consumers on 1,699 inpatient treatment orders. Additionally, statutory contact was made by letter, in person or by phone with 426 adults and children on community treatment orders. This increase in the

⁹⁸ Chief Psychiatrist's Standards for Clinical Care, As required under Section 547 of the *Mental Health Act 2014*, November 2015, located at – http://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/12/CP_Standards_2015.pdf, last accessed 20 November 2017.

⁹⁹ *Mental Health Act 1996*, s175.

¹⁰⁰ *Mental Health Act 1996*, s186(c).

¹⁰¹ Council of Official Visitors Annual Report July – November 2015.

number of contacts by MHAS is evidence of the increased support provided to consumers under the Act.

Data provided by the MHAS regarding the time taken for HSPs to notify the MHAS of a new Form 5A (community treatment order), Form 6A (inpatient treatment order in authorised hospital) and Form 6B (inpatient treatment order in general hospital) indicate that the vast majority were provided well within the required timeframes. Between 1 July 2016 and 30 June 2017, only a small number of all three types of Forms were received late or not at all – approximately 3% of all Forms received for adults and approximately 24% for children¹⁰². The MHAS subsequently contacted 92.6% of adults on inpatient treatment orders within seven days and 84.3% of children on inpatient treatment orders within 24 hours following notification.

The MHAS 2016-17 Annual Report identifies that in 2016-17, five out of 12 (41.6%) children not contacted within the 24 hour timeframe were as a result of MHAS delays. However, it is noted by the MHAS that one of these contacts was 15 minutes late due to the consumer being treated by health staff when the Advocate arrived on the ward, and the other four late contacts were children who were on Compulsory Treatment Orders (CTOs) and in regular contact with the Advocates in hospital. In 2015-16, two out of four (50%) children not contacted in the required timeframe were as a result of minor delays (10-30 minutes) of the Advocates¹⁰³.

MHA Survey Results:

Respondents to the MHA Survey regarding contact from the MHAS include:

- “She was understanding, empathetic and helpful, but ultimately she didn't help get me out any quicker than if she hadn't been there and this got me questioning her use” [consumer].
- “I contacted them” [consumer].

MHT – more frequent reviews

Under the Act, the MHT is required to provide more frequent reviews of consumers on involuntary orders. For example, the initial review period was reduced from 56 days under the 1996 Act to 35 days for adults and 10 days for children. In addition, the periodic review was reduced from six months under the 1996 Act to three months for adults and 28 days for children.

By way of recourse under the Act, the MHT also has additional functions, including reviewing the validity of orders, issuing compliance notices, and review of other decisions affecting rights. The functions of the MHT are in support of all Objects of the Act.

In support of the Objects, the MHT is required under the Act to have specifically qualified people attend hearings under certain circumstances. For example, if the consumer is a child the MHT must include a child and adolescent psychiatrist, and if the MHT is considering psychosurgery for a consumer the MHT must include a neurosurgeon.

¹⁰² The higher percentage reflects the small number of children subject to Forms under the Act, with the 24% relating to eight out of 51 Forms received late or not at all.

¹⁰³ MHAS 2015-16 and 2016-17 Annual Reports detail these data.

Data:

The MHT 2016-17 Annual Report, tabled in Parliament on 28 November 2017, is the first published annual report of the MHT and includes data from 2015-16, as well as comparative data from the operation of the former MHRB since 2009-10.

The MHT 2016-17 Annual Report provides data regarding MHT reviews, however provides the following caveat over this data:

“The Tribunal regularly checks the accuracy of its list of names of patients who are the subject of involuntary treatment orders, by cross checking the list with the hospitals and clinics, thus ensuring that no patient is overlooked as regards the Tribunal’s statutory duty to review whether or not the patient should remain subject to an involuntary treatment order. However, due to difficulties experienced with designing and implementing a new database system in place of the system used for many years by the Mental Health Review Board, some of the data referred to in this Section is indicative only”¹⁰⁴.

With consideration to this, the MHT 2016-17 Annual Report details that during that same financial year, a total of 2,103 reviews were completed for consumers both detained in hospital and on community treatment orders. In the MHT 2016-17 Annual Report, the 2015-16 financial year is split into pre- (1 July 2015 – 29 November 2015) and post- (30 November 2015 – 30 June 2016) commencement of the Act. During that year, a total of 1,779 reviews were completed. During the 2013-14 financial year, 1,101 reviews were completed by the then MHRB. The MHT 2016-17 Annual Report details the types of reviews held, such as requested reviews, the initial period reviews, and the six-month period review, with data provided dating back to the 2009-10 financial year¹⁰⁵.

Data provided in the MHT 2016-17 Annual Report identifies that of the 3,320 reviews scheduled in 2016-17, 1,217 (37%) reviews did not proceed. The reason cited for cancellation in the majority of those cases was that the person had ceased to be an involuntary patient by the scheduled review date¹⁰⁶.

Data from the MHAS and the MHLC regarding their involvement with MHT hearings indicates an increase in the number of hearing attendances since the Act’s implementation. The MHAS 2016-17 Annual Report indicates that Advocates attended an average of 62 MHT hearings per month, in comparison to an average of 40 per month in the first seven months of the operation of the Act¹⁰⁷. Similarly, the MHLC 2015-16 Annual Report indicates that during that financial year, the MHLC has represented 281 involuntary patients at MHT hearings, compared with 193 in the 2014-15 financial year¹⁰⁸. These increases are likely to be a result of the increase in the number of reviews required under the Act, in addition to the MHAS contacting all consumers to offer assistance with MHT hearings. Similar data are not provided in the MHLC 2016-17 Annual Report, therefore contemporary comparison is not possible.

¹⁰⁴ MHT 2016-17 Annual Report, page 11.

¹⁰⁵ The MHT 2016-17 Annual Report can be viewed for further details, and is located at – http://www.mht.wa.gov.au/publications/pdfs/Annual_Report_2017.pdf (page 12), last accessed 7 December 2017.

¹⁰⁶ MHT 2016-17 Annual Report, page 13.

¹⁰⁷ MHAS 2016-17 Annual Report, page 49.

¹⁰⁸ MHLC 2015-16 Annual Report, page 12.

Key Issues Raised:

Impact of increased frequency of reviews

While recognising the benefits of the increased frequency of MHT reviews, the MHLC and the RANZCP note that additional reviews can create additional tension between the consumer and their treating practitioners. Additionally, the reviews may unnecessarily re-traumatise consumers and their families, resulting in a possible further delay to the consumer's recovery. The RANZCP are of the view that the reviews of children and young people are too frequent, which causes unnecessary distress to the young consumers and their families.

The MHT 2016-17 Annual Report identifies that “there has been a significant decrease in the attendance rates of inpatients” at MHT hearings. The MHT 2016-17 Annual Report further states that the “decline in the rate of participation in inpatient reviews [by consumers] may be due to the increased frequency with which reviews are held, particularly as regards patients who are less than 18 years old”¹⁰⁹.

Additional concerns raised

Stakeholders, consumers and personal support persons have raised a number of concerns regarding MHT hearing processes. These include inconsistencies of the MHT processes, delayed notice of hearings, lack of access to relevant documentation for the hearing and issues with the conduct of MHT hearings. These matters will be explored further as part of the preparation of the statutory review of the Act.

The President of the MHT acknowledged these concerns and advised that she will shortly commence the process required to formalise practices and procedures through the development of practice directions as well as rules pursuant to s472 of the Act¹¹⁰.

Way Forward:

The President of the MHT has advised that when hearing dates are set, the MHT sends a letter to the consumer, advising why the hearing is occurring, where and when it will be held, and informing that a report regarding the involuntary order has been requested from the treating team. The consumer is also sent a pamphlet outlining how the hearing will be conducted and the general process of the MHT. The consumer is encouraged to involve relevant personal support persons, including inviting them to the hearing.

The MHT 2016-17 Annual Report states¹¹¹ that a notice of the hearing is sent to the treating team and any representative(s) of the consumer that the MHT are aware of, such as a lawyer or para-legal from the MHLC. A notice, including date, time and venue, is also sent to the MHAS and any close family member, carer, or other personal support person whose name and contact details have been provided to the MHT¹¹².

With regard to the frequency of children and young people being reviewed by the MHT, the RANZCP recommend this be reviewed with some urgency. The RANZCP suggest any review of this frequency takes into account advice from specialist child and youth

¹⁰⁹ MHT 2016-17 Annual Report, page 16.

¹¹⁰ MHT submission to the MHC for the PIR (unpublished), January 2018.

¹¹¹ MHT 2016-17 Annual Report, page 8.

¹¹² Ibid.

psychiatrists regarding more appropriate measures that are able to uphold rights without negatively affecting the mental health of this vulnerable cohort.

Additionally, the MHT provided the MHC with an article¹¹³, which explored the mental health tribunal experiences of consumers admitted involuntarily under the Irish *Mental Health Act 2001*¹¹⁴. Though the service sample was small (23 consumers), the majority of these consumers reported mixed experiences comprising both positive and negative aspects regarding information provision, emotional support and an inclusive atmosphere. Some consumers reported receiving accessible information about the process of the tribunal, felt emotionally supported through the process, and experienced respectful tribunal practices. However, it is also reported in the article that many of the consumers surveyed reported experiences of non-inclusive practices, being ill-informed of tribunal processes, not being supported emotionally during and after the tribunal hearing, and feeling distressed by the perceived adversarial tribunal proceedings.

Overall the findings of this review concluded that¹¹⁵;

“Systemic changes could ensure that the positive experiences encountered by the minority of participants in this study are more consistently experienced. Ongoing education and training of stakeholders in the provision of inclusive tribunal practices, and the provision of accessible information and emotional support to service users through the stages of the involuntary admission process appear likely to be beneficial. Service users should automatically be offered the option of having a support person of their choosing present during tribunals”.

The MHAS has voiced their support of these findings, noting that this supports the MHAS contacting all those with a MHT hearing scheduled to ensure they know about the upcoming hearing, in addition to what to expect and their rights in relation to the hearing, including the right to a lawyer or advocate.

In order to address the issues identified regarding the MHT proceedings and processes, it is essential that the MHT work with all relevant stakeholders. The continued collection and reporting of relevant data by the MHT will allow for further analysis that will contribute significantly to the completion of the statutory review of the Act.

Recommendations:

22. In order to determine compliance with the Act, the MHT to facilitate the ongoing collection of all relevant quantitative data regarding MHT reviews for further data analysis and to contribute to the statutory review of the Act.
23. The MHT to work with all relevant stakeholders to address the concerns raised regarding MHT proceedings and processes, including apparent inconsistencies of MHT processes, delayed notice of hearings, lack of access to relevant documentation for the hearing and issues with the conduct of MHT hearings.

¹¹³ Murphy, R., McGuinness, D., Bainbridge, E., Brosnan, L., Keys, M., Felzmann, H., Murphy, K., Hallahan, B., Higgins, A., and McDonald, C. *Service users' experiences of mental health tribunals in Ireland: a qualitative analysis*. Irish Journal of Psychological Medicine (2017).

¹¹⁴ *Mental Health Act 2001* (Ireland).

¹¹⁵ Murphy, R., McGuinness, D., Bainbridge, E., Brosnan, L., Keys, M., Felzmann, H., Murphy, K., Hallahan, B., Higgins, A., and McDonald, C. *Service users' experiences of mental health tribunals in Ireland: a qualitative analysis*. Irish Journal of Psychological Medicine (2017), page 1.

5.2 Rights for personal support persons

There was no mention of families or carers under the 1996 Act. In comparison, the Act enshrines requirements around clinicians collaborating with those people who are important in the consumer's life, in addition to the consumers themselves. Previously, under the 1996 Act there was a lack of clarity around what information could be provided to these important people and under what circumstances. This impacted on clinician engagement with others due to concerns regarding consumers' confidentiality and the legal implications of sharing consumer information.

Personal support persons, as defined in s4 and s7 of the Act, is a collective definition for five categories of support people: enduring guardian or guardian; the parent or guardian of a child; a nominated person; a carer; or a close family member. The same person could identify with more than one of these categories. In accordance with Objects 1(b), (c), (d) and (e), Part 17 of the Act is dedicated to the recognition of the rights and roles of families and carers.

When a consumer is admitted or received into a mental health service, it is a requirement under the Act (s296) that they be asked whether they have a carer or a close family member that should be engaged. If the consumer does identify either of these, the consumer must consent to these people being provided with information about, and involved in, the consumer's treatment or care. Under the Act, responses to these questions are required to be documented.

a. Personal support persons

Under the Act, personal support persons have extended rights¹¹⁶ in comparison to the 1996 Act. These include the right to be told when the consumer is placed on an involuntary treatment order and the right to information and being involved in the preparation and review of TSD plans. However, it is important to note that any information relating to the consumer's treatment and care may only be disclosed to their personal support persons with the consent of the consumer¹¹⁷. Additionally, the consumer's psychiatrist may decide that informing the personal support person(s) is not in the best interest of the consumer. The psychiatrist is required to document this decision and the reasons for it, and provide a copy to the consumer and the MHAS.

The Act also requires that the MHAS be given the name and contact details of any personal support person who has been notified of a consumer placed on an involuntary treatment order and, if no-one is notified, the reasons for this.

Data:

According to the MHAS, in 2015-16, 1,670 people were placed on 2,324 involuntary treatment orders; however, only 202 notifications of personal support persons were received by the MHAS¹¹⁸. The MHAS 2015-16 Annual Report states that there were no reasons given to the MHAS for any consumer who did not have a personal support person

¹¹⁶ Details pertaining to the rights of a personal support person can be found in a brochure on the MHC website – https://www.mhc.wa.gov.au/media/1410/information_for_personal_support_persons-2017.pdf, last accessed 20 November 2017.

¹¹⁷ *Mental Health Act 2014*, Part 17, Division 2.

¹¹⁸ MHAS 2015-16 Annual Report, page 26.

notified. Although contrary to the requirements of the Act, it is acknowledged by the MHAS that this may not necessarily mean that the personal support persons were not being notified.

Key Issues Raised:

Personal support person not being identified

In accordance with the Act, personal support persons should be identified as part of the development of the TSD plan. A NGO mental health support service, along with numerous other stakeholders, advised that personal support persons are not always identified when the person is admitted on an involuntary basis. This is reportedly the case even when the personal support person has accompanied the consumer to the emergency department and/or visited them a number of times in hospital.

Consumer not informed when information withheld from personal support person

A consumer's psychiatrist has the discretion to withhold information from a personal support person if this is believed to be in the best interest of the consumer. For transparency, all decisions relating to this, and associated reasons, must be documented and copies provided to the consumer and the MHAS. The MHAS reports that no notifications were provided to them in the first seven months of the operation of the Act, although it is not known whether this is because there were no such decisions to withhold information, or that the MHAS was not notified¹¹⁹.

Complexity of terms

On the overall use of the term 'personal support person' under the Act, the Chief Psychiatrist raised concerns over the complexity it adds in the context of also having the terms 'carer' and 'nominated person'.

Way Forward:

There is some evidence that not all personal support persons are being identified, which reflects non-compliance with the Act in some instances. However, this cannot be quantified due to lack of adequate recording and data collection. It is important to acknowledge that although all reasonable efforts must be made to contact a consumer's personal support person (s141), there may be legitimate reasons for the personal support person not being contacted or informed of decisions. As previously discussed, the treating psychiatrist may determine that this is not in the consumers' best interest. It is also not known whether, in some cases, personal support persons were not contactable due to matters such as no contact number being provided, or that they were not contactable on the number provided.

¹¹⁹ MHAS submission to the MHC for the PIR (unpublished), August 2017.

Recommendations:

24. The MHC to further explore the complexity of the different terms used for personal support persons, nominated persons and carers, and identify and implement potential solutions such as greater communication and education options to address the reported complexity.
25. Through the Mental Health Data Management Group, the DoH and HSPs to progress improved data recording and reporting with regard to personal support persons including consultation with other stakeholders, as required.

b. Nominated persons

The notion of the nominated person did not exist under the 1996 Act. A consumer may now nominate one adult, who may or may not also be a personal support person, to be their nominated person (via a Form 12A). A nominated person has additional rights and responsibilities, including that they be informed of, and involved with, a number of matters as set out in s266.

These matters include: being provided with detailed information relating to the consumer's treatment and care, including any use of seclusion or restraint; being advised of the services available to meet the consumer's needs; being involved in the consideration of options for treatment and care, including TSD planning; and being provided with information about the consumer's rights and their rights as the nominated person.

The nominated person is able to act as an advocate for the consumer's rights and may be anyone the consumer chooses, including a friend, carer, or close family member who already has rights to information under the Act. The role of a nominated person is to assist the consumer who made the nomination by ensuring that, in performing a function under this Act in relation to the consumer, a person or body –

- observes that person's rights under the Act; and
- takes that person's interests and wishes into account.

The consumer is also entitled to have uncensored communications with their nominated person and the nominated person must be given information and may exercise, on behalf of the consumer, any rights conferred under the Act on the consumer. The MHAS Annual Report 2015-16 explains that, for example, a nominated person can say that the consumer does not object to an Advocate looking at the consumer's file in a situation where the consumer might not otherwise be able to speak for themselves¹²⁰.

Key Issues Raised:

Role of nominated person not well understood

The MHAS highlight in their 2015-16 Annual Report that the role of the nominated person is not always well understood, and details some practical issues with this:

¹²⁰ MHAS 2015-16 Annual Report, page 26.

- Health services staff advised that documenting the nominated person on the file notes was adequate and a Form 12A was not required, as it was unnecessary paperwork.
- Ward staff not routinely advising consumers or their personal support persons about the possibility of having or being a nominated person, and the advantages this brings.
- Access to Form 12A is not obvious and occasionally not provided when requested by consumers.
- Regional locations face challenges for the nominated person to sign and return the Form 12A accepting the nomination, if methods for return, such as fax, email or scanner are not available¹²¹.

MHA Survey Results:

Many personal support persons (48) responded to the MHA Survey, of which 40 (83%) were family members or carers. Of these 40, eight (20%) were parents or guardians of a child, five (12.5%) nominated persons, and three (7.5%) guardians or enduring guardians of an adult. It is noted that a person may identify in more than one category of personal support person. The responses provided by these personal support persons are captured under the relevant headings below.

Way Forward:

The anecdotal evidence and information provided by stakeholders indicates that the use and involvement of personal support persons (inclusive of nominated persons) does not in all cases currently meet the Objects of the Act. However, greater communication and education around these roles may assist in addressing this issue. Education and training may also address the reported complexity of terms such as personal support persons, nominated persons and carers.

Recommendations:

26. The MHC to promote existing education materials, including eLearning resources and brochures, regarding the role of nominated persons and personal support persons to assist with the understanding of these roles.
27. The DoH to develop potential solutions for access to and submission of Form 12A (Nomination of nominated person) to ensure equity of access to this right by consumers throughout the State.

c. Involvement of personal support persons in MHT hearings

Under the Act, the MHT has a significantly expanded scope compared with the previous Mental Health Review Board under the 1996 Act. For example, proceedings may now be initiated by personal support persons. This is in support of Objects 1(b), (c) and (d), and is specifically in recognition of the important role support people have in the review of a consumer's involuntary status. The MHT can make recommendations to the psychiatrist,

¹²¹ MHAS 2015-16 Annual Report, page 27.

which was intended to open dialogue between treatment services, the consumer, their support person and the MHT to best meet the consumer's mental health needs.

As identified by the MHT President, the benefits of having a personal support person present at MHT hearings include:

- the support person may assist the consumer communicate any objections to being involuntary;
- the presence of the support person may alleviate the consumer's anxiety from the hearing process; and
- the support person may provide assistance to the MHT in gaining greater insight into the consumer's history and family support¹²².

Data:

The MHT 2016-17 Annual Report identifies the number of review hearings for children and adolescents that were attended by family members. In 2016-17, out of a total of 81 review hearings completed, 42 (52%) were attended by family members of the consumer. In the seven months after implementation of the Act, a total of 34 review hearings were completed, with 22 (65%) being attended by family members. From 1 July 2015 to 29 November 2015 there were seven reviews completed, with three (43%) attended by family members¹²³.

For the 2016-17 financial year, a total of 390 out of 2,103 (18.5%) MHT review hearings were attended by a personal support person. In addition, the MHAS provided representation at 738 (35%) review hearings, and the MHLC provided representation at 166 (8%) review hearings. For the previous financial year of 2015-16, the MHT 2016-17 Annual Report identifies that 311 out of 1,747 (18%) MHT review hearings were attended by a support person.¹²⁴ However, for all years the MHT 2016-17 Annual Report highlights that some consumers were supported or represented by the MHAS, in addition to the MHLC and/or another person, such as a carer, friend, family member or guardian¹²⁵.

Key Issues Raised:

Challenges of involving personal support persons in hearings

Along with the benefits of involving personal support persons in MHT hearings, as detailed in the previous section, the President of the MHT has also identified a number of challenges. For example, the increase in the number of people attending hearings will sometimes require a larger hearing room, which is often not available at the relevant venues. The President additionally cites the increased security risk due to the increase in numbers of people attending the hearing and an absence of information about the additional persons attending¹²⁶.

Other challenges identified by the President include personal support persons being invited without the MHT's knowledge, and in some cases, the MHT is unable to advise the

¹²² MHT submission to the MHC for the PIR (unpublished), January 2018.

¹²³ MHT 2016-17 Annual Report, page 19.

¹²⁴ MHT 2016-17 Annual Report, page 18.

¹²⁵ MHT 2016-17 Annual Report, page 17.

¹²⁶ MHT submission to the MHC for the PIR (unpublished), January 2018.

personal support person of changes to the scheduled hearing. However, it is noted that the most significant impact of involving personal support persons in MHT hearings is related to time constraints. The standard time allocation for each hearing is 30 minutes, and this is significantly increased when those who have substantial speaking or advocacy roles are in attendance. The effect of this is a significant impact on MHT resources, in addition to possibly substantially increasing wait times for hearings¹²⁷.

MHA Survey Results:

Due to the low number of respondents to the question¹²⁸, it is difficult to draw any firm conclusions from the MHA Survey questions around personal support persons' attendance at MHT hearings. However, comments provided illustrate that some personal support persons have concerns about the functioning and independence of the MHT:

- "MHT seems mostly to just reinforce the hospital view. hospital 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].

Way Forward:

Based on the data and information regarding the involvement of personal support persons at MHT hearings, the Objects appear to be met in this regard, as personal support persons are involved in MHT hearings.

d. Notifiable events

Notifiable events are a new provision under the Act and in support of Objects 1(a)(ii), (b), (c) and (d), require that carers, close family members and other personal support persons be notified as soon as practicable (s140), of the 25 notifiable events listed in Schedule 2. Examples of these events include: the making of various orders¹²⁹, the discharge of a consumer; and the making of transport orders. Schedule 2 also prescribes who is responsible for notifying personal support persons of the notifiable event.

Data:

Feedback received from a stakeholder group representing consumers, families and carers confirms an increase in notifications being received over time under the Act. The DoH provided statewide data regarding notifications to both consumers and personal support persons. Due to data limitations this was not able to be separated out in order to identify notifications to personal support persons only.

¹²⁷ MHT submission to the MHC for the PIR (unpublished), January 2018.

¹²⁸ Eight out of 44 personal support persons (18%) advised they were informed of an upcoming MHT hearing, and 12 of the 44 (27%) advised they have personally attended a MHT hearing.

¹²⁹ Examples of orders to be notified include: an inpatient treatment order, a community treatment order, an order authorising the continuation of the person's detention at an authorised hospital to enable further examination.

Key Issues Raised:

Notifiable events not consistently being provided to personal support persons

The DoH advised that HSPs are not able to consistently advise personal support persons of notifiable events. It is reported that this is a result of the number of notifiable events being required, which is an increase from the 1996 Act¹³⁰.

An example provided by DoH includes the possibility of a consumer being placed on several different orders in a short period of time as circumstances change, such as being referred for an examination on a Form 1A (with three individual notifications required from this Form), but also detained at the current place on a Form 3A (two individual notifications). The consumer may then require a Form 4A for transport to the place of examination (three individual notifications), before finally being put on a Form 6A as an involuntary inpatient (up to six individual notifications, if the order is not completed directly in PSOLIS). The timeframe of these circumstance changes may be half a day, and if the notifications are not entered immediately the earlier notifications regarding examination, detention and transport may no longer be as relevant, given the final outcome of an involuntary treatment order being imposed¹³¹.

The inclusion of notifiable events in the Act was in recognition of the role personal support persons play in the treatment, care and support of people who have a mental illness, and the need to facilitate their involvement in the process of recovery. Consequently, the inclusion of notifiable events in the Act directly supports Objects 1(b), (c) and (d).

Way Forward:

Given that the notification of notifiable events to consumers and personal support persons is a significant factor in achieving the Objects of the Act, consideration needs to be given by the DoH and HSPs to possible methods of streamlining the process to ensure that compliance with the requirements of the Act is consistently achieved.

Additionally, addressing issues pertaining to the identification and improved recording of notifiable events data will assist with the collection of appropriate data to contribute to the statutory review of the Act. Consultation with stakeholders will be undertaken as part of that process.

Recommendations:

28. The DoH and HSPs, in consultation with other stakeholders, to develop ways to streamline the notification process regarding notifiable events, to ensure consumers and personal support persons are notified in accordance with the requirements of the Act.
29. Through the Mental Health Data Management Group, the DoH and HSPs to address issues around data identification and recording regarding notifiable events, to better identify and ensure compliance with the Act and to inform the statutory review of the Act.

¹³⁰ Email advice from the DoH provided in February 2018.

¹³¹ *Ibid.*

5.3 Recourse

a. MHT additional functions

The scope of the MHT has been expanded under the Act, with family members, carers or other personal support persons (s390(2)) able to initiate hearings by applying for a review under specified circumstances (s390(1)). Circumstances for applying for a review may include, but are not limited to, review of an inpatient treatment order, review of a community treatment order, or review of a transfer order. This aligns with the additional rights of the consumer and personal support persons as per all of the Objects.

Additionally, under the Act (Part 21, Division 8), the MHT may issue a compliance notice to a service provider if they have not complied with a prescribed requirement (s422), such as provision of document(s) or other information to a consumer, or ensuring a TSD plan is prepared, reviewed or revised. The notice directs a service provider to undertake a specific action or report to the MHT in a specified manner within the specified period. Section 426 of the Act requires the MHT to report on compliance notices in their Annual Report¹³². The MHT 2016-17 Annual Report states that “the Tribunal has not issued any compliance notices”¹³³.

Data:

The MHT 2016-17 Annual Report details “requested reviews”, however, it is not clear how many of these have been requested by consumers themselves and how many from personal support persons. Additionally, the specific circumstances for applying for a review are not identified. Data and information has been acquired from alternate sources where possible.

Way Forward:

The MHC will continue to work with the MHT Registrar and staff to improve the use of information systems, and data reporting processes.

Recommendation:

30. 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.

¹³² *Mental Health Act 2014*, s426.

¹³³ MHT 2016-17 Annual Report, page 22.

b. Making a complaint

The Charter of Mental Health Care Principles and background to the HaDSCO

Protecting the human rights and dignity of people experiencing severe mental illness is a cornerstone of the Act. Part 16 of the Act relates to the protection of consumers' rights. In addition, the Charter of Mental Health Care Principles (Schedule 1 of the Act) is a rights-based set of principles that mental health services must make every effort to comply with when providing treatment, care and support to consumers. If a consumer of mental health services or a personal support person feels that a person or body performing a function under the Act has not had regard to these Principles, the consumer or representative has the right to make a complaint to the relevant mental health service. Part 19 of the Act provides for complaints about mental health services.

The DoH's Operational Directive (OD 0589/15), titled WA Health Complaint Management Policy 2015¹³⁴, outlines the process for handling complaints to HSPs, including mental health services. As the release date of OD 0589/15 was 11 February 2015, the 1996 Act is referenced and as such will require updating.

Each of the HSPs has options for providing feedback or complaints on their respective websites. There is no consistency in the way this information is presented and the detail about the complaints process also varies. This is consistent with the feedback received from an organisation representing consumers, families and carers.

As per the intention of Objects 1(a)(ii), (b), (c) and (e), if dissatisfied with the outcome of a complaint to a mental health service, a person has a right to subsequently lodge the complaint with the HaDSCO. Part 19 of the Act provides for the HaDSCO having responsibility to formally manage complaints about mental health services relating to all public, private and not-for-profit service providers.

The HaDSCO had previously dealt with these complaints as part of their health complaints jurisdiction, however, the Act provides specific processes and protections for complaints that take account of additional vulnerabilities and needs of people with a mental illness. Additionally, under the Act, prescribed providers of mental health services must provide the Director of the HaDSCO within a prescribed period after 30 June each year, a report relating to the complaints received by the service provider and action taken on the complaints. A process to prescribe the providers for this purpose (public, private and non-government service providers) is to be established by the HaDSCO in consultation with the MHC¹³⁵.

The Complaints Process

The HaDSCO 2015-16 Annual Report¹³⁶ outlines that the service collects, analyses, evaluates and reports on complaints data, to identify broad trends relating to the number of complaints received, the types of issues raised, the time taken to resolve complaints, the outcomes achieved and demographic information of the people making the complaints.

¹³⁴ OD 0589/15 is located at – <http://www.health.wa.gov.au/circularsnew/pdfs/13196.pdf>, last accessed 20 November 2017.

¹³⁵ *Mental Health Act 2014*, s309.

¹³⁶ HaDSCO 2015-16 Annual Report, page 47.

In line with the Act, the HaDSCO requires that the complainant must have first tried to resolve the complaint with the HSP or agency. However, feedback from an agency representing consumers, families and carers advised that navigating the complaints process through the DoH is confusing and complex. As a result, the agency reported that families are less likely to lodge complaints with HSPs; however, complaints are still lodged by consumers and personal support persons to the HSPs despite the reported difficulties.

The DoH's Patient Safety Surveillance Unit, reports annually on patient safety data. The data assists with identifying patient safety issues that may require greater focus, and assists clinicians and researchers in finding solutions to further improve health care delivery. The 2016 Your safety in our hands in hospital report highlights that DoH aims to strengthen the collection of complaints data relating to mental health episodes of care and continue to work with the HaDSCO in this space.

Further, the 2016 Your safety in our hands in hospital report¹³⁷ highlights:

“Considerable initiatives and resources have been invested to improve patient safety within WA Health. The overarching goal is to address clinical incidents at the local and system level, analyse contributory factors, and raise awareness/undertake education to prevent the recurrence of clinical incidents”.

Findings of the report (detailed below) are summarised as key messages regarding mental health complaints:

“Mental health complaints exhibited the same top four issue categories as total WA Health complaints, suggesting that consumers of mental health services face similar issues to the rest of the WA Health consumer population in their interactions with our health system. Of note is the greater proportion of mental health complaint issues stemming from the ‘Rights, Respect and Dignity’ category ... in comparison to the whole of WA Health. Staff engaging with mental health clients should be mindful of patient rights under the *Mental Health Act 2014*, and the application of the Charter of Mental Health Care Principles”.

Data:

Details of the mental health complaints that have been closed by the HaDSCO, such as the service providers identified most frequently in the complaints and the top issues identified, are outlined in the HaDSCO Annual Reports, as per **Table 2**. The number of complaints lodged has increased over the years, (there was a 47% increase in complaints received between 2013-14 to 2016-17) although the service providers identified most frequently in the complaints lodged through the HaDSCO have consistently been psychiatrists and psychiatry practices, in addition to mental health services in prisons.

¹³⁷ Your safety in our hands in hospital; and Integrated Approach to Patient Safety Surveillance in WA Hospitals, Health Services and the Community: 2016, located at – http://ww2.health.wa.gov.au/~media/Files/Corporate/Reports%20and%20publications/Patient%20Safety/Your_Safety_In_Our_Hands_Report_2016.pdf (pages 3 and 103), last accessed 20 November 2017.

Table 2: HaDSCO complaints data, 2013-14 to 2016-17

Annual Report	Number of complaints closed	Providers most identified in complaints	Top issues identified in complaints (most to least complained about)
2013-14	252	psychiatrist and psychiatry practices (65%) prison mental health services (17%) community mental health services (5%)	attitude/manner involuntary admission or treatment inadequate treatment prescribing medication diagnosis ¹³⁸
2014-15	286	psychiatrist and psychiatry practices (70%) prison mental health services (13%) psychologists (8%)	attitude/manner prescribing medication excessive treatment inadequate consultation ¹³⁹
2015-16 ¹⁴⁰	357	psychiatrist and psychiatry practices (71%) prison mental health services (12%) mental health nurses (4%)	treatment quality of clinical care communication and information consent (regarding involuntary admission or treatment) decision making ¹⁴¹
2016-17	377	psychiatrist and psychiatry (59%) prison mental health services (11%) community mental health service (11%) administration (5%) psychologist/psychotherapist (5%) ¹⁴²	quality of clinical care communication decision making rights, respect and dignity access

¹³⁸ A detailed description of these categories of complaints is provided in the HaDSCO 2013-14 Annual Report, which is located at – <https://www.hadsco.wa.gov.au/docs/reports/2013-14/FullHaDSCOAnnualReport2013-14.pdf>, last accessed 20 November 2017.

¹³⁹ Examples of the types of complaints can be found in the HaDSCO 2014-15 Annual Report, which is located at – https://www.hadsco.wa.gov.au/docs/reports/2014-15/HaDSCO_AR_1415.pdf, last accessed 20 November 2017.

¹⁴⁰ The categorisation of the issues complained about was changed in the 2015-16 financial year to bring the categories in line with the DoH reporting categories. This is reflected in the table with some changes in terminology in the 2015-16 period.

¹⁴¹ Further details of the complaints is provided in the HaDSCO Annual Report 2015-16, which is located at – https://www.hadsco.wa.gov.au/docs/reports/2015-16/AR_2015-16.pdf, last accessed 20 November 2017.

¹⁴² The HaDSCO 2016-17 Annual Report contained many more mental health service types than previous years. The top five have been included as the most relevant. For further information, the HaDSCO 2016-17 Annual Report can be located at – https://www.hadsco.wa.gov.au/docs/reports/2016-17/HaDSCO_2016-17_Annual%20Report_FINAL%20interactive.pdf, last accessed 20 November 2017.

In response to the rise in the number of mental health complaints received by their office from 2009 to 2014, the HaDSCO published a paper on mental health complaints in May 2014.¹⁴³ The paper identified a number of trends and issues regarding these complaints, including the reasons for the increase in reporting. The reasons identified by the HaDSCO include: the increased recognition of mental illness and possible resulting empowerment of consumers and their families or carers; possible increase in referrals from other agencies such as the MHLC; and the HaDSCO staff provided with training during this period to better identify complaints relating to mental health service delivery.

The MHLC noted that since the commencement of the Act most of the legal advice provided to their clients (consumers) via their telephone advice line relate to complaints under the Act. These include complaints regarding restriction of human rights, mental health services, and the conduct of treating clinicians¹⁴⁴. Specifically, many clients complain about the use of force to detain them when being placed on an inpatient treatment order or receiving medication.

The MHLC also anecdotally reported that the number of calls by clients to their telephone advice line for assistance with complaints under the Act is far higher than under the 1996 Act¹⁴⁵. However, it is not clear whether there has been an actual increase in complaints or whether consumers and personal support persons are contacting agencies such as the MHLC in preference to the HSPs.

Similarly, the increase in number of complaints to the HaDSCO in the 2015-16 reporting period may also be a result of the increased rights of consumers and personal support persons, and increased awareness of those rights. In addition, there may also be an increased assertiveness and greater confidence in exercising their rights when complaints are seen to not be handled appropriately at the HSP level.

MHA Survey Results:

In the MHA Survey, consumers and personal support persons were asked three questions relating to complaints regarding mental health services. These included whether they had made a complaint about mental health services, how they lodged the complaint, and what the outcome was. In responding to these targeted questions, respondents may have provided a number of comments in response to each question. From these comments, 22 out of 58 (38%),¹⁴⁶ responses indicated that they were too scared to complain or that their complaints were being ignored:

- “nothing changed, I wasn't listened to” [consumer].
- “I daren't. I'm very scared of the power of psychiatrists and wa mental health. Petrified. Traumatized” [consumer].
- “I did call HADSCO but have been concerned that future care will be jeopardised in this regional location I have bee (sic) told by other carers grit your teeth and smile or he will be sent to Perth or worse” [regional personal support person].

¹⁴³ HaDSCO Occasional Paper No. 1; An Overview: Mental health complaints May 2014.

¹⁴⁴ Feedback provided by the MHLC in their submission for the PIR (unpublished), June 2017.

¹⁴⁵ Ibid.

¹⁴⁶ The MHA Survey allowed respondents the option to comment on each of the questions, so the total number of comments is not reflective of the number of individuals, as each respondent may have provided responses to each of the three questions.

Numerous comments provided by personal support persons indicated that their priority is in supporting the consumer, with little energy left to make a complaint. Therefore, lodging a complaint was not their main focus:

- “It was suggested to me numerous times that I should have made a complaint, but at the time I felt our sons health was priority and time has gone on” [personal support person].

However, regarding a complaint being lodged, one personal support person commented:

- (the) “process was acted on in a timely manner. Further professional mental support was put in place to ensure the individual needs were met” [personal support person].

The Chief Psychiatrist highlighted a lack of understanding in the community and mental health services about the complaints resolution process under the Act. This is evidenced by the Chief Psychiatrist continuing to receive a number of complaints, despite this not being the role of the Chief Psychiatrist¹⁴⁷.

Way Forward:

The HaDSCO launched the multi-agency Mental Health Complaints Partnership Agreement (Agreement) in August 2015. The Agreement outlines a set of principles to improve the effective resolution of complaints about mental health services. The parties to the Agreement are the HaDSCO, the DoH, the CoOV (now the MHAS), the OCP and the MHC. The purpose of the Agreement is to:

- clarify the respective roles and inter-relationships of key government agencies that are involved in managing complaints;
- outline principles to guide effective complaint resolution; and
- develop a mechanism for State Government agencies to work collaboratively to resolve complex mental health complaints.

The Agreement was complemented by an Addendum, which had a 12 month term. The Addendum aimed to ensure that the principles of the Agreement transferred into relevant and meaningful operational initiatives for individuals, carers and service providers. An important part of the Addendum was an Action Plan to ‘operationalise’ the Agreement. Although the term of the Addendum expired in August 2016, the HaDSCO has continued to progress a number of initiatives identified in the Action Plan. This currently includes the development of some complaint handling guidelines and training.

As outlined in the HaDSCO 2015-16 Annual Report, in development of the Agreement, feedback received highlighted themes centred on the rights of consumers, relatives, carers and nominated persons. Additional themes included clarification of the roles of each of the co-signatories, as well as other government agencies involved in managing complaints, and the transparency of complaint processes and review¹⁴⁸. The MHC, as a signatory to the Agreement, will continue to assist in monitoring the progress of the Agreement and overall complaints process for the statutory review of the Act.

¹⁴⁷ Chief Psychiatrist submission to the MHC for the PIR (unpublished), August 2017.

¹⁴⁸ HaDSCO 2015-16 Annual Report, pages 53-54.

The HaDSCO continues to refine and streamline its complaints process to ensure complaints about mental health services are managed in an efficient and effective manner under the Act. Additionally, the promotion of a ‘fast-dial’ telephone system set up between the OCP and the HaDSCO now enables the direct transfer of matters that are more appropriate for the HaDSCO to handle¹⁴⁹. This enables telephone calls to be directly transferred to the HaDSCO by the OCP, without the need for the complainant to make a second call.

In addition, in 2017 the HaDSCO developed an information sheet to assist individuals in making a complaint about a mental health service. This was launched during a presentation at the Western Australian Mental Health Conference in July 2017 and has been well received. It is available on the HaDSCO’s website and has been distributed to stakeholders. Further information about the HaDSCO’s jurisdiction and process for managing complaints about mental health services is available on the HaDSCO’s website or by contacting the HaDSCO’s enquiry line service¹⁵⁰.

Anecdotal evidence obtained from the MHA Survey reflects that the complaints process for HSPs is not currently meeting the Objects of the Act in some cases. However, available data suggest that there is an increase in the number of complaints, for HSPs and the HaDSCO, which could be a result of an increase in consumers and personal support persons exercising their rights.

Feedback from consumers, families and carers, and their representatives, indicated inconsistencies in the way HSPs manage and report on complaints about mental health services. This feedback suggests that the DoH Operational Directive 0589/15, relating to the management of complaints across all health services, is not being consistently adhered to by mental health services. Education and training of staff is crucial to ensure the complaints process is understood and communicated appropriately.

Recommendations:

31. The HaDSCO continue to strengthen the promotion of the complaints process under the Act.
32. The DoH to improve the mental health complaints handling process at the service level, including education and training of staff.

¹⁴⁹ HaDSCO submission to the MHC for the PIR (unpublished), January 2018

¹⁵⁰ *Ibid.*

5.4 Other advancements

a. Referral and detention timeframes

Referral and detention timeframes were reduced in the Act (**Table 3**) to ensure the least interference with an individual's rights, and the least restrictive means of providing treatment and care, in accordance with Objects 1(a) and (d).

Table 3: Referral and detention timeframes

	1996 Act	2014 Act
Referral	Metropolitan: 7 days	Metropolitan: 72 hours Non-metropolitan: 144 hours
Initial Involuntary Treatment Order	Adult: 28 days Child: 28 days	Adult: 21 days Child: 14 days
Continued Involuntary Treatment Order	Adult: 6 months Child: 6 months	Adult: 3 months Child: 28 days

Benefits of having shorter referral periods and more regular reviews are that consumers are potentially released sooner, if they no longer meet the criteria for an involuntary treatment order. This is in accordance with the least restrictive means of care, which is consistent with the Objects of the Act.

Way Forward:

Measuring the impact of reduction of referral and detention timeframes requires data evidence, which will also contribute to the statutory review of the Act. Consultation with relevant stakeholders will be undertaken as part of this process.

Recommendation:

33. Through the Mental Health Data Management Group, the DoH and HSPs to identify and record data regarding referral and detention timeframes, for reporting in the statutory review of the Act.

b. Audiovisual communication

Under the Act, referral assessments occurring in non-metropolitan areas may be conducted by audiovisual communication, when a face-to-face assessment is not possible. The intention, as per Objects 1(a), (c), (d), (e) and (f), is that this option would allow earlier intervention for consumers in remote communities who are experiencing mental illness and are placing their own or someone else's health and safety at risk. This helps to reduce the likelihood that the consumer will be removed from their families and communities and transported over great distances for examination, and enables the consumer to be placed on a CTO or be detained involuntarily in a general hospital. As per s50 of the Act, a specified health professional or an Aboriginal mental health worker must be present with Aboriginal patients when such an assessment is conducted.

The Chief Psychiatrist highlighted that this technology also benefits clinicians, as the use of video conferencing in rural and remote areas improves access to specialists/psychiatrists and reduces travel time for clinicians, thereby allowing additional time providing clinical services.

The MHT 2016-17 Annual Report identifies¹⁵¹ the following details regarding the use of audiovisual communication for review hearings being conducted at either metropolitan or regional locations:

Time period	Number of metropolitan hearings	Number of metropolitan locations	Number of regional hearings	Number of regional locations
30 November 2015 – 30 June 2016	11	8	154	22
1 July 2016 – 30 June 2017	36	17	253	24

These figures equate to approximately 21 regional MHT review hearings per month being conducted utilising audiovisual communication.

In their submissions, HSPs have stated that audiovisual assessments and examinations are now occurring when the consumer requires assessment for a Transfer Order (Form 4C), Inpatient Treatment Order in Authorised Hospital (Form 6A) and Inpatient Treatment Order in General Hospital (Form 6B).

Way Forward:

The ACMHN has recommended an expansion of the use of audiovisual communication in order to provide improved support to non-specialist staff in regional emergency departments. This may also create opportunities to reduce the use of sedation for acutely unwell consumers until transfer becomes available.

Improvements are required to the method of data capture around the use of audiovisual communications, as currently HSPs are required to verify any data collated centrally via a manual count.

Recommendations:

34. The DoH to develop potential options for the expansion of the use of audiovisual communication to support the implementation of the Act, in particular, to improve support to non-specialist staff in regional emergency departments.
35. Through the Mental Health Data Management Group, the DoH and HSPs to identify and record data regarding audiovisual communication, for reporting in the statutory review of the Act.

¹⁵¹ MHT 2016-17 Annual Report, page 9.

c. Transportation

Should there be a requirement to transport a consumer to a place of examination or between facilities, the Act states this should be undertaken in the least restrictive way, in support of Object 1(a). Under the 1996 Act only police officers were able to undertake transport orders; however, the Act now extends this provision to transport officers. Currently, transport orders are to be carried out by police officers only when there is a significant risk of serious harm to the person being transported or to another person. Police officers may also carry out a transportation order when a transport officer is not available to carry out the order within a reasonable time and any delay beyond that time is likely to pose a significant risk of serious harm. All other transports that are assessed as low to high risk are undertaken by transport officers.

The introduction of transport officers aims to reduce waiting times in emergency departments along with other potential issues, such as distress of the consumer over being transported by police officers. Additionally, under the Act, transport orders are linked to the timeframes in the referral orders, reducing these from seven days to three days in metropolitan areas and to six days in non-metropolitan areas, thereby providing greater consistency across legislative requirements and thus simplifying the process.

On commencement of the Act, the DoH adapted the transport risk assessment form¹⁵² to determine the level of risk and therefore identify whether a transport officer or a police officer is required to carry out the transport order. As a result of uncertainty by the contracted transport service provider as to whether or not the Act allowed transport officers to use physical or mechanical restraints, delays have been reported in the provision of a transport service where the assessed level of risk was high. During that time, police officers carried out transport orders where there was a high level of assessed risk, in addition to carrying out transport orders with a significant level of assessed risk.

On 6 September 2017, this situation was resolved when the DoH issued two mandatory policies, Requesting Transport Officers and WA Police Assistance in Transporting Mental Health Patients Policy (MP 0063/17)¹⁵³ and Use of Physical and/or Mechanical Restraint during Road-based Transportation of Mental Health Patients Policy (MP 0060/17)¹⁵⁴. MP 0063/17 clarified the requirements regarding risk assessment and the selection of the relevant transport provider. MP 0060/17 also provides guidance around the use of reasonable force by transport officers, which includes the use of physical or mechanical restraints in certain circumstances and compliance with the principles of detention set out in s170 of the Act¹⁵⁵.

¹⁵² The Mental Health Transport Risk Assessment Form is available on the DoH website, located at – <http://www.health.wa.gov.au/circularsnew/attachments/1247.pdf>, last accessed 20 November 2017.

¹⁵³ MP 0063/17 is located at – <http://www.health.wa.gov.au/circularsnew/pdfs/13370.pdf>, last accessed 20 November 2017.

¹⁵⁴ MP 0060/17 is located at – [health.wa.gov.au/circularsnew/pdfs/13367.pdf](http://www.health.wa.gov.au/circularsnew/pdfs/13367.pdf), last accessed 20 November 2017.

¹⁵⁵ *Mental Health Act 2014*, s170 sets out the principles relating to detention, as follows:

- (a) the person must be detained for as brief a period as practicable;
- (b) the degree of any force used to detain the person must be the minimum that is required to be used for that purpose;
- (c) while the person is detained —
 - (ii) there must be the least possible restriction on the person's freedom of choice and movement consistent with the person's detention; and

Additionally, a two-year Mental Health Co-Response Trial (MH CRT) has been underway in the metropolitan area since January 2016. The MH CRT is a joint initiative of the MHC, the DoH and Western Australia Police (WA Police), and forms part of an early priority action outlined in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2015. The MH CRT was established to improve the response to mental health related calls to police for assistance and intervention. The three agencies have worked together to develop an appropriate response model to incidents where mental health is a factor. The purpose of the MH CRT is consistent with Object 1(a), which aims to ensure that people with a mental illness are provided with the best possible treatment and care, with the least restriction of their freedom and interference with their rights, and with respect for their dignity. The WA Police Annual Report 2015-16¹⁵⁶ reveals an 80% decrease in mental health transportations within the first six months of the trial alone. The overall evaluation of the MH CRT is being prepared by Edith Cowan University and is expected to be completed in 2018.

Key Issues Raised:

Regional concerns regarding transportation and lack of mental health services

The lack of mental health services in the Midwest region, including the absence of an inpatient mental health facility, is cited by the RFDS¹⁵⁷ as a reason for the high demand for transfers of mental health consumers from the Midwest region. Although a mental health residential rehabilitation and community care unit was opened in Broome in 2012, the RFDS report that a significant number of consumers are still requiring transport to Perth from the Kimberley and Pilbara regions¹⁵⁸.

Similarly, the ACMHN advise¹⁵⁹ that there are issues around delays in access to acute specialist mental health care within regional areas, in addition to delays waiting for police and RFDS transfers. The significant delays in transferring consumers have resulted in health staff in these locations having to sedate consumers for lengthy periods, until transport becomes available. The ACMHN states this does not align with the Objects of the Act as it does not reflect the best possible treatment and care. The ACMHN assert that this places substantial restriction of freedom on the consumer, which interferes with rights, compromises dignity and creates barriers to meaningful assessment and provision of therapeutic interventions which may assist in alleviating distress¹⁶⁰.

In their submission, the RFDS cites the increase in the number of transfers being required as a reason for delays in transfers occurring, and supports the expansion of audiovisual

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- (iii) the person is entitled to reasonable privacy consistent with the person's detention; and
 - (iv) the person must be treated with dignity and respect.

¹⁵⁶ WA Police 2016 Annual Report, page 13.

¹⁵⁷ RFDS submission to the MHC for the PIR (unpublished), July 2017.

¹⁵⁸ Ibid.

¹⁵⁹ ACMHN submission to the MHC for the PIR (unpublished), May 2017.

¹⁶⁰ Ibid.

communication (for example Telehealth¹⁶¹) in providing mental health services, in order to reduce the number of patients requiring aeromedical transfer.

Way Forward:

The DoH policies MP 0060/17 and MP 0063/17 set out compliance, monitoring and evaluation requirements in relation to transportation of mental health patients. The MHC will work with the Mental Health Data Management Group, to implement data systems in line with the requirements set out in the policies.

The ACMHN has recommended the identification of causes and potential solutions for the delays in regional mental health transfers.

Recommendations:

36. The MHC to coordinate and work with stakeholders for the promotion of the transport officers eLearning training package, which will assist with ensuring compliance with the Act regarding transport requirements.
37. The MHC to work with the relevant stakeholders to support the continuation of the MH CRT and the continued collaboration between the DoH and WA Police.
38. Through the Mental Health Data Management group, the DoH and HSPs to implement data systems in line with the requirements set out in Mandatory Policies, MP 0060/17 (Use of Physical and/or Mechanical Restraint during Road-based Transportation of Mental Health Patients Policy) and MP 0063/17 (Requesting Transport Officers and WA Police Assistance in Transporting Mental Health Patients Policy).
39. The DoH to identify causes and potential solutions to reduce delays in regional mental health transfers, including the use of audiovisual communication.

d. Children

The 1996 Act was silent on the treatment and care of children. Currently, Part 18 of the Act states that when performing a function under the Act, the best interests of the child must be a primary consideration, and regard must also be given to the child's wishes and the views of the child's parent or guardian. This is in accordance with all Objects of the Act. Additionally, s303 in the Act refers to the importance of protecting the safety of a child while they are in hospital, with regard to the segregation of children from adult inpatients.

Although some stakeholders raised concerns regarding children on adult wards, a child can only be admitted to an adult ward if the mental health service can provide the child with appropriate treatment, care and support having regard to the child's age, maturity, gender, culture and spiritual beliefs. Further, the child may need to be provided with treatment, care and support in a separate part of the service from adults, depending on the child's age and maturity. A report setting out how the child's individual needs will be met if

¹⁶¹ "Telehealth is the use of information and communication technology to provide healthcare over a distance. This includes the transmission of images, voice, data and videoconferencing between two or more sites." <http://www.wacountry.health.wa.gov.au/telehealth>, last accessed 7 February 2018.

placed on an adult ward, must be provided to the child's parent or guardian and to the Chief Psychiatrist.

A further protection for children under the Act is that when a MHT hearing is being held for a consumer who is a child, then a child and adolescent psychiatrist must be present (s383(c)(i)). A non-specialist psychiatrist may be present only if a child and adolescent psychiatrist is not available. The MHAS expressed concern regarding compliance with this requirement in the Act, suggesting that greater attempts be made by the MHT to include a child and adolescent psychiatrist in the constitution of the MHT when considering a matter relating to a child¹⁶².

Further, the Act requires that when the MHT makes a decision on a review or considers an application for ECT in relation to a child, and is not constituted with a child and adolescent psychiatrist, the MHT must have regard to the views of a medical practitioner or mental health practitioner with qualifications, training or experience relevant to children who have a mental illness and who is authorised by the Chief Psychiatrist for this purpose. The President of the MHT advised that, in consultation with the Chief Psychiatrist, consideration is being given to increasing the number of authorised medical practitioners or mental health practitioners for this purpose.¹⁶³

Additionally, the MHLC advised¹⁶⁴ of a relatively new initiative where they are actively working with the MHAS to provide legal support to child and youth patients and potentially, their family or guardians. The MHLC believe the legal process is often fraught for children and youth, hence their decision to provide legal representation to this cohort.

Data:

The Chief Psychiatrist 2016-17 Annual Report identifies that there were 11 instances of a child being admitted to a mental health service, which does not generally admit children and therefore needed to be segregated from adult patients. The average age of these children was 16.5 years of age. The primary reasons identified for admission to an adult ward were: adolescent consumers in the metropolitan area waiting for transfer to an available bed in an adolescent mental health unit; lack of adolescent mental health units in regional areas; and <5 adolescent patients waiting for transfer from regional areas to a metropolitan adolescent mental health unit¹⁶⁵.

Way Forward:

The Chief Psychiatrist's role includes monitoring the placement of children on adult wards, with a requirement in the Act that a report be provided to the Chief Psychiatrist when such a placement occurs. This enables the Chief Psychiatrist to monitor the suitability of wards where children are placed and to identify trends and improvements that may be required.

The MHAS suggests that the Act be amended to require the Chief Mental Health Advocate to be notified when a child is placed on an adult ward¹⁶⁶. This will supplement existing data

¹⁶² MHAS submission to the MHC for the PIR (unpublished), January 2018.

¹⁶³ Feedback provided by the MHT President to the MHC for the PIR (unpublished), February 2018.

¹⁶⁴ MHLC submission to MHC for the PIR (unpublished), June 2017.

¹⁶⁵ Chief Psychiatrist 2016-17 Annual Report, page 75.

¹⁶⁶ MHAS submission to the MHC for the PIR (unpublished), January 2018.

and will ensure that the child and their parent or guardian will be contacted by an Advocate to confirm they have been informed of their rights and compliance with the Act.

The President of the MHT, in consultation with the Chief Psychiatrist, is exploring ways of increasing participation by child and adolescent psychiatrists in MHT hearings and increasing the number of authorised medical practitioners or mental health practitioners with qualifications, training or experience relevant to children who have a mental illness¹⁶⁷.

The continuation of the engagement between the MHLC and the MHAS to provide legal support to child and youth consumers, and potentially their families or guardians is encouraged and seen to be a positive way forward.

Recommendations:

40. The MHC to consider an amendment to the Act requiring the Chief Mental Health Advocate to be notified of any child placed on an adult ward.
41. The MHT to develop options to increase participation by child and adolescent psychiatrists in MHT hearings when considering a matter involving a child.
42. The Chief Psychiatrist to develop options to increase the number of authorised medical practitioners or mental health practitioners with qualifications, training or experience relevant to children who have a mental illness.

e. Electroconvulsive Therapy

Safeguards contained within the Act around the use of ECT, are an example of providing the best possible care and protection of rights, as per Object 1(a). The performance of ECT requires approval of the MHT for adult involuntary patients and mentally impaired accused detained at an authorised hospital, and voluntary and involuntary children who have reached 14 years of age but are under 18 years of age. ECT cannot be used for children under 14 years of age. These are vastly different and stronger safeguards than were documented in the 1996 Act and are arguably the most stringent in Australia for the protection of individuals with a mental illness.

Data:

The MHT may approve the application of ECT on voluntary and involuntary children, in addition to involuntary adults (s409). The MHT 2016-17 Annual Report details that between 30 November 2015 and 30 June 2016 the MHT received 58 applications for the approval of ECT, and subsequently approved 51 (88%) of these. Of those not approved, “four applications were withdrawn, two applications were not proceeded with because the Tribunal revoked the involuntary treatment order and therefore did not have the jurisdiction to hear the application, and one application was withdrawn because the treating team considered that the patient was too manic for treatment to be provided”¹⁶⁸.

The MHT 2016-17 Annual Report also details that between 1 July 2016 and 30 June 2017, the MHT received 112 applications for the approval of ECT and approved 107 (95.5%) of

¹⁶⁷ Feedback provided by the MHT President to the MHC for the PIR (unpublished), February 2018.

¹⁶⁸ MHT 2016-17 Annual Report, page 7.

these. For those not approved, “two applications were withdrawn, one application was not proceeded with because the Tribunal revoked the involuntary treatment order and therefore did not have the jurisdiction to hear the application, one application was rescheduled and one application was not approved”¹⁶⁹.

The Chief Psychiatrist’s Annual Report 2015-16¹⁷⁰ provides a breakdown of data pertaining to ECT courses being completed from 30 November 2015 until 30 June 2016. Of note, is that during this period there were no ECT treatments completed for children under 18 years of age. Overall, 2,902 ECT treatments were undertaken, with 2,513 (87%) of these being on voluntary patients and 369 (13%) on involuntary patients. Of the ECT treatments on voluntary patients, eight of these were categorised as emergency ECT, compared with 12 of the involuntary treatments.

The Chief Psychiatrist’s 2016-17 Annual Report identifies that less than five ECT courses were administered to children aged 15 to less than 18 years. During the 2016-17 full reporting period, a total of 5,459 ECT treatments were completed, with less than 1% of these being emergency treatments. For adult consumers, a total of 5,430 ECT treatments were undertaken, with 4,615 (85%) of these being on voluntary patients and 657 (12%) on involuntary patients¹⁷¹.

It is evident from the Chief Psychiatrist’s reported ECT data that there was a slight decrease in the overall number of ECT treatments from the seven month reporting period from 30 November 2015 to 30 June 2016, to the full 2016-17 reporting period. Irrespective of the data reported, it is significant to note the Chief Psychiatrist’s position on ECT treatments and the associated benefits. The Chief Psychiatrist’s 2016-17 Annual Report states that “ECT is a very effective evidence-based treatment in some situations”¹⁷².

Key Issues Raised:

Legislating ECT and reporting serious adverse effects

The RANZCP raised concerns around legislating ECT and allowing the MHT to determine the clinical parameters of this treatment such as the frequency, quantity and location. Regarding their concerns, the RANZCP specifically state:

“The number of treatments to be given and their frequency is a clinical issue, and is adjusted during treatment according to the patients response, depending on how long any improvement is maintained and any side effects. The task of weighing up the balance between benefits and unwanted effects, monitoring the effects or making adjustments or alterations to the length of treatment requires specialist clinical expertise”¹⁷³.

The Chief Psychiatrist additionally raises concerns about the Act requiring the reporting of serious adverse effects of ECT (s201), stating that this requirement does not enhance the treatment and care received by those experiencing mental illness. The Chief Psychiatrist

¹⁶⁹ MHT 2016-17 Annual Report, page 7.

¹⁷⁰ Further information and statistics regarding ECT can be accessed at www.chiefpsychiatrist.wa.gov.au, last accessed 20 November 2017.

¹⁷¹ The Chief Psychiatrist’s 2016-17 Annual Report, page 50.

¹⁷² The Chief Psychiatrist’s 2016-17 Annual Report, page 49.

¹⁷³ RANZCP submission to the MHC for the PIR (unpublished), July 2017.

argues that the reporting under s201 is duplicative, given that death or serious negative outcomes associated with ECT must already be reported to the Chief Psychiatrist under s525 of the Act¹⁷⁴.

Age restriction of ECT

The Chief Psychiatrist highlights that the restriction for ECT to not be applied to children under 14 years of age is more a reflection of an unresolved and complex social and ideological debate, rather than a practical and prioritised enhancement of rights. This is as records indicate that there has been no more than one child under 18 years of age undergoing ECT in any given year.

Way Forward:

Considering the data available for ECT from the MHT and the OCP, it appears the Objects of the Act are being met with regard to the application for approval, and the review of, ECT treatments.

Issues have been raised about the over-prescriptive nature of the Act in relation to treatment options. The RANZCP suggest that, as with other treatment, decisions around ECT should be managed by the treating psychiatrist, with the use of clinical guidelines and practice standards, in consultation with the psychiatrist and treating team.

Recommendation:

43. The MHC will liaise with relevant stakeholders, in particular the Chief Psychiatrist and ECT clinicians, in considering any potential amendments to the Act regarding ECT.

f. Seclusion and restraint

Initiatives under the Act regarding seclusion and restraint were implemented in line with the Objects 1(a), (e) and (f). Protections for consumers under the Act include the requirement that seclusion and restraint can only be utilised where there is no less restrictive option.

Additionally, in line with the Objects, the Chief Psychiatrist now has oversight of treatment and care of consumers, and the reporting of seclusion and restraint episodes to the Chief Psychiatrist through Approved Forms is mandatory (s224 and s240 respectively). The benefits of this are that the OCP is able to; validate the reported data against the data collected by the HSPs; review the Approved Forms received to ensure standards were met; and notify HSPs when errors are identified, providing an opportunity to educate HSP staff.

These notifications enable the Chief Psychiatrist to identify trends, and report on the rate of seclusion and restraint in the Chief Psychiatrist's Annual Report. As required under s547 of the Act, the Chief Psychiatrist has developed a 'seclusion and bodily restraint reduction' Standard for Clinical Care. The National Mental Health Commission has also released the National Principles to Support the Goal of Eliminating Mechanical and

¹⁷⁴ Chief Psychiatrist's submission to the MHC for the PIR (unpublished), August 2017.

Physical Restraint in Mental Health Services¹⁷⁵, which detail matters such as prevention strategies, managing escalating behaviours, and the importance of partnerships with key agencies and training of relevant staff.

Under the Act, copies of forms relating to seclusion and restraint must be provided to the consumer.

Seclusion

Although not considered to be a treatment option, seclusion may have therapeutic value in some circumstances. A seclusion order is available solely for the protection of the individual and/or others in an authorised hospital, if there is a risk of harm to either party, and can also occur if the person is causing serious damage to property. Seclusion involves the consumer being confined to a part of the hospital, preventing free exit. A seclusion order can only be made if there is no less restrictive way of preventing injury or damage, which is in line with the principle throughout the legislation of using the least restrictive measures (Object 1(a)).

The Act outlines a two hour maximum time limit for seclusion, with examination by a medical practitioner required before any further extension (to a maximum of two hours) is allowed. Additionally, the Chief Psychiatrist must be notified via the use of up to seven different forms, depending on the stage and duration of the seclusion. For example, a Form 11A is required for recording oral authorisation of seclusion, and a Form 11G is required for a post-seclusion examination. Many of these Forms also require that the consumer's personal support person be notified.

Where a seclusion order is revoked, or the order expires, the individual must be released from seclusion and advised of their rights. There are stringent procedural requirements present, which reflect the deprivation of a person's freedom, dignity and autonomy with regards to being placed in seclusion. Additionally, a post-seclusion examination must occur within six hours of the person being released from seclusion.

Data:

Seclusion episodes are a national key performance indicator for Australian public mental health services. Data on this indicator are collated by the Australian Institute of Health and Welfare (AIHW). Reports from AIHW indicate that Western Australia has a lower than national rate of seclusion events. The most recent data captured indicates that in 2015-16 Western Australia had 4.8 seclusion events per 1,000 bed days, compared to 8.1 as a national total. Historically, during 2014-2015 these figures were 4.3 for Western Australia and 7.9 nationally. In 2013-14 Western Australia had 5.2 seclusion events, compared to 8.2 nationally, and in 2012-2013 the Western Australia figure was 6 and 9.8 nationally¹⁷⁶.

The Chief Psychiatrist's Annual Report 2015-16 provides details on seclusion episodes from 30 November 2015 to 30 June 2016¹⁷⁷. There were a total of 219 consumers experiencing 556 seclusion episodes out of 6,706 total separations (8% of the total

¹⁷⁵ The National Principles are located at – <http://www.mentalhealthcommission.gov.au/media-centre/news/national-mental-health-commission-acts-on-seclusion-and-restraint.aspx>, last accessed 20 November 2017.

¹⁷⁶ Further information and statistics regarding seclusion can be accessed at www.mhsa.aihw.gov.au, last accessed 20 November 2017.

¹⁷⁷ Data prior to 30 November 2015 is not available for comparison purposes.

separations) during this seven month period. The 219 consumers are comprised of the following:

Consumer age	Number of consumers	Seclusion episodes
under 18 years	20	40
18 to 65 years	191	501
65 years and older	8	15

Information provided by the Chief Psychiatrist identifies that, of the 191 consumers aged 18-65 years who were secluded, 169 (89%) were secluded less than five times, 14 (7%) between five and 10 times, and eight (4%) were secluded more than 10 times.

Due to the small number of seclusions reported for the consumers under 18 years of age, specific details are not reported; however, 95% of these consumers were secluded less than five times. Of the eight consumers aged 65 years and older, all eight (100%) were secluded less than five times¹⁷⁸.

The median duration of seclusion events across all age groups in authorised mental health units from 30 November 2015 to 30 June 2016 was 111 minutes. The time of seclusion ranged from four minutes to 15 hours.

Of all reported cases:

- 55% of seclusion events lasted between 60 and 120 minutes;
- 28% of events were over 120 minutes; and
- 16% were less than 60 minutes.

The Chief Psychiatrist's Annual Report 2016-17 states there were 1,008 seclusion episodes for consumers of all ages, out of 11,966 (8%) total separations during this 12 month period¹⁷⁹, with the following details:

Consumer age	Number of consumers	Seclusion episodes
under 18 years	28	124
18 to 65 years	326	879
65 years and older	> 5	5

Of the 326 consumers aged 18-65 years, 275 (84%) were secluded less than five times, 39 (12%) between 5-10 times and 12 (4%) consumers were secluded more than 10 times. Of the 28 consumers under 18 years of age who were secluded, 19 (68%) were secluded less than five times, five (18%) between 5-10 times and less than five (approximately 14%)

¹⁷⁸ Chief Psychiatrist's submission to the MHC for the PIR (unpublished), January 2018.

¹⁷⁹ The Chief Psychiatrist's 2016-17 Annual Report: the total number of patients not provided in interests of patient privacy and confidentiality.

consumers were secluded more than 10 times. As a result of the small number of consumers over 65 years old, further details of the seclusion episodes are not reported¹⁸⁰.

Of all these reported cases:

- 21% lasted less than 60 minutes;
- 48% lasted between 60 and 120 minutes; and
- 31% lasted more than 120 minutes.

Restraint

The 1996 Act provided for mechanical restraint only, while the Act also includes physical bodily restraint, which is the type of restraint more frequently used (s227). This is in accordance with Objects 1(a) and (e).

The Act outlines a 30 minute maximum time limit in restraint, with a review required before any extension (to a maximum of 30 minutes) is allowed. Requirements also require that the Chief Psychiatrist is notified via the use of up to nine different forms, depending on the stage and duration of the period of restraint. For example, Form 10A for recording oral authorisation of the bodily restraint and a Form 10I for recording a post-bodily restraint examination. As with seclusion, many of the restraint Forms require that the consumer's personal support person be notified.

While in restraint, the consumer's personal needs are still to be met and the initial 30 minute period of restraint can only be extended by a further 30 minutes at a time, upon examination by a medical practitioner. If the person is restrained for longer than six hours, a psychiatrist must examine them. Additionally, a post-restraint physical examination must occur within six hours of the person being released from the restraint to ensure there is no deterioration of mental or physical condition. This is important to ensure the protection of the consumer, as per Object 1(e).

Data:

Reports from AIHW indicate that Western Australia has a lower rate of restraint events than nationally¹⁸¹.

The Chief Psychiatrist's Annual Report 2015-16 provides the following data on restraint for the period 30 November 2015 to 30 June 2016¹⁸².

- In total, 240 consumers were restrained, with 474 episodes of restraint reported. These data comprised of the following details:

¹⁸⁰ The Chief Psychiatrist's 2016-17 Annual Report, page 55.

¹⁸¹ Further information and statistics regarding restraint can be accessed at www.mhsa.aihw.gov.au, last accessed 20 November 2017.

¹⁸² The Chief Psychiatrist's 2015-16 Annual Report, pages 36-38.

Consumer age	Consumers restrained	Episodes of restraint reported
under 18 years	31	81
18 to 65 years	184	336
65 years and older	25	57

The Chief Psychiatrist's 2015-16 Annual Report further identifies that of the 31 consumers under 18 years of age who were restrained, 81% were restrained for less than five minutes at a time, and 19% were restrained between 5-10 times. No consumers were restrained more than 10 times.

The Chief Psychiatrist's Annual Report 2016-17 provides the following data for the full 2016-17 reporting period¹⁸³:

- In total, 416 consumers were restrained, with 951 episodes of restraint reported. These data comprised of the following details:

Consumer age	Consumers restrained	Episodes of restraint reported
under 18 years	48	172
18 to 65 years	325	692
65 years and older	44	87

The Chief Psychiatrist's 2016-17 Annual Report details that of the 416 consumers who were restrained, 378 (91%) were restrained less than five times, 26 (6%) consumers between 5-10 times, and 12 (3%) consumers were restrained more than ten times¹⁸⁴.

Way Forward:

Appropriate data collection and reporting of seclusion and restraint incidents is currently undertaken. Seclusion and restraint practices in Western Australia continue to be lower than the national average, and oversight of the practices is the responsibility of the Chief Psychiatrist and HSPs. Additionally, the Chief Psychiatrist sets standards for clinical care around the use of seclusion and restraint practices.

The Chief Psychiatrist is committed to reducing the rate of seclusion and where possible eliminating the use of restrictive practices in mental health services across Western Australia. There is considerable interest nationally and internationally to reduce and eliminate the use of seclusion¹⁸⁵. This is evidenced by the facilitation of the *Towards Elimination of Restrictive Practice 11th National Forum* in Perth in May 2017, a co-sponsored initiative between the Chief Psychiatrist (the lead agency), the MHC, the DoH, WAAMH, the National Mental Health Commission and the Australian Government

¹⁸³ The Chief Psychiatrist's 2016-17 Annual Report, page 56.

¹⁸⁴ The Chief Psychiatrist's 2016-17 Annual Report, page 57.

¹⁸⁵ The Chief Psychiatrist's 2016-17 Annual Report, page 52.

Department of Health. The forum was an opportunity for mental health services to share best practice and work collaboratively towards eliminating restrictive practices throughout Australia. Progress towards this goal was assisted by the national release during the forum of the National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services.

It is acknowledged that there is a large number of Approved Forms relating to seclusion and restraint (seven and nine Forms, respectively), with stringent requirements and specified timeframes for completion of the Forms. The Approved Forms are to ensure the protection of consumer rights, and for transparency and accountability. Information on seclusion¹⁸⁶ and mechanical restraint¹⁸⁷ was required to be recorded under the *Mental Health Regulations 1997* and mental health services were required to maintain a register of seclusions and mechanical restraints.¹⁸⁸

Recommendation:

44. The Chief Psychiatrist to continue to work with mental health services to reduce the incidence and use of restrictive practices in mental health services in Western Australia.

g. Interstate arrangements

Part 24 of the Act allows for interstate arrangements and agreements with other jurisdictions, including the transfer of orders and corresponding laws. This is in line with providing the best possible treatment and care with the least restriction on a consumer's freedom and rights (Object 1(a)), and helping to minimise the effect of mental illness on family life (Object 1(d)) by allowing a consumer to receive treatment in their home location.

Key Issues Raised:

The corresponding laws of other Australian jurisdictions are yet to be prescribed in the Regulations, which must occur before interstate agreements with other jurisdictions can be entered into. The Chief Psychiatrist advises that the lack of formalisation of interstate transfer arrangements leads to delays in consumers receiving consumer focused care close to their home, and as such Part 24 of the Act is not presently meeting the Objects, specifically with regard to minimising the effect of mental illness on family life (Object 1(d)). MHAS has advised that the lack of agreements with other jurisdictions has caused issues for less than five consumers who would like to be treated in their home state¹⁸⁹.

Way Forward:

The MHC is committed to progressing the necessary amendment to the Regulations and the development of interstate agreements, which will enable consumers to move interstate, including a return to their home location in some instances, while still subject to

¹⁸⁶ *Mental Health Regulations 1997*, ss11-13.

¹⁸⁷ *Mental Health Regulations 1997*, ss14-16.

¹⁸⁸ *Mental Health Regulations 1997*, s17.

¹⁸⁹ MHAS 2015-16 Annual Report, page 29.

an involuntary treatment order. This will lead to the Objects being more effectively achieved.

Recommendation:

45. The MHC to progress necessary amendment to the Regulations and the development of interstate agreements for consumers to move interstate while subject to an involuntary treatment order.

5.5 Unintended consequences

a. Administrative burden

A common theme reported by some stakeholders, although not directly related to the Objects, is a perception that the Act has placed additional administrative burden on clinicians. However, as the timeframes attached to activities carried out by these roles were not captured prior to the implementation of the Act, it is not possible to measure this impact for the purposes of the PIR.

Specifically, with regard to the administrative burden, the Chief Psychiatrist asserts that a reduction in clinicians' time in providing direct clinical care has, in some circumstances, reduced the ability to provide the best possible treatment and care, which is contrary to Object 1(a)¹⁹⁰.

The former DoH Office of Mental Health (now Mental Health Unit) produced a *Mental Health Act 2014: Review of Impact Report (Impact Report)*¹⁹¹ and provided this to the MHC in May 2016. The report highlighted the administrative burden on clinicians and other staff and linked this to the following reasons: the increase in the overall number of Forms; the increase in the number of Approved Forms required for specific purposes (examples of seclusion and restraint were raised); Approved Forms that were perceived to address legal matters rather than clinical need; issues around the Chief Psychiatrist's writeable PDFs; increased non-Form documentation processes (for example, recording notifications and consumer consent); an increase in the volume of notifications to personal support persons; and processes around recording of notifications as per Part 9 of the Act.

Despite this, it has also been reported that the suite of notifications to the Chief Psychiatrist are well thought out in terms of monitoring standards, and that requirements are now more predictable. Additionally, it has been acknowledged that some of the Approved Forms merely capture previously existing recording requirements that were not previously documented in a legal Form. This has provided greater clarity and consistency regarding recording requirements, with copies also provided to consumers and personal support persons. The provision of copies of Approved Forms to consumers and personal support persons is in support of Objects 1(a), (b), (c), (d) and (e).

¹⁹⁰ Chief Psychiatrist's submission to the MHC for the PIR (unpublished), August 2017.

¹⁹¹ The Department of Health's former Office of Mental Health produced the *Mental Health Act 2014: Review of Impact Report* in May 2016.

The Act mandates the Chief Psychiatrist to be an independent body, with statutory powers. As outlined in the Chief Psychiatrist's Annual Report 2015-16, the role of the Chief Psychiatrist has been redefined under the Act, in order to broaden the focus on system-wide issues and the support of mental health clinicians in order to deliver safe and effective mental health treatment and care. Part of this expanded and independent role includes the increased mandatory reporting regarding notifiable incidents, ECT, children being treated in adult facilities, physical care, and restrictive practices, along with other treatment matters. Benefits of this are the ability for the Chief Psychiatrist to review compliance with the Act and the Chief Psychiatrist's standards, in addition to ease of monitoring and evaluating trends.

Ensuring compliance with the Act is important and the notification and monitoring requirements will provide the evidence to assess whether the rights of consumers, families and carers are being protected in the way the Holman Review and the subsequent Objects of the Act intended.

Way Forward:

It is important that ongoing training for clinicians includes not only an understanding of their responsibilities under the Act but also an understanding of the intent of the legislative changes, including the documented rights of consumers and the benefits of involving personal support persons in the treatment and care of mental health consumers. It is acknowledged that increased safeguards may have increased the administrative requirements for clinicians. However, increased safeguards are considered essential and embody the 'spirit' of the Act, through protecting the rights of consumers and their personal support persons, and ensuring collaboration with and involvement in their treatment and care. It is further acknowledged that cultural change can take several years to take effect.

b. Training and education

The Chief Psychiatrist has raised concern that following the initial training for the implementation of the Act, there has been no consistent training for clinicians across mental health services, delivered by mental health services¹⁹².

The Chief Psychiatrist advised he has written to mental health services advising them that responsibility for Act training lies with them, that the CeLP is required to be completed by new clinicians, and that targeted face-to-face training sessions must be made available at local services. However, according to the Chief Psychiatrist, there is limited face-to-face training occurring and the CeLP completion rate is unclear.¹⁹³ This potentially has an impact on the Objects of the Act being achieved, as a fundamental understanding of these is required when working under the Act.

The Chief Psychiatrist further advised that topic-specific training sessions are provided by the OCP, on identified trends from clinician queries to the OCP Clinical Helpdesk¹⁹⁴. These tailored training sessions may include matters such as CTOs, confidentiality in information sharing, and assessing capacity. Additional tailored training is provided by the

¹⁹² Chief Psychiatrist's submission to the MHC for the PIR (unpublished), August 2017.

¹⁹³ Ibid.

¹⁹⁴ Chief Psychiatrist's submission to the MHC for the PIR (unpublished), February 2018.

OCP to non-mental health clinicians when a need is identified. This includes general hospital staff, NGOs, St John Ambulance and MHLC staff.

Some stakeholders have raised concerns about the 'spirit' of the Act not yet being realised, with there being a lack of cultural change in the provision of mental health services, as experienced by consumers, families and carers. It has been raised by one stakeholder that clinicians' concerns around the administrative burden may impact on their ability to work in the 'spirit' of the Act, if they do not 'own' the overall Objects and Principles.

Online training programs and the various Approved Forms are referenced by one stakeholder as examples of compliance tasks, rather than being about effecting cultural change and working within the 'spirit' of the Act, which is exemplified through the Objects and Charter of Mental Health Care Principles.

Way Forward:

Contemporary training is essential to ensure mental health staff are trained in the Objects and Charter of Mental Health Care Principles and understand the importance of compliance with the requirements of the Act for ensuring quality mental health care for consumers. The MHC will continue to work with relevant stakeholders to promote, monitor and maintain the CeLP, including updating the online training in accordance with any Act or Regulation amendments, to ensure staff completing the relevant modules will be doing so with the most contemporary information.

Addressing many of the issues identified through the PIR may assist with embodying the 'spirit' of the Act, through effecting cultural change. Given the limited timeframe and scope of the PIR, it is anticipated that evaluation of the degree to which the 'spirit' of the Act is applied will be captured more effectively in the statutory review.

Recommendations:

46. The MHC will continue to work with relevant stakeholders to promote, monitor and maintain the CeLP, including updating the online training in accordance with any Act or Regulation amendments.
47. The DoH and HSPs to implement a requirement for all new mental health staff to complete the CeLP as part of their induction program.
48. The MHC to ensure the 'spirit' of the Act, in achieving cultural change as experienced by consumers, families and carers in the provision of mental health services, is assessed and captured more effectively in the statutory review of the Act.

6. Summary

6.1 Summary of findings

In accordance with the recommendations of the Holman Review, the primary focus of the Act is the protection of the rights of people experiencing mental illness. The Act requires consumers to be treated with respect and dignity, along with respecting their right to make decisions about their own lives, treatment and care. Recognising the role of families and carers, and upholding their rights are also integral elements of the Act.

The increased focus on consumers and carers has been acknowledged by many stakeholders as a benefit of the Act, including in the Review of Impact Report completed by the former Office of Mental Health. However, feedback received from consumers, personal support persons, and their representative organisations, indicated that the focus of implementation has been on compliance with the legislative requirements of the Act, rather than the 'spirit' of the Act.

Identified areas that reflect positive outcomes in relation to the Objects of the Act include:

- some initial improvements in collaboration with Aboriginal mental health workers and significant members of the person's community, compared with the 1996 Act, although further assessment is required;
- the MHAS (in the majority of cases) meeting the requirement to contact all 'identified persons' within certain timeframes;
- an increase in the number of reviews by the MHT and assistance provided to consumers by the MHAS at MHT hearings;
- anecdotal feedback of consumers and carers receiving notification of notifiable events, although current difficulties with HSP notifications have been identified;
- increase in number of complaints registered, which may reflect increased awareness and assertiveness of consumers and carers regarding the complaints process;
- solid data collection processes around seclusion and restraint incidents, and national and local initiatives to reduce the occurrence of such incidents;
- positive initiatives such as:
 - use of audiovisual communication (such as Telehealth), reducing the requirement for transport from regional areas and removal from the home environment;
 - the MH CRT, resulting in greater focus on a health response and reduced involvement by the justice system; and
- addition of rights of children under the Act, although ongoing monitoring of the application of these rights is required.

A number of issues have been raised throughout the PIR, which may be addressed through a variety of approaches, including legislative, operational, administrative or educational responses. These will require further exploration by relevant stakeholders as to potential solutions. Some areas where it is considered that more needs to be done to achieve the outcomes intended by the Objects of the Act include:

- consistent and regular TSD planning, including the involvement of personal support persons and coordination with local support services on discharge;

- delays in transportation in regional areas resulting in greater restrictions on consumers;
- concerns regarding the application of MHT proceedings and processes on outcomes for consumers, particularly the impact on children; and
- current lack of availability of interstate arrangements preventing freedom of movement for consumers in some cases.

Some areas were difficult to assess regarding the outcomes and whether the Objects of the Act were met, and require further work to assess the outcomes. These include the explanation of rights to consumers and carers, the use of interpreters, identification of personal support persons, and their involvement in MHT hearings, the role of nominated persons, and the use of AHDs.

Overall, two consistent themes have emerged throughout the development of the PIR, with regard to future improvements which may assist further in achieving the Objects. These are training and education for those working within mental health services, both around compliance with and the 'spirit' of the Act, and improved data collation and reporting.

The identification of data gaps and inconsistencies through the PIR process provides an opportunity for consideration to be given to improving the recording and collection of data for key matters, such as:

- engagement with relevant Aboriginal or Torres Strait Islander support persons;
- explanation of rights to consumers and personal support persons;
- use of interpreters;
- measuring capacity;
- further opinions;
- TSD planning;
- audiovisual communication; and
- transportation.

6.2 Implementation of recommendations

A summary list of issues identified throughout the PIR, including the proposed recommendations to respond to those issues, is provided at **Appendix 4**. The MHC, as the administrator of the Act, will continue to work with stakeholders, where appropriate, to address the recommendations of the PIR and provide oversight and tracking of the implementation of the recommendations, which will inform the statutory review of the Act.

The DoH noted their involvement in a significant number of recommendations and confirmed that the DoH "will consider with the MHC, the feasibility of the implementation of the recommendations subject to resourcing, systems and business process development requirements and DoH priorities"¹⁹⁵.

The Mental Health Data Management Group is an existing, established group attended by the MHC, the DoH and HSPs, to provide advisory support and recommendations to improve the quality of mental health data collections and management. This group will continue to address the requirements to collect and record data under the Act, for

¹⁹⁵ DoH's response to the MHC regarding the PIR (unpublished), February 2018.

consideration by the DoH PSOLIS Governance Committee, and improve the scope, consistency and accuracy of the data for ongoing monitoring and evaluation, and to contribute to the statutory review of the Act.

The Act continues to be required to protect the rights of consumers of mental health services and the rights and involvement of their families and carers. In response to issues identified through the PIR and other consultative processes, some legislative amendments to the Act and Regulations may need to be considered. Where this is the case, these will be developed by the MHC and submitted through the necessary Government and Parliamentary processes.

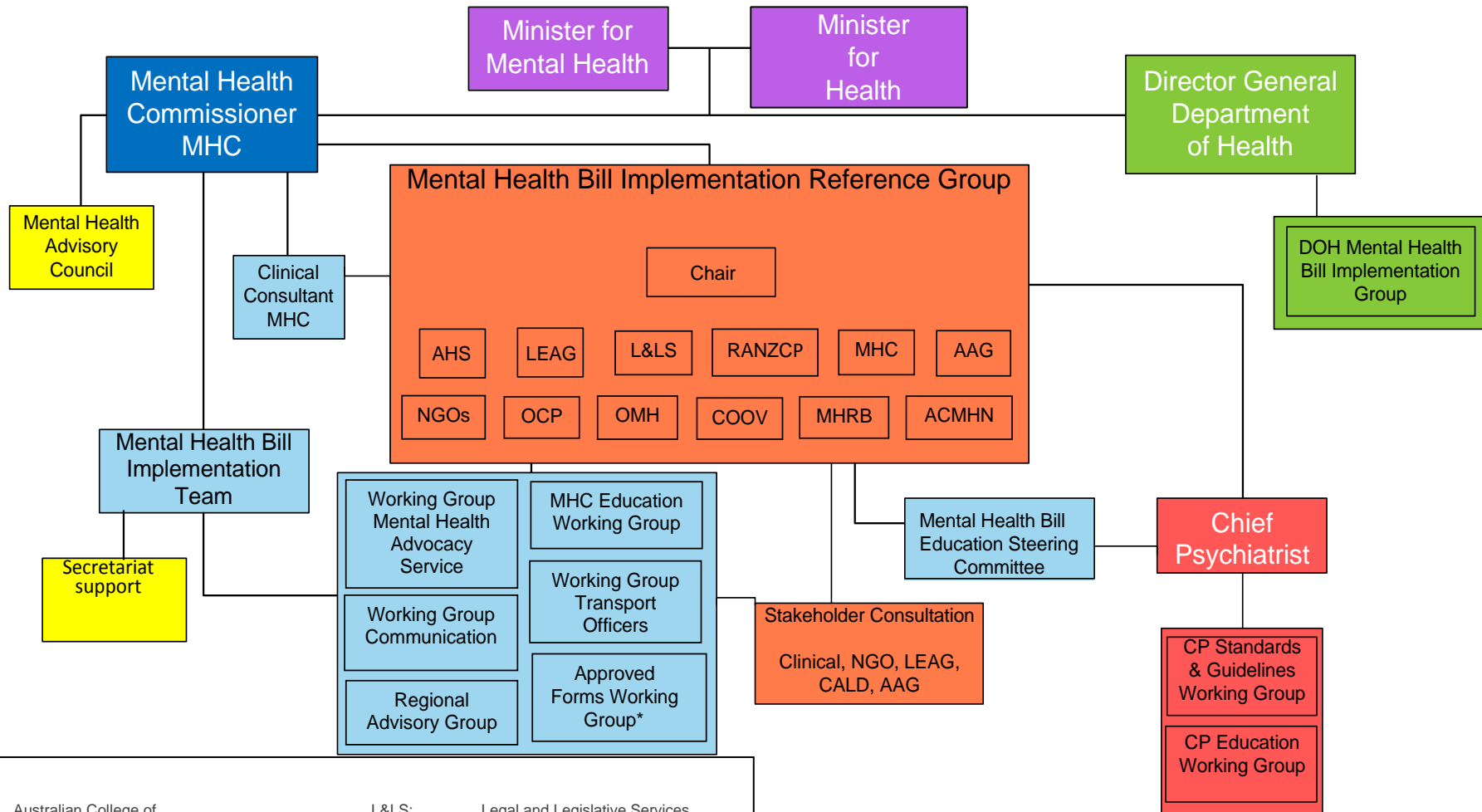
A statutory review of the operation and effectiveness of the Act is required to commence as soon as practicable after 30 November 2020. This will be a comprehensive review of the Act, and will capture any additional issues that have been deemed outside of the scope of the PIR, inclusive of adequate data comparisons. Additionally, progress made regarding the implementation of the recommendations resulting from the PIR will be reported on by the MHC, in collaboration with stakeholders, in the statutory review.

APPENDIX 1 – Stakeholders Consulted and Information Received

Stakeholder	Dates	Information Received
Aboriginal Alcohol and Drug Service	July 2017	Nil response
Australian College of Mental Health Nurses	August 2016, March – October 2017, January 2018	Written submissions
Carers WA	August 2016, March – October 2017	Email
Consumers of Mental Health WA	March – June 2017; January 2018	Email
Department of Health	August 2016, March – October 2017, December 2017 – February 2018	Written submissions, emails
Derbarl Yerrigan Health Service	July 2017	Nil response
Families4Families	April 2017	Email
Health and Disability Services Complaints Office	September 2016, March – October 2017, December 2017 – January 2018	Email
Health Consumers Council	August 2016, March – October 2017	Written submission, email
Health Service Providers <ul style="list-style-type: none"> - Child and Adolescent Health Service - East Metropolitan Health Service - North Metropolitan Health Service - South Metropolitan Health Service - WA Country Health Service 	April – July 2017, December 2017 – February 2018	Written submissions, email
HelpingMinds	April – July 2017	Written submission
Mental Health Advisory Council	August 2016, March – October 2017	Written submission
Mental Health Advocacy Service	August 2016, March – October 2017, December 2017 – January 2018	Written submissions, email
Mental Health Commission internal	March – October	Email

Stakeholder	Dates	Information Received
business areas – Performance, Monitoring and Evaluation; Strong Spirit Strong Mind Aboriginal Programs	2017, December 2017 – February 2018	
Mental Health Law Centre	September 2016, March – October 2017, January 2018	Written submission, email
Mental Health Matters 2	September 2017	Email
Mental Health Tribunal	August 2016, March – October 2017, December 2017 – January 2018	Email, written submission
Office of the Chief Psychiatrist	August 2016, March – October 2017, December 2017 – February 2018	Written submissions, email
Royal Australian and New Zealand College of Psychiatrists	August 2016, March – October 2017, January 2018	Written submission, email
Royal Flying Doctor Service	July – October 2017, February 2018	Written submission, email
Western Australian Association for Mental Health	August 2016, March – October 2017, January 2018	Email
Yorgum Aboriginal Corporation	July 2017	Nil response

APPENDIX 2 - Mental Health Bill Implementation Reference Group Organisational Chart



LEGEND

ACMHN:	Australian College of Mental Health Nurses	L&LS:	Legal and Legislative Services
AHS:	Area Health Services	MH:	Mental Health
AAG:	Aboriginal Advisory Group	MHC:	Mental Health Commission
CALD:	Culturally and Linguistically Diverse	MHRB:	Mental Health Review Board
COOV:	Council of Official Visitors	NGO:	Non Government Organisation
CP:	Chief Psychiatrist	OCP:	Office of the Chief Psychiatrist
DoH:	Department of Health	OMH:	Office of Mental Health
LEAG:	Lived Experience Advisory Group	RANZCP:	Royal Australian and New Zealand College of Psychiatrists

* The Forms WG was established by the CP but was transferred across to the MHC due to lack of resources to support the WG.

15 August 2015

APPENDIX 3 - Mental Health Commission website resources

Mental Health Act 2014 Resources from Implementation

Information contained within this Appendix is available on the MHC website, located at – <https://www.mhc.wa.gov.au/reports-and-resources/resources/mental-health-resources/mental-health-act-2014-resources/>

Mental Health Act 2014 resources

The brochures listed below are available to consumers, family and carers and mental health professionals to download and print for use.

Brochures:¹⁹⁶

- Being referred to a psychiatrist for an examination
- Community treatment orders
- Information for personal support persons
- Information for voluntary patients
- Inpatient treatment orders
- Nominated persons
- Receiving treatment for a Mental Illness

These brochures have been translated into 19 other languages.

Resources for mental health professionals

- **Clinicians' eLearning package** – recommended for all mental health service staff, and includes the following modules:
 - Patient Centred Approach
 - Patient Decision Making
 - Referrals
 - Police Powers
 - Examinations
 - Involuntary Inpatient Care
 - Community Treatment Orders
 - Patient Rights
 - Carer and Family Rights
 - Treatment
 - Seclusion and Restraint
 - Mental Health Advocacy Service
 - Mental Health Tribunal
 - Chief Psychiatrist
 - Complaints
- **Clinicians' Practice Guide** - published by the Chief Psychiatrist, the guide sets out to explain the *Mental Health Act 2014*, suggests how it should be interpreted and outlines practices to adopt when performing a function under the Act.
- **Checklists**
 - Community Treatment Order
 - Inpatient Treatment Order
- **Flowcharts**
 - Community treatment order
 - Inpatient treatment order in a general hospital
 - Inpatient treatment order in an authorised hospital

¹⁹⁶ At the time of implementation of the Act, a brochure titled Transitioning to the *Mental Health Act 2014* was also available online. However, as this is no longer relevant it has been removed from the website.

- **Posters**
[Charter of Mental Health Care Principles](#)
[Consumer and Carer eLearning MHA 2014](#)
[List of MHA Forms](#)
[List of notifiable events](#)

Resources for referrers to mental health services

- Referrers' **eLearning package** - key information about requirements related to referrals
[Information for referring practitioners](#)
[Information for staff at Non-Government Organisations](#)
[Information for staff at private psychiatric hostels](#)
- **Flowchart** - a visual guide to the referral process under the MHA 2014
[Examination of a person at a place other than an authorised hospital](#)
[Examination of a person at an authorised hospital](#)

Resources for people experiencing mental illness and their support persons

- Consumers' and Carers' **eLearning package** – how mental health law applies to people experiencing mental illness as well as their support persons
- **Fact sheets** - what the Act is about, major changes in the legislation, rights of patients and their personal support persons, further opinions and the Charter of Mental Health Care Principles
[Further opinions fact sheet](#)
[Charter of Mental Health Care Principles](#)
- **Consumer Handbook** – written by consumers for consumers
[Consumer handbook to the *Mental Health Act 2014*](#)
- Family and Carer **Handbook** – written by carers for carers

Resources for non-government organisations and private psychiatric hostels

The *Mental Health Act 2014* applies to non-government and private organisations.

- [Non-government organisations](#)
- [Private psychiatric hostels](#)
- [Private psychiatric hospitals](#)

Resources for Transport Officers

The *Mental Health Act 2014* created a new role – Transport Officers, whose job is to carry out transport orders.

- Transport Officers' [eLearning package](#)
- [Information booklet](#)

Additional resources available from the Chief Psychiatrist website

Resources for Mental Health professionals

- Standards and Guidelines
 - [Chief Psychiatrist's Standards for Clinical Care](#)
 - [Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy](#)
 - [Chief Psychiatrist's Guidelines](#)
- Flowcharts
 - [Seclusion Reporting Flowchart](#)
 - [Restraint Reporting Flowchart](#)
- Video
 - [A Guide to Filling in Writable Forms](#)

APPENDIX 4 – PIR Issues Identified and Recommendations

Acronyms:

Act:	<i>Mental Health Act 2014</i>	HSPs:	Health Service Providers	OCP:	Office of the Chief Psychiatrist
CeLP:	Clinicians' eLearning Package	MH CRP:	Mental Health Co-Response Team	PSOLIS:	Psychiatric Services Online Information System
DoH:	Department of Health	MHAS:	Mental Health Advocacy Service	SSAMHS:	Statewide Specialist Aboriginal Mental Health Service
ECT:	Electroconvulsive Therapy	MHC:	Mental Health Commission	SSCD:	Statewide Standardised Clinical Documentation
HaDSCO:	Health and Disability Services Complaints Office	MHT:	Mental Health Tribunal	TSD:	Treatment, Support and Discharge

PIR topic area	Issues identified	Recommendations
Rights for consumers		
Importance of explaining rights	Consumers' rights are not always explained in accordance with the Act.	<ol style="list-style-type: none"> 1. Greater promotion by the MHC of the existing eLearning and other resource materials regarding the explanation of rights to consumers, which are currently available online. 2. The DoH and HSPs to provide an operational response to the issue of consumers not consistently having their rights explained, including potential further education and training of mental health staff. 3. The OCP, as part of their role in the education of relevant staff, including AMHPs, to continue to provide education and training regarding the explanation of rights to consumers. 4. The MHAS, as part of their role in promoting compliance with the Charter of Mental Health Care Principles, specifically Principle 13 (Provision of information about rights), continue to provide education to mental health staff regarding the explanation of rights to consumers. 5. The DoH to ensure appropriate data collection regarding the explanation of rights to consumers, to identify compliance and to inform the statutory review of the Act.

PIR topic area	Issues identified	Recommendations
Social and Emotional Wellbeing of Aboriginal people	<p>Mental health services are not consistently undertaking examinations and providing treatment to Aboriginal consumers in collaboration with Aboriginal mental health workers and/or significant members of the person's community.</p> <p>Inconsistent and lack of validation of data regarding engagement with Aboriginal mental health workers, elders and traditional healers.</p>	<ol style="list-style-type: none"> 6. The DoH to work with the HSPs in their provision of the SSAMHS, to improve access to Aboriginal mental health workers and/or significant members of the person's community for Aboriginal consumers, and consider options for increasing the provision of mental health services in regional/remote communities. 7. The MHT to develop ways of increasing representation of Aboriginal and Torres Strait Islander peoples in tribunal membership. 8. The MHAS to conduct an inquiry into and prepare a report on services available to assist in the assessment, examination and treatment of Aboriginal people, in accordance with the requirements in the Act. 9. Through the Mental Health Data Management Group, the DoH and HSPs to assess and improve where necessary, the requirements and appropriate data capture for improved recording and reporting of data relating to collaboration with Aboriginal mental health workers and/or significant members of the person's community. 10. The MHC to promote the CeLP training package, particularly with regard to the specific requirements in the Act for the assessment, examination and treatment of persons of Aboriginal or Torres Strait Islander descent.
Use of interpreters	<p>Lack of interpreters being offered.</p> <p>Inconsistent and limited data across HSPs.</p>	<ol style="list-style-type: none"> 11. The MHC to further promote the online availability of Act related brochures in languages other than English to improve communication with non-English speaking persons under the Act. 12. The MHT to consult with other stakeholder to determine ways to improve the identification of the need for interpreters at MHT hearings. 13. DoH and the HSPs to determine the most effective solution(s) at

PIR topic area	Issues identified	Recommendations
		<p>an operational level, including provision of education and training for mental health services staff engaged with assessment of consumers on admission, in order to identify the need for an interpreter, promote this option being available and raise awareness of the processes required to engage an interpreter.</p> <p>14. Through the Mental Health Data Management Group, the DoH and HSPs to develop requirements and appropriate data capture for improved recording and reporting of relevant data pertaining to the use of interpreters, to identify areas for improvement and to support the statutory review of the Act.</p>
Advance Health Directives	Lack of data on AHDs.	<p>15. The DoH to work with HSPs and other relevant stakeholders to improve data collection and processes regarding AHDs, including identifying how the use of AHDs interacts with other forms of consumer-collaborative planning.</p>
Further opinions	<p>Currently no system for collecting total numbers of further opinion requests across the system.</p> <p>Lack of psychiatrists available for further opinions.</p> <p>Mental health services staff are not consistently advising consumers and personal support persons of the option of obtaining a further opinion.</p>	<p>16. The DoH to complete the Further Opinions Impact Study and coordinate the implementation of outcomes from this review across all relevant stakeholders, including consideration of formal reciprocal arrangements between services for the provision of further opinions.</p> <p>17. The DoH to work with all relevant stakeholders to improve access to further opinions under the Act, to ensure compliance and inform the statutory review of the Act.</p> <p>18. The DoH to review the current database in place for recording further opinions, with a view to ensure more consistent recording and reporting of data, to ensure compliance and inform the statutory review of the Act.</p>

PIR topic area	Issues identified	Recommendations
Treatment Support and Discharge planning	<p>TSD planning not being done.</p> <p>Use of the standardised clinical document for TSD plans.</p> <p>Lack of involvement of personal support persons in TSD planning.</p> <p>Confusing TSD terminology.</p> <p>Issues with discharge stage of TSD planning.</p>	<p>19. The DoH to collaborate with the HSPs and other relevant stakeholders in order to identify the specific issues relating to TSD planning and determine appropriate solutions for implementation, including training and education requirements, adding the SSCD TSD plan on PSOLIS, and monitoring and reporting on compliance with the requirements of the Act relating to TSD planning (ss186-188).</p>
Physical health assessment	<p>No issues raised by stakeholders, however, consumers report concerns about physical health assessments.</p>	<p>20. The DoH to collaborate with the HSPs and other relevant stakeholders to identify potential barriers at an operational level to undertaking physical health assessments, and assist the DoH and HSPs develop and implement strategies to increase compliance with the Chief Psychiatrist's Standards.</p> <p>21. Through the Mental Health Data Management Group, the DoH and HSPs to identify opportunities to assist with appropriate data collection, monitoring and reporting regarding consumers being offered and receiving physical health assessments.</p>
MHT – more frequent reviews	<p>Continued and consistent data collection and reporting required regarding MHT functions.</p> <p>Negative impact of more frequent reviews, including on children and young people.</p> <p>A number of other issues including – inconsistencies of the MHT processes, delayed notice of hearings, lack of access to relevant documentation for the hearing and issues with the conduct of MHT hearings.</p>	<p>22. In order to determine compliance with the Act, the MHT to facilitate the ongoing collection of all relevant quantitative data regarding MHT reviews for further data analysis and to contribute to the statutory review of the Act.</p> <p>23. The MHT to work with all relevant stakeholders to address the concerns raised regarding MHT proceedings and processes, including apparent inconsistencies of MHT processes, delayed notice of hearings, lack of access to relevant documentation for the hearing and issues with the conduct of MHT hearings.</p>

PIR topic area	Issues identified	Recommendations
Rights for personal support persons		
Personal support persons	<p>Personal support persons are not always being identified.</p> <p>Consumer possibly not advised when their psychiatrist has withheld information from the personal support persons.</p> <p>Complexity with terms such as personal support persons, carer and nominated person.</p>	<p>24. The MHC to further explore the complexity of the different terms used for personal support persons, nominated persons and carers, and identify and implement potential solutions such as greater communication and education options to address the reported complexity.</p> <p>25. Through the Mental Health Data Management Group, the DoH and HSPs to progress improved data recording and reporting with regard to personal support persons including consultation with other stakeholders, as required.</p>
Nominated persons	Role of the nominated person is not well understood.	<p>26. The MHC to promote existing education materials, including eLearning resources and brochures, regarding the role of nominated persons and personal support persons to assist with the understanding of these roles.</p> <p>27. The DoH to develop potential solutions for access to and submission of Form 12A (Nomination of nominated person) to ensure equity of access to this right by consumers throughout the State.</p>
Notifiable events	Data on notifiable events is currently subject to a manual count.	<p>28. The DoH and HSPs, in consultation with other stakeholders, to develop ways to streamline the notification process regarding notifiable events, to ensure consumers and personal support persons are notified in accordance with the requirements of the Act.</p> <p>29. Through the Mental Health Data Management Group, the DoH and HSPs to address issues around data identification and recording regarding notifiable events, to better identify and ensure compliance with the Act and to inform the statutory review of the Act</p>

PIR topic area	Issues identified	Recommendations
Recourse		
MHT additional functions	MHT data collection systems and processes require improvement.	30. 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.
Making a complaint	<p>Consumers and personal support persons too afraid to complain.</p> <p>Lack of understanding in the community and mental health services about the complaints resolution process under the Act.</p>	<p>31. The HaDSCO continue to strengthen the promotion of the complaints process under the Act.</p> <p>32. The DoH to improve the mental health complaints handling process at the service level, including education and training of staff.</p>
Other advancements		
Referral and detention timeframes	No issues raised by stakeholders, however, measuring the impact of reduction of referral and detention timeframes requires data evidence.	33. Through the Mental Health Data Management Group, the DoH and HSPs to identify and record data regarding referral and detention timeframes, for reporting in the statutory review of the Act.
Audiovisual communication	<p>Expansion of the use of audiovisual communications.</p> <p>Improvements to data capture required.</p>	<p>34. The DoH to develop potential options for the expansion of the use of audiovisual communication to support the implementation of the Act, in particular, to improve support to non-specialist staff in regional emergency departments.</p> <p>35. Through the Mental Health Data Management Group, the DoH and HSPs to identify and record data regarding audiovisual communication, for reporting in the statutory review of the Act.</p>
Transportation	Regional concerns regarding transportation, including delays.	36. The MHC to coordinate and work with stakeholders for the promotion of the transport officers eLearning training package, which will assist with ensuring compliance with the Act regarding transport requirements.

PIR topic area	Issues identified	Recommendations
		<p>37. The MHC to work with the relevant stakeholders to support the continuation of the MH CRT and the continued collaboration between the DoH and WA Police.</p> <p>38. Through the Mental Health Data Management group, the DoH and HSPs to implement data systems in line with the requirements set out in Mandatory Policies, MP 0060/17 (Use of Physical and/or Mechanical Restraint during Road-based Transportation of Mental Health Patients Policy) and MP 0063/17 (Requesting Transport Officers and WA Police Assistance in Transporting Mental Health Patients Policy).</p> <p>39. The DoH to identify causes and potential solutions to reduce delays in regional mental health transfers, including the use of audiovisual communication.</p>
Children	Children on adult wards.	<p>40. The MHC to consider an amendment to the Act requiring the Chief Mental Health Advocate to be notified of any child placed on an adult ward.</p> <p>41. The MHT to develop options to increase participation by child and adolescent psychiatrists in MHT hearings when considering a matter involving a child.</p> <p>42. The Chief Psychiatrist to develop options to increase the number of authorised medical practitioners or mental health practitioners with qualifications, training or experience relevant to children who have a mental illness.</p>
Electroconvulsive therapy	<p>Concerns about legislating ECT and allowing the MHT to determine the clinical parameters of this treatment such as the frequency, quantity and location.</p> <p>Concerns about the Act requiring the reporting</p>	<p>43. The MHC will liaise with relevant stakeholders, in particular the Chief Psychiatrist and ECT clinicians, in considering any potential amendments to the Act regarding ECT.</p>

PIR topic area	Issues identified	Recommendations
	<p>of serious adverse effects of ECT, in isolation, without regard to the benefits of ECT for some patients.</p> <p>Unnecessary age restriction on ECT.</p>	
Seclusion and restraint	No issues to note. Appropriate data collection and reporting currently being undertaken, and the Chief Psychiatrist continues to be committed to reducing the rate of seclusion and where possible eliminating the use of restrictive practices in mental health services.	44. The Chief Psychiatrist to continue to work with mental health services to reduce the incidence and use of restrictive practices in mental health services in Western Australia.
Interstate arrangements	The lack of formalisation of interstate transfer arrangements leads to delays in consumers receiving consumer focused care close to their home.	45. The MHC to progress necessary amendment to the Regulations and the development of interstate agreements for consumers to move interstate while subject to an involuntary treatment order.
Unintended consequences		
Training and education	<p>Lack of consistent training being provided.</p> <p>Online training and various legal Forms are referenced as examples of compliance tasks.</p>	<p>46. The MHC will continue to work with relevant stakeholders to promote, monitor and maintain the CeLP, including updating the online training in accordance with any Act or Regulation amendments.</p> <p>47. The DoH and HSPs to implement a requirement for all new mental health staff to complete the CeLP as part of their induction program.</p> <p>48. The MHC to ensure the ‘spirit’ of the Act, in achieving cultural change as experienced by consumers, families and carers in the provision of mental health services, is assessed and captured more effectively in the statutory review of the Act.</p>