
SUBMISSION

Statutory Review of the Mental Health Act (2014)

Western Australian Mental Health Commission

sent via statutoryreview@mhc.wa.gov.au

January 2022



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A U S T R A L I A

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Contents

| | |
|--|-----------|
| Statutory Review of the Mental Health Act (2014) | 1 |
| Introduction | 6 |
| Overview | 6 |
| Theme 1 | 6 |
| 1.1 Identifying Aboriginal and Torres Strait Islander status on Approved forms | 6 |
| What change to the Act do you think is required? | 7 |
| 1.3 Apprehension and Return Orders | 7 |
| What change to the Act do you think is required? | 7 |
| 1.4 Restriction on freedom of communication | 8 |
| What change to the Act do you think is required? | 8 |
| 1.5 Voluntary inpatient rights (including older adult inpatients) | 8 |
| What change to the Act do you think is required? | 8 |
| 1.6 Restraints in non-authorized hospital wards | 8 |
| What change to the Act do you think is required? | 9 |
| 1.7 Private psychiatric hostel definition | 9 |
| What change to the Act do you think is required? | 10 |
| 1.8 Definition of ‘mental health service’ | 10 |
| What change to the Act do you think is required? | 10 |
| 1.9 Referral and detention timeframes - back-to-back use of Forms 1A and 3 | 10 |
| What change to the Act do you think is required? | 10 |
| 1.10 Further Opinions | 10 |
| What change to the Act do you think is required? | 11 |
| 1.11 Treatment, support and discharge plans | 11 |
| What change to the Act do you think is required? | 12 |
| Theme 2 | 12 |
| Carers, family members and supporters | 12 |
| 2.1 Decision not to notify personal support person | 13 |
| What change to the Act do you think is required | 13 |
| Theme 3 | 14 |
| Children | 14 |
| 3.1 Mandatory notification to Mental Health Advocacy Service when child admitted as | 14 |
| an inpatient to an adult ward | 14 |
| What change to the Act do you think is required | 14 |
| 3.2 Restraint of children in non-authorized hospitals | 14 |
| What change to the Act do you think is required | 14 |
| 3.3 Segregation of children from adult inpatients | 14 |
| What change to the Act do you think is required | 14 |
| 3.4 Off-label treatment for children | 14 |

| | |
|--|-----------|
| What change to the Act do you think is required..... | 15 |
| Theme 4 | 15 |
| 4.1 Reporting of electroconvulsive therapy statistics..... | 15 |
| What change to the Act do you think is required..... | 15 |
| 4.2 Application to the Tribunal to use electroconvulsive therapy | 15 |
| What change to the Act do you think is required..... | 15 |
| Theme 5 | 15 |
| Mental Health Advocacy Service..... | 15 |
| 5.1 Engagement of advocates | 16 |
| What change to the Act do you think is required..... | 16 |
| 5.2 Chief Mental Health Advocate delegate..... | 16 |
| What change to the Act do you think is required..... | 16 |
| 5.3 The term ‘financial interest’ | 16 |
| What change to the Act do you think is required..... | 16 |
| Theme 6 | 16 |
| Mental Health Tribunal..... | 16 |
| 6.1 Written reports for hearings | 16 |
| What change to the Act do you think is required..... | 17 |
| Theme 7 | 17 |
| Interstate arrangements..... | 17 |
| 7.1 Mutual recognition of mental health orders and interstate arrangements | 17 |
| What change to the Act do you think is required..... | 17 |
| Theme 8 | 17 |
| 8.1 Use of audio-visual communications under the Act | 17 |
| What change to the Act do you think is required..... | 17 |
| Theme 9 | 17 |
| Select Committee Into Alternate Approaches To Reducing Illicit Drug Use And Its Effects On The Community..... | 17 |
| 9.1 Select Committee - Recommendation 41 | 17 |
| Theme 10..... | 17 |
| Clinical Governance Review..... | 17 |
| 10.1 Mental health governance - legislate for Lived Experience partnerships..... | 17 |
| What change to the Act do you think is required..... | 18 |
| Theme 11..... | 18 |
| Culture and Spirit of the Act | 18 |
| 1. <i>Human rights of consumers, families, and carers.</i> | 18 |
| 2. <i>Trauma Informed Practice and awareness.</i> | 19 |
| What change to the Act do you think is required | 19 |
| 1. <i>Information system (PSOLIS)</i> | 19 |

| | |
|--|-----------|
| 2. Terminology | 20 |
| 3. Reporting requirements and Forms | 20 |
| 4. Administration and compliance | 20 |
| 5. Objects of the Act and Charter are being met..... | 20 |
| What change to the Act do you think is required..... | 20 |
| 1. What needs to be done better to ensure the Objects of the Act and Charter are being met..... | 20 |
| What change to the Act do you think is required..... | 21 |
| 2. Barriers to implementing change..... | 21 |
| What change to the Act do you think is required..... | 22 |
| 11.1 Post-implementation review recommendation | 22 |
| What change to the Act do you think is required..... | 22 |
| Part 2 | 22 |
| LEA has provided comments to the amendments which we believe require some consideration. Those not mentioned below, we agree with..... | 22 |
| Amendment 3 - Use of reasonable force with respect to a person on: a referral for examination by a psychiatrist, a transport order, or an apprehension and return order | 23 |
| What change to the Act do you think is required..... | 23 |
| Amendment 5 - Provide for continuation of detention at a general hospital to allow for further examination by a psychiatrist | 23 |
| Amendment 7 – Leave of Absence..... | 23 |
| What change to the Act do you think is required..... | 23 |
| Part 10..... | 23 |
| Amendment 9 – Transport orders..... | 23 |
| What change to the Act do you think is required..... | 23 |
| Part 11..... | 23 |
| Amendment 10 - Apprehension by police for assessment | 23 |
| What change to the Act do you think is required..... | 23 |
| Amendment 11 - Gender of person conducting search | 24 |
| What change to the Act do you think is required..... | 24 |
| Part 14..... | 24 |
| Amendment 13 - Emergency psychiatric treatment..... | 24 |
| What change to the Act do you think is required..... | 24 |
| Amendment 15 - Informing treating psychiatrist of seclusion or bodily restraint | 24 |
| What change to the Act do you think is required..... | 24 |
| Amendment 17 - Voluntary Patients in locked inpatient mental health services | 24 |
| What change to the Act do you think is required..... | 24 |
| Part 20..... | 24 |
| Amendment 20 - Timing of notifications to the Mental Health Advocacy Service..... | 24 |
| What change to the Act do you think is required..... | 24 |
| Part 21..... | 24 |

| | |
|--|-----------|
| Amendment 23 - Application to Mental Health Tribunal for provision of electroconvulsive therapy..... | 24 |
| Amendment 26 - Provide for a transcript of oral reasons delivered during a Tribunal hearing to suffice as compliance with a request for reasons..... | 25 |
| What change to the Act do you think is required..... | 25 |
| Amendment 27 - Enable the Tribunal to correct any clerical mistakes, accidental errors, omissions, miscalculations, or defects of form, contained in its decisions or reasons | 25 |
| What change to the Act do you think is required..... | 25 |
| Part 23..... | 25 |
| Other Matters not addressed elsewhere..... | 25 |
| 1. <i>Recovery-oriented practice</i> | 25 |
| 2. <i>Conflicting Opinions between Doctors</i> | 26 |
| Contact..... | 26 |
| Appendix One..... | 27 |

Introduction

Lived Experience Australia is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

LEA is represented in Western Australia by our Director and Coordinator Ms Lorraine Powell together with the WA State Advisory Forum and as such, we are providing this Submission to inform the Western Australian Mental Health Commission's consultation about the Statutory Review of the Mental Health Act (2014) Discussion Paper. This comes from the perspectives and experiences of people with lived experience of mental health issues, their families, and carers.

LEA has undertaken a survey of our WA members and friends who have experiences relating to the Act and conducted several individual interviews with consumers and family members/carers, to inform this Submission. A copy of the survey questions appears as Appendix One.

Given the narrow focus of the topic, we were pleased with the number of respondents with 11 consumers and 5 family carers, a total of 16 people undertaking the survey. Of those, 5 respondents indicated a willingness to be interviewed with 1 consumer and 2 family carers further informing this Submission.

Critically, we have used their voices within the quotes throughout this Submission.

"My concern and experience is in "how" these things are done as I don't consider myself as having the expertise to critique so much "what" is done."

Overview

LEA supports the objectives of the Act and notes these are still relevant. Similarly, Part 4 Charter of Mental Health Principles remain relevant and integral to the use of the Act for the purposes of containment. Decision making and informed consent processes are also crucial in a person's ability to make decisions about their mental health and wellbeing.

"Suffering people need not just medication but to be treated with dignity, respected for their strengths, valued for their experience and a humble recognition that "but for the grace of God, go I."

"We can put up with a hell of lot more sadness, suffering and distress when we are a human being, with another human being working it out together."

We address this Submission mostly with regard to the area of Previously Identified Issues and proposed amendments. An extra section is included which addresses matters not otherwise requested within the published discussion paper yet arose from our consultations with people with lived experience which we believe are crucial to detail herewith.

Theme 1

1.1 Identifying Aboriginal and Torres Strait Islander status on Approved forms

LEA supports the identification of Aboriginal or Torres Strait Islander peoples (ATSI) to be recorded. LEA does not believe there is further administrative burden given the form is already being completed and would prompt compliance with the remaining parts of the Act.

What change to the Act do you think is required?

- 1) LEA would recommend reference to the percentage of ATSI peoples held under the Act. This is a marginalised group, and frequently lacks the ability to receive support from ATSI organisations, elders, or traditional healers. Furthermore, there are often different kin groups and languages that need to be considered.
- 2) Similarly, LEA supports not moving ATSI peoples around once they have been admitted to an authorised hospital, as this causes increased distress and confusion for them and their family. There is also an issue of relationships established in familiar or close settings. However, LEA does understand that some consumers may request transfer for varying reasons, (e.g., closer locations to family and support networks, prior negative experiences with the service and the associated trauma experienced which triggers negative emotional responses.

1.3 Apprehension and Return Orders

LEA understands the need for this section; however, this is complicated because the issue of using police in the transport of the consumer. Police do not have the requisite skills or knowledge to support someone or determine their needs; individual officers may demonstrate desired capabilities, but this is not consistent across the police workforce.

Similarly, this situation does not allow the person to explain the reason for absconding, e.g., they may be or have experienced trauma, poor treatment, or been the victim of aggression and/or violence, coercive practices etc, and this prompts them to consider absconding in order to feel safer, not because they do not want treatment, rather for the reasons noted here. Consideration must be given to the person who is being detained and their wishes and reasons for absconding. A study on this topic from Professor Eimear Muir-Cochrane et al (2013), examines consumers experiences of hospitalisation and their decisions to abscond. This study showed that consumers felt both safe or unsafe in hospital depending on individual, social, physical, and symbolic aspects of the ward. Negative experiences of the ward environment and relationships with staff and other consumers led consumers to feel unsafe and more likely to abscond¹.

A further study from Professor Eimear Muir-Cochrane et al (2021b)² found that many consumers abscond because they have everyday things to do or need to contact with friends or family. These findings suggest agency on the part of consumers, acting autonomously in ways to keep themselves emotionally and/or physically safe. Consumers also absconded sometimes when they were acutely unwell, experienced bad news or were in conflict with other consumers or staff.

What change to the Act do you think is required?

- 1) Develop and implement a policy which allows admission to the one authorised hospital. This is supported by the Charter of Mental Health Care Principles.
- 2) This could be resolved by an amendment that a person must be transported to a local service for assessment of their physical and mental health to ensure they are fit to travel, i.e., Fit to Travel Permit.
- 3) LEA supports a telehealth session to the original service for support.
- 4) Developing a formal communication procedure between police, the originating service and the receiving mental health service is crucial.

¹ Muir-Cochrane, E., Oster, C., Grotto, J., Gerace, A. & Jones, J., (2013) The inpatient psychiatric unit as both a safe and unsafe place: Implications for absconding. *International Journal of Mental Health Nursing* 22(4), 304-312.

² Muir-Cochrane E., Muller, A. & Oster, C. (2021b). Absconding: A qualitative perspective of patients leaving inpatient psychiatric care. *International Journal of Mental Health Nursing*, 30(5), 1127-1135. Muir-Cochrane et al., (2021b)

1.4 Restriction on freedom of communication

“Had my mobile removed due to ward policy. Unable to contact family.”

LEA strongly supports an amendment to the Act to ensure a copy of the Order is made available to the Mental Health Advocacy Service (MHAS).

What change to the Act do you think is required?

LEA recommends that the MHAS be notified under the provision, with supplying of the form taking care of both matters as the same time.

1.5 Voluntary inpatient rights (including older adult inpatients)

LEA certainly understands that there is a real issue for older and other patients reporting being held in a locked ward even though they have voluntary status. The problem with this is, whilst people are being ‘contained’, their freedom of movement is restricted. Having to ask a nurse to exit the building means the nurse must decide to permit the person to leave; wherein the restriction of movement is in breach of the Act.

LEA is also concerned that some older people being held in locked wards without the approval or a Guardianship Order. LEA strongly supports the right to freedom of movement and believes this should be made available to the consumer in writing, alongside other written statements of their rights and a copy of the Charter of Mental Health Care Principles. This allows the principle of ‘least restrictive and recovery focussed’ care to be realised in practice. However, without formal processes affirming this freedom of movement, possible coercive approaches by staff could be brought to bear on the consumer i.e., ‘if you try to leave, we will make you involuntary’ This is not in the spirit of good care and is considered coercive, punitive and not in the spirit of the least restrictive means.

What change to the Act do you think is required?

LEA strongly support amendments to the Act referencing that, where a voluntary consumer is placed in a locked ward, the voluntary consumer has the right to leave without permission i.e., that the decision is based on the consumer’s preference, not over-ridden or unduly influenced by staff’s opinion which may not align with that of the consumer, unless there are good grounds/evidence for concern for the consumer’s welfare. Open discussion, free from coercion or undue persuasion or influence should always underpin discussion between the consumer and staff at such times.

1.6 Restraints in non-authorised hospital wards

LEA believes the Act is not strong enough around the use of restraints only in authorised hospitals.

Recognition is needed that at times a consumer may become acutely unwell and/or at risk of harm to themselves or others and therefore require restraining.

LEA is of the understanding that there are other instances of restraint (and sometime seclusion) occurring in non-authorised locations, and by the nature of the Act, are not reported.

“I held my boy, and told him it was going to be OK. I was holding my hand up to the police, asking them to back off. The police moved closer and pulled out their handcuffs. I put my hand up again, they kept coming. It was instantaneous, they grabbed him and slammed him face first into the dirt. They handcuffed him. You are being detained under the Mental Health Act. We are taking you back inside. I had this, I screamed. I was convincing him to go back inside. Why didn’t you respect me? They dragged my boy upright, his face was bleeding, he had tears streaming down his face. “Help me mum, I’m scared”. As a mother, witnessing him being slammed to the ground, handcuffed, dragged unwillingly and restrained to a bed was heartbreaking and a rolling set of images I will never forget.”

As for Emergency Departments, LEA believes that only staff who are adequately trained in mental health and in restrictive practices are to be used in any site providing care for someone who is unwell. Where the use of restraint in a non-authorized facility- including in ED's- all reporting and other requirements under the Act should be completed. If the consumer experiences these actions, they are currently not protected by the Act, have no access to the Mental Health Advocacy Service, nor understand the practices and why they are being subjected to these.

LEA believes the use of restraint is extremely traumatic for consumers, families, bystanders, and staff, and we believe is in breach of the rights of the individual (United Nations Convention for the Rights of People with a Disability). We would encourage the implementation of the National Principles for Communicating about Restrictive Practices with Consumers and Carers³.

In terms of children, LEA understands that, for any instances of restraint use involving children reporting is required to the Office of the Chief Psychiatrist.

Anecdotally, we are also aware of consumers on 'open wards' who are subjected to being placed in a room with a nurse 'specialling' them while sitting outside, and refusing to let the consumer leave the room. In line with the definition used in the Act, this is seclusion. It is recommended all staff working in a mental health setting are required to receive basic education on what constitutes a 'restrictive practice'. Furthermore, it must be a requirement that any instance of this occurring is also reported in line with the requirements of the Act.

What change to the Act do you think is required?

- 1) LEA recommends amendment to the Act to include recognising possible restraint in other settings, however only as a last resort, and if deemed necessary, it should only be undertaken by qualified and trained practitioners, and in the safest way possible. Immediate review is required, together with written information and mandatory reporting to the Office of the Chief Psychiatrist.
- 2) LEA recommends mandatory de-escalation training be incorporated into the regular training calendar of all those clinical staff who will be at the forefront of these incidents. This would include use of the National Principles for Communicating about Restrictive Practices with Consumers and Carers.
- 3) Part 12, Division 2 s172 allows for reasonable assistance and force. LEA believes this section is lacking the necessary guidelines to be followed post-incident which should be present as per s227 and 228.
LEA recommends undertaking of further work to ensure the Act represents the necessary actions and settings.
- 4) LEA recommends a clearer definition of what constitutes 'restrictive practice' and the requirements for reporting be incorporated within the Act.

1.7 Private psychiatric hostel definition

LEA strongly supports the right of any individual, regardless of their circumstances and place of residence or location, to have access to reasonable supports and advocacy.

LEA strongly supports people receiving care, treatment, and support from any accommodation services to have access to MHAS.

³<https://www.mentalhealthcommission.gov.au/getmedia/1c6caf3a-a0bc-4aed-ba22-e71e973280c4/National-Principles-for-Communicating-about-Restrictive-Practices> 2016

What change to the Act do you think is required?

- 1) LEA suggests broadening the scope and definition within the Act, away from private psychiatric hostels to any place providing bed-based mental health care, treatment, and support.
- 2) Furthermore, reference could also be made to the Private Hostels Act.

1.8 Definition of 'mental health service'

LEA raises the issue of definitions or language here; i.e., community mental health service, is this a government run community-based clinical service or a private psychiatric hostel or similar? LEA believes the regulations need to prescribe services such as those within Community Managed Organisations (Non-government organisations) private sector accommodation etc specifically for mental health care and treatment. We believe this section fails to use the language of recovery.

What change to the Act do you think is required?

- 1) LEA would recommend an additional clarification that includes 'mental health specific community-based accommodation and recovery support services'
- 2) Amend the language to better reflect recovery. Suggested wording is "Provide treatment, care, support, person-led and recovery-oriented services"

1.9 Referral and detention timeframes - back-to-back use of Forms 1A and 3

We note the content of this section that people can be detained for over 3 days and LEA has concerns this is highlighting the lack of beds available, reflecting administrative need and convenience rather than being a decision based on true assessment of the patient's needs and mental health status. Holding someone for over 72 hours, without an initial psychiatric assessment is unreasonable in our view, adding to the distress of the consumer and their family/carer and delaying and therefore lengthening their recovery time, is a disruption to the person's life, and is a greater drain on clinical resources.

"It was four days before I saw a psychiatrist. I didn't think they could extend a 1A, but it was over Christmas and they were clearly short-staffed."

What change to the Act do you think is required?

LEA notes that when this issue was discussed and developed in previous consultations, consumers and carers were adamant the timeline of 72 hours be upheld. We support this position.

1.10 Further Opinions

Section of the Act: Sections 182,183 and 184

LEA is concerned around the content of this section. Allowing a person to seek a further or second opinion across all health settings is difficult. Many people do not wish to be treated differently by staff and services because of asking for and seeking a second opinion, and fear of adverse repercussions by doing so restricting many from taking up this option.

It is no different in mental health settings, potentially more so as psychiatrists are often seen by their patients as holding a sense of 'power' over them. We see this section of the Act as requiring the approval of the treating psychiatrist for a second opinion enforced the 'power based' differential and is disempowering for the consumer.

Whilst it appears from the content that the Act permits the request for a further opinion, at present, and despite a consumer's wishes, the psychiatrist holding the power can decide if the person can or cannot access one or not.

"We were told it (a further opinion) was part of the plan. It was not resolved"

The Act should clearly articulate that the psychiatrist or the Chief Psychiatrist should not have the right to refuse a further opinion. This would assist the consumer to exercise their right to seek an opinion from outside the service i.e., a private practitioner who currently does not exist within the Act.

LEA notes that the Clinicians Practice Guide explains this in greater detail which allows for this situation. LEA is therefore concerned that this may represent a cultural and/or practice issue, rather than a legislative one.

Currently, when a consumer requests a further opinion, it is generally from a clinician in the same service, and consumers do not feel this is sufficiently independent. They are concerned about the issue of 'culture and practice' and attitudes between colleagues, which leads to mistrust of the further opinion, particularly and mostly is the same. LEA notes there is a provision for the further opinion to be held via audio/visual methods.

LEA also references the year 2016/2017 where 304 requests were made for a further opinion in which only 8.5% of all involuntary inpatient orders and 3.5% of Community Treatment Orders that the MHAS4 were involved in which seems low and not an onerous number.

What change to the Act do you think is required?

- 1) LEA recommends reference within the Act for a list of practitioners willing to undertake an independent further opinion, be made available to the consumer.
- 2) LEA recommends that this section be re-written to better reflect the needs of the consumer.
- 3) Strengthen the language, to state that a person has the right to seek a further opinion
- 4) Change text: *A person to whom this section applies has the right to obtain the opinion (a further opinion) from an independent psychiatrist regarding their treatment. This request can be made orally or in writing to the patient's psychiatrist or the Chief Psychiatrist.*

1.11 Treatment, support and discharge plans

LEA notes that in our opinion the Treatment, Support and Discharge Plan (TSDP) is one of the biggest issues in relation to the Act.

"I didn't even know I was meant to have one"

In reading through, perhaps the issue is more around the inclusion of the statement 'as soon as practicable' otherwise this is far too open to interpretation and therefore timing. It is crucial that treatment is in alignment with agreed plans and consumer and carers/nominated supports also have a copy of this plan, as well as active inclusion in its development. This also aligns with the National Safety and Quality Healthcare Standards- Standard 2.

"As a support person, I was never invited to participate in any way in her treatment planning, ongoing support, or discharge planning (prior to the decision having been made)."

"I was not even collaborated on with regards to my treatment, care and discharge and I was denied access to my treatment plan."

4 <https://mhas.wa.gov.au/assets/documents/Final-Further-Opinions-Report-and-Survey-by-MHAS-July-2016-to-June-2017.PDF>

“The initial care plan was made with very little input from me due to my inability to speak, most of the information was given by my housemate.”

A real area of concern within the Paper is reference to the Inquiry which noted a contributing reason for this included clinicians being unaware of the requirements of the Act. We purport that a TSD plan should be at the heart of clinical service provision and a core requirement despite requirements to the contrary and the renewed 2021 Framework to guide use within services. This aligns with the Charter, and best practice principles in recovery-oriented service provision.

“He wrote a treatment plan, as if my daughter had written it, before he even met her.”

“I was left to sort out my own treatment plan and source all my own treatment team (post discharge).”

We acknowledge people are very unwell when placed under the Act; however, as they improve, every effort should be made to actively include them in their treatment, support, and discharge planning.

“My input was valued and taken into consideration when planning my care, whereas with some it was ignored and even scorned.”

“Be willing to explain the thinking behind their treatment plans and hear and answer our admittedly, sometimes dumb questions without feeling their expertise is being questioned or that we are being argumentative.”

“One Dr did invite us to participate in our daughters’ treatment, support, or discharge planning (after having been an inpatient for a number of weeks and working with various Dr’s).”

We have also ascertained that 55% of adjournments of the Tribunal refer to the adequacy, or lack of adequacy, of medical evidence.⁵

What change to the Act do you think is required?

- 1) Recommend changing reference to ‘within 3 days’ to align with s186 1 – treatment, care and support is governed by a TSDP.

Theme 2

Carers, family members and supporters

LEA strongly supports the inclusion and reference within the Act to personal support persons, i.e., as carers, family members and other support people as part of the team. We also note this must be in accordance with the consumer’s wishes. If the consumer declines to nominate a secondary person such as a carer or family member/supporter at the first instance, clinical staff should revisit this issue and ask this question again when the consumer has stabilised.

“The service stated it was the consumers responsibility to pursue collaboration with family/support person rather than a service policy or procedure.”

Whether a consumer does or doesn’t agree to the involvement of another, the carer/family member/supporter should still have the opportunity to provide relevant information about the consumer to assist clinical staff to better understand the background and current reasons for

⁵ Mental Health Tribunal Annual Report 2021

deterioration. They must be viewed as an integral part of the treatment, care and support provided. Respect for their understanding must be afforded.

“(The) Psychiatrist on the ward didn’t see that I should have any say or question on what he was recommending.”

A nominated family member or carer also has the right to information which is not in breach of confidentiality or privacy requirements. This is in line with the Carers Recognition Act. Our consultations suggest family members/ carers are mostly not given regard or respected in their interaction with the system at the practice level.

A common concern expressed was around lack of information. Given that family members/carers are the ones that most commonly support the consumer, they need to have information about a diagnosis, medications, what to look for if a person deteriorates, and when and who to go to in a crisis.

“The only support I received from anyone other than ward staff was someone who took the time to sit with me in my daughter’s final week of admission. This only occurred after I engaged an advocate, submitted two complaints, and requested to see the centre policies on service provision, discharge planning, and carer consultation.”

“no one EVER, still, ever asked me if I was ok, if I needed support, how I might cope with seeing her there like that, or the guilt of having trusted her (my daughter).”

“I begged them not to take him to (a particular ED_ because that was where his dad passed away from a heart attack. They transported him to that hospital despite what I had asked.”

2.1 Decision not to notify personal support person

This section refers to notification of family members/supporters as soon as practicable and LEA agrees with this if these attempts are documented. We believe the timeframe is realistic, if it is revisited if at first the notification is unsuccessful within a period of no more than 3 days.

“Any contact I had with the service was always instigated by me, as were any family meetings.”

We believe this notification is core business for services, and not an administrative burden. A consumer nominating a family member/supporter and the engagement and involvement of the family member/supporter respects the right of the consumer and family member/supporter and the application of the Charter of Mental Health Care Principles and the rights of carers.

Given that often it is the family or supporter who directly assist the consumer with many tasks, they do so in the main without clinical backgrounds, and information is crucial as well as involvement within the TSD Plan. People should never be discharged without notification of a relevant and appropriate person.

“I was totally confused, annoyed and frightened on what was going to happen with his care if he was discharged.”

What change to the Act do you think is required

LEA recommends the contact is revisited if at first the notification is unsuccessful within a period of no more than 3 days.

Theme 3

Children

LEA strongly supports that when performing a function under the Act, the best interests of the child must be a primary consideration, as well as regard given to the child's wishes and the views of the child's parent or guardian.

3.1 Mandatory notification to Mental Health Advocacy Service when child admitted as an inpatient to an adult ward

LEA strongly supports the amendment to the Act which would require mandatory notification to the MHAS when a child is admitted as an inpatient to an adult mental health ward, irrespective of when voluntary or involuntary.

What change to the Act do you think is required

Include mandatory notification to MHAS when a child is admitted to an inpatient adult mental health ward.

3.2 Restraint of children in non-authorised hospitals

Restraint of children under any circumstances should be the last resort irrespective of where the health care is provided.

LEA believes the issue is only stating 'in authorised facilities' and should change to be wherever mental health care and treatment is provided and this of course includes eating disorders. The same reporting and regulatory requirements must be observed.

What change to the Act do you think is required

- 1) LEA recommends the amendment of the wording, 'in authorised facilities' to wherever mental health care and treatment is provided.
- 2) The same reporting and regulatory requirements must be observed.

3.3 Segregation of children from adult inpatients

Inpatient units can be a frightening place for children and LEA notes the identified issues of consumers aged 16-24 years. We know that mental ill health/mental illness can be present in the earlier years of children aged under 18 and these children require specific and separate care in a child and adolescent mental health unit. Those from 18-24 are still vulnerable and should, wherever possible, not be admitted to an adult mental health facility; rather a youth mental health unit is a more desirable setting to protect them, staffed by youth-friendly and specifically trained staff.

LEA is of the view that this section is confusing as s303 is specifically relating to children admitted to adult wards. We recognise there are limited youth beds in W.A. contributing to the challenges of the experiences of consumers, families and carers.

What change to the Act do you think is required

Given the vulnerabilities, ages, and diagnoses, clear directions are required under the Act. LEA recommends an entirely new section needs to be written that more formally addressed the needs of children and adolescents within the mental health and suicide prevention system.

3.4 Off-label treatment for children

LEA notes the Chief Psychiatrist's 2019-2020 Annual Report around 13 notifications with the average age being 16 years.

We note the suggestion that section 304 of the Act be revoked. LEA strongly disagrees. We know that psychotropic medications, particularly anti-psychotics, have major effects on the physical health of young people, especially children.

LEA believes the protection, wellbeing and physical health of our children is of utmost importance, and the use of psychotropics as this section suggests, has minimal evidence to support the use in this age group.

Whilst we note the other mechanism such as the WA Therapeutics Advisory Group and existing standards and guidelines, this section references the lack of evidence, and we believe there is a risk not all practitioners will be across the requirements, leaving this provision as is, will add an additional layer of surety and confidence to families and supporters.

What change to the Act do you think is required

LEA recommends this section must stay to protect children and young people, practitioner practices, and confidence and surety for families.

Theme 4

4.1 Reporting of electroconvulsive therapy statistics

LEA does not support the removal of this section. We believe this will contribute to confusion between 'notifiable incident' (often considered by mental health services as a SAC 1 or sentinel event) and a 'serious adverse event' listed in this section of the Act (many of which would be considered as a SAC3). This may result in no or under reporting of effects and events.

What change to the Act do you think is required

LEA recommends this section must stay to ensure no confusion between 'incidents' and or 'events' and the need for reporting.

4.2 Application to the Tribunal to use electroconvulsive therapy

ECT can be a treatment of last resort for a consumer and/or their family or supporter. Many are fearful and if this is determined under the Act, it leave very little opportunity of the consumer to respond and provide informed consent amongst other things.

LEA strongly believes the Mental Health Tribunal MUST retain oversight of any compulsory ECT. Given the challenges with consumers receiving independent further or second opinion on their treatment options, this will result if they do not agree to the treatment, there is little or minimal opportunity to challenge decisions being made under the Act without their consent.

All decisions about ECT or any other treatment should be made with the consumer, their family member/supporter wherever possible, and leaving the decision in the hands of only a clinician does not represent empowerment or exercise of a consumer's rights.

LEA does agree to amend the Mental Health Tribunal to consider legal status when considering ECT for approval or otherwise.

What change to the Act do you think is required

LEA strongly supports the additional oversight of the Tribunal.

Theme 5

Mental Health Advocacy Service

From our consultations, we have heard that the MHAS is well-respected among consumers and carers, but people have raised the issue that they do not believe it is funded sufficiently to do its work. There

is a believe that, as such, the service relies on the goodness of the independent advocates to work beyond their formally recognised and paid hours, with insufficient payment for their services.

5.1 Engagement of advocates

Given the critical nature of this work, LEA agrees entirely with the suggested amendments to the Act to enable advocates to be engaged directly on a contractual basis by the Chief Mental Health Advocate.

What change to the Act do you think is required

Enable advocates to be engaged directly by the Chief Mental Health Advocate on a contractual basis allowing for the full-time, part-time, and casual contracts.

5.2 Chief Mental Health Advocate delegate

LEA is of the view that the Chief Mental Health Advocate should have assistance via a 'deputy' Chief Mental Health Advocate process.

What change to the Act do you think is required

LEA agrees with the changes as outlined, i.e., include a provision for the Chief Mental Health Advocate to appoint one or more mental health advocates as a Senior Mental Health Advocate who is delegated functions of the Chief Mental Health Advocate.

5.3 The term 'financial interest'

Ensuring the probity of actions relating to the Act is essential. Financial interests is one such example relevant to this area. However, LEA understands that, at present, the definition requires amendment. LEA supports adding a concise definition to the Regulations.

What change to the Act do you think is required

Add a concise definition of 'financial interest' to the regulations.

Theme 6

Mental Health Tribunal

Consumers and carers rely on the independent decision-making powers of the Tribunal.

6.1 Written reports for hearings

LEA believes that there is room for compromise in this section. We believe that a psychiatrist must submit a written report IF they are not attending the hearing in person.

We note the requirement for the psychiatrist to submit a current Treatment, Support and Discharge Plan (TSDP) and have concerns there is currently a poor rate of compliance with this requirement.

Furthermore, consumers should have access to and be provided with a copy of that psychiatrist's written report. Given the significance of impositions under the Act regarding a person's right of freedom of movement as a detained person and/or involuntary treatment, a person must have fair and equitable access to the appeal process. This discussion must be based upon full disclosure and reasoning of all involved, otherwise the Tribunal is unable to provide a fair hearing for a person without understanding all the facts. These facts would be provided in a report from their treating psychiatrist.

Providing a written report must be seen through the lens of fairness, facts, and in the person's best interest clinically, rather than the timeliness in providing a report, or indeed the failure to provide a report, being seen merely an administrative workload issue.

What change to the Act do you think is required

LEA believes strongly that a written report by a psychiatrist must be provided to the Tribunal even if they are not in attendance.

Theme 7

Interstate arrangements

7.1 Mutual recognition of mental health orders and interstate arrangements

LEA notes the current arrangements and the work that is progressing in this area nationally.

What change to the Act do you think is required

We agree with the suggestion of the provision of a descriptive definition on 'corresponding orders' from other jurisdictions.

Theme 8

8.1 Use of audio-visual communications under the Act

LEA considers there needs to be alternatives within the Act for face to face assessments where clinically indicated and necessary. Of note would be for Aboriginal people who may have cultural reasons for refusing to use these means (e.g., many believe a camera 'steals' their spirit) Further, additional considerations need to be made to allow for interpreters.

What change to the Act do you think is required

We note the text as 'clinically appropriate' and believe this should change as we have indicated above, to 'clinically indicated and necessary'

Theme 9

Select Committee Into Alternate Approaches To Reducing Illicit Drug Use And Its Effects On The Community

We note the recommendation made by the WA Parliament Select Committee *Help, Not Handcuffs: Evidence-based approaches to reducing harm from illicit drug use*.

9.1 Select Committee - Recommendation 41

LEA does not have anything further to recommend on this section; rather, we consider reference to the Select Committee's Report and the interpretation of actions will determine any changes to this section. As it stands, once the psychosis has been successfully treated and the person has recovered i.e., no longer meets the criteria, then it does not seem logical to further detain the person under an involuntary order. Every effort should be made to engage the person in psychoeducation and support to build self-care skills and capabilities once their mental health is stabilised sufficiently.

Theme 10

Clinical Governance Review

10.1 Mental health governance - legislate for Lived Experience partnerships

LEA considers lived experience partnerships within all governance areas are an essential criterion for all aspects of mental health service delivery, including oversight of the Act.

Part 3 s22 item 4A of the Disability Services Act 1993 (WA) states "*they are all persons who have disability, or knowledge of, and experience in, matters relevant to people with disability*". The key to this section is to enshrine the percentage of lived experience as the majority and LEA recommends a

minimum 75% as lived experience persons. We believe this provides a reasonable ratio of persons with a lived experience and clinicians, with one additional lived experience person.

Given the importance of the Act and the restrictions to people's freedom, choice and control, LEA would support the ratio being included in the Act. Furthermore, LEA also notes the remaining wording in the Disability Services Act 1993 which we support.

We do note however, that as the suggested process i.e., Ministerial Advisory Council refers to 'Advisory' LEA does not consider this to be a true reflection of governance.

LEA acknowledges the reference within this section to the Mental Health Executive Committee and the Community Mental Health, Alcohol and Other Drug Council has lived experience representation, however LEA considers the inclusion of one or two individuals is insufficient, lacks diversity, and therefore does not allow for experiences in a much broader context. LEA believes a greater ratio of lived experience persons to other members of these two committees, needs to be introduced to ensure the voices of people with a lived experience are central to the decision-making processes.

What change to the Act do you think is required

LEA recommends a stated ratio of lived experience persons to that of other members of committees is required.

Theme 11

Culture and Spirit of the Act

Being treated with dignity and respect, respecting the rights of persons to make decisions about their own treatment, care and support is essential to patient centred care, which also applies to the application of the Act. We heard inconsistencies regarding consumers families and carers receiving copies of their forms, suggesting improvement is needed in the provision of these.

"Nothing has changed. They still do things to us and for us, not with us. They don't talk to us."

"I have been engaging with mental health professionals for almost 30 years. I have never been spoken to like that, and I have never witnessed a psychiatrist speak to their patient in such a manner. It was rude, dismissive, and aggressive, and not conducive to collaborative and safe care."

We were fortunate to hear from one person who reported their experience in being detained as positive:

"This order saved my life on many occasions as I was extremely suicidal. Without these involuntarily enforcements I would have died. My psychiatrist was extremely caring and gave me all the facts. I was very grateful that that particular person cared for me as a human being."

1. Human rights of consumers, families, and carers.

LEA is concerned that with the origins of the 1996 Act, there seem to be no or minimal shift in the culture of mental health services. Coercive treatment, by its nature, violates the United Nations Convention on the Rights of Persons with Disabilities. We have heard from our consultations, there is a belief that clinicians still focus on risk and pharmaceutical-based treatment. We also note there are inconsistencies between practitioners on the provision, explanation and discussion on rights and the Charter.

"It needs to be explained more what the mental health act is once a person has de-escalated."

"(Psychiatrist) Explained my rights clearly. This included expectation of time and steps in assessing process"

We also question whether clinicians are aware of the Convention and the Charter and apply the rights of people adequately. We heard varying descriptions of the provision of rights and the Charter, and often, if given, was at a time of crisis (usually admission) when a person was unable to ingest the information. The provision of the Charter and rights needs to be repeated perhaps a few days after someone's mental distress has settled.

During some of LEA's consultations people talked about feeling disempowered by what they perceived as power and control over them, paternalistic approaches, lack of trust both clinicians and the system, and the ability to make their own voices heard.

"What I could have done with was a normalisation of where I was at. Self-hatred because I was needing this help. When I have been helped- someone who made me feel like I'm not stupid or weird for being this way. This is just another condition that can be treated, not a sign of your incompetence. It stops me from drowning in the shame."

"Don't write me up for effusing medication. I felt like I was bad at school and had done something wrong."

2. Trauma Informed Practice and awareness.

Our survey respondents spoke of the de-humanising experience of being placed under the Mental Health Act and spoke of feeling disrespected beyond their current circumstances. The experience of being detained can be exacerbated by any prior history of personal trauma. People with a trauma history speak to feeling they do not deserve any help and feel shamed and embarrassed when they find themselves forced into treatment. A natural trauma-response, from the consumer perspective, is to react, sometimes aggressively, to that intervention. We heard people ask if it was possible for all staff to be informed about trauma and be more understanding of our distress, rather than over-medicate, restrain, and control behaviour, which can lead to further trauma.

"Inability for medical professionals to see us as fellow human beings- it's as basic as that. All of us are one disaster, one trauma away from a mental health problem."

"I have a deep concern for bringing compassion, empathy, respect and dignity into the processes and addressing what I see as the gap between the Act and what happens after a person has been subject to it."

"Sometimes I'm not in a good space and make bad choices. It's the need to create the sense you can speak your truth and accepted as your truth an important. It's not railroaded onto the box they want to fit it in."

"I'm in a different frame of mind when it's all happening. Difficult to find your strength and act like this crazy mother. You got through the anger- how did this happen. That's your bit of trauma."

Family and carers spoke of experiencing their own trauma while witnessing their loved one not only being unwell, but also their observations of the way they, and their loved ones, were being treated. LEA encourages trauma-informed practices as being a requirement of the Mental Health Act, and those practices apply equally and equitably to the consumer and any family member or carer who is supporting them.

What change to the Act do you think is required

1. Information system (PSoLIS)

Ensure the Psychiatric Services Online Information System (PSoLIS) has all the required forms, all staff have access to PSoLIS, and the use of hardware such as iPads/tablets which

can be used at the bedside of the consumer allowing for the completion of the forms in collaboration with them, when it can them be immediately logged onto the system.

2. *Terminology*

LEA believes the term 'consider' should be changed to 'must apply'

3. *Reporting requirements and Forms*

We do not consider the reporting requirements and forms to be administrative exercises; rather, the receipt of these forms and reporting is central to preserving the rights of individuals. LEA is concerned that clinicians may consider these tasks to be a burden, however we believe the focus should be away from burden, to being accountable and providing necessary information to the consumer and carer to support recovery and therapeutic relationships.

4. *Administration and compliance*

LEA is of the view that the background has been rather an attempt to change culture and practice and hence we agree that these tasks have increased, yet we consider from reports during our consultations, that this has not been entirely successful. Having documents completed in a timely manner is essential. Further, we are concerned about completion of the documents without full interaction and involvement with the consumer. The Treatment, Support and Discharge Plan (TSDP) is a critical issue.

5. *Objects of the Act and Charter are being met*

Our consultations suggest the Mental Health Advocacy Service does a good job in having contact with consumers and investigating the physical environments where people are held, however reports indicate they are also left to explain the rights to consumers, their family, and carers. This is despite posters of the Charter and other rights being available in services, reports of consumers feeling unsafe to discuss or challenge these issues, because of perceived threats to their treatment and safety, which in essence is coercive practices.

Our respondents mostly reported not being aware of the Charter, did not recall receiving a copy of it, nor seeing it within the inpatient units they were in.

"A treatment approach that attempts to mitigate the shame and stigma around your situation would reduce the suffering so much."

What change to the Act do you think is required

There is a requirement for staff to discuss the Charter with the consumer on admission. This can also be re-discussed after the consumer has managed to 'settle/ stabilise' on the ward and is more able to process information. Naturally, there would also be the requirement the information is provided in a manner that is understandable to the consumer and their family and carer (including language, culture, and other disability requirements).

1. *What needs to be done better to ensure the Objects of the Act and Charter are being met*

LEA considers changing the wording from 'have regard' to 'must' apply.

Additional posters in each clinical interview room and the inpatient bedrooms, in other words greater awareness raising is needed to inform consumers, their family and carers. Additionally, ongoing training and education for clinicians by lived experience educators on what epistemic trust means from a consumer placed under the Act means, and why the Charter is needed to provide comfort to the consumer and their family and carers.

At this point also, a safe way to challenge real or perceived breaches of a person's rights is needed, noting the MHAS is limited in its capacity, with consumers not necessarily being aware of other avenues such as the Office of the Chief Psychiatrist, Health and Disability Services Complaints Office, Health Consumers' Council of WA etc.

LEA also believes there needs to be contained within the Act provisions for breaches of failure to comply with the Charter.

What change to the Act do you think is required

LEA recommends the appointment of a 'rights and concerns' officer in each service.

2. *Barriers to implementing change*

To bring about lasting change, LEA believes a move away from risk aversion to one genuinely focussed on patient centred/ led care is required. This gives consumers the right to made determinations in their own best interest, is strengths-based, empowers choice, control and changes the focus from providing treatment, care, and support 'for and to' to that of 'with' the person. Until there is a cultural change to embrace this, little will change.

We heard from our survey and interviews recognition of the limited funding and staff who appear over-worked and under pressure. While some described positive experiences, it appeared dependent upon an individual clinicians' efforts, rather than a system-wide approach to a culture of recovery and consumer and family/ carer led/centred practice. This does not require an investment of funding- rather an alternative approach to training, mentoring and support for clinicians.

"I am hopelessly caught in the revolving door of an inadequate mental health support system that can only "help" when I am at the extreme end of my mental health spectrum and then the most they can do is put me on yet another cocktail of medications."

"physicians that are overworked, stressed and have had to put their empathy on hold to just survive their jobs."

"the good physicians who can no longer watch the never-ending train wreck that is our health care system. Eventually they have to become immune to the plight of their patients"

"The Act seems akin to one person trying to manage multiple leaks in the dyke holding back flood waters."

"I have experienced in every aspect within the WA Mental Health Act as a Consumer for many years. I cannot complain From me being in hospital we have blocks from the locked wards of patients going to the open ward due to the fact that we have a lot of homeless people, alcohol, drug issues. No place for these people to go. A bag (sic) log occurs. No rehabilitations centres for drug and alcohol. So consequently that other people that don't have these issues find it hard to get in. This is not my experience. But I have viewed this happening."

Mention was also made of the value and the importance of the therapeutic relationship, and the constant staff changes and use of staff from other areas as being disruptive to their recovery. Having staff available to spend time with people was suggested; nurses were named as the most empathetic, yet seemed to lack the time to spend with individuals.

"It is about the staff- who's on, rather than the culture of the service."

The new locum Dr was calm, professional, and spent time talking to her in a beneficial therapeutic manner."

“My psychiatrist (sic). He was extremely caring and gave me all the facts. I was very grateful that that particular person cared for me as a human being”.

“Nobody ever had time to talk. All too busy.”

Extra concern was expressed when a consumer or carer asserted their right to be involved in their (or their loved ones) care. They were viewed as being ‘aggressive’, belligerent, non-compliant, or ‘difficult’.

“The practitioner needs to truly believe that even “people like me” can have insight into their condition and are not attention seeking or being deliberately belligerent and self-sabotaging”

“You Are Judged- straight away. If you do ask something- you are fobbed off. Nothing’s validated.”

What change to the Act do you think is required

Enable through the Act a review of the language and a real change in focus from doing ‘for and to’ to ‘with’ consumers would go a long way to cultural change for the betterment of consumers, families, and carers.

LEA understands people held under the Mental Health Act may have limited decision-making capacity in some areas of their lives. However, this does not necessarily mean that they are unable to contribute in some way to decisions made about their treatment and care. We strongly support the inclusion of ongoing conversations with the consumer, their family and carer/s regarding their care and support towards recovery. Supported decision-making requires staff to have more skills to work with consumers, within the capabilities of consumers at that time and stage of their lives.

11.1 Post-implementation review recommendation

Completion of information and forms which are about the treatment, care and support for consumers and carers should be a normal part of the business. In any other field of medicine, medical practitioners are required to ensure the safety of the patient, which includes quality record-keeping. The forms, communications and record-keeping are undertaken with timeliness and suitability in line with all and any policies/ law/ codes/ registration requirements.

LEA strongly believes that this should be just as applicable in the mental health sector as any other and to suggest these forms, which are designed for the protection of the consumer, is an administrative burden is not acceptable.

What change to the Act do you think is required

The use of lived experience educators through stages of university, early practice training and registration is essential. A cultural shift is required, interestingly this seems exactly why the forms were created. A shift away from compliance and risk management, to one of genuinely working with the consumer, their family and carers towards recovery is, LEA strongly believes, is the essence of patient centred and led care and recovery.

Part 2

LEA has provided comments to the amendments which we believe require some consideration. Those not mentioned below, we agree with.

Amendment 3 - Use of reasonable force with respect to a person on: a referral for examination by a psychiatrist, a transport order, or an apprehension and return order

Proposed Amendment: LEA has some concerns about the inclusion of 'a health professional at the place' who may not have received contemporary training in suitable manoeuvres, placing the individual at further risk of harm.

What change to the Act do you think is required

LEA recommends the text to change to 'a health professional suitably trained in containment manoeuvres at the place'

Amendment 5 - Provide for continuation of detention at a general hospital to allow for further examination by a psychiatrist

Many people are left sitting in an uncomfortable and often unsafe over-stimulating environment of an Emergency Department waiting for an assessment. The issue with this amendment is the timeliness of the assessment and the 24-hour maximum time we believe is a reasonable timeline.

Amendment 7 – Leave of Absence

What change to the Act do you think is required

LEA would like to see consideration given to an 'extended day leave' which would be we suggest over 6 hours.

Part 10

Amendment 9 – Transport orders

What change to the Act do you think is required

We would like to see the provision within the Act for the notification of the consumer's family and carers of any transportation.

Regarding transport, LEA understands a review of this service has occurred and yet to be published. In our survey and consultations, we heard commentary on the experience of consumers and carers, which we note here:

"It was traumatic and inhumane the way it was done. I had a safe way to take my son to the ED but it was not an option."

"I was advised my daughter would be transferred by Ambulance as she was now under the MHA, and this could take anywhere from 1 hour to 24 hours."

"The ED refused to assess my son because I had driven him there."

Part 11

Amendment 10 - Apprehension by police for assessment

What change to the Act do you think is required

LEA suggests a person must be seen within the current 4-hour period for initial examination in an ED however, we acknowledge this could become complicated because an initial consultation may not be comprehensive enough to determine ongoing apprehension etc.

This can reflect the extra challenges with insufficient mental health staff in ED's, and the waiting lists; a time limit of the 24 hours as per Division 3 of the Act would be acceptable.

Amendment 11 - Gender of person conducting search

This can be an ambiguous area even in the physical presentation of the person and their gender identity.

What change to the Act do you think is required

LEA believes it is the inherent right, and to protect the dignity of any person, to be asked who they would prefer to be searched by rather than an assumption made based upon external physical presentation.

Part 14

Amendment 13 - Emergency psychiatric treatment

What change to the Act do you think is required

Consider extending definition to a suitably qualified and registered health practitioner with a medical practitioner's authorisation.

Amendment 15 - Informing treating psychiatrist of seclusion or bodily restraint

What change to the Act do you think is required

Remove the term 'in due course' as this could be done via electronic communications (email) and should not add to the burden of reporting.

Amendment 17 - Voluntary Patients in locked inpatient mental health services

LEA has commented regarding this issue previously within this Submission but will reinforce the issue of 'control' that is, if a person request to leave a ward, this could be denied. Voluntary inpatients may leave a treatment centre at any time unless an inpatient treatment order then applies to the person.

What change to the Act do you think is required

Reference within the Act to state inpatient wards for voluntary patients must allow for the free egress and entry of the consumer, family, and carers.

Part 20

Amendment 20 - Timing of notifications to the Mental Health Advocacy Service

What change to the Act do you think is required

LEA is of the view that notification to the MHAS for children should be within 4 hours.

Part 21

Amendment 23 - Application to Mental Health Tribunal for provision of electroconvulsive therapy

LEA is of the view that such restrictive provisions are included in the Act for the protection of the consumer, and it gives them an alternative for decision-making. If this is removed from the Act, it suggests treatment can be given without opportunity for discussion or consideration by another external body.

Although it could be argued a person has the right to gain another opinion, this is also notoriously difficult to obtain, and is often in this case done by another practitioner who is supportive of ECT often as a first line of treatment.

LEA has difficulty in supporting a number of these amendments, we agree for the need for ECT specifications retained for the information of the Tribunal as it can be a person's choice to challenge a

decision made about ECT as a treatment methodology. By removing these provisions, while seeming restrictive to practitioners, it is about respecting the rights and wishes of a person.

It is acknowledged a person may seek another opinion; however, as previously identified, these are incredibly difficult to obtain, and are often done by a practitioner who is a supporter of ECT, therefore we do not believe it is sufficiently independent.

We recognise ECT can be an effective form of treatment for some individuals. This does not dismiss the ideal that a consumer and their family/ carer needs to be involved in the discussions and decisions about receiving this treatment. LEA supports the statement made by the MHAS, Tribunal, and the Chief Psychiatrist that any application for ECT must be supported by a person's treatment, support, and discharge plan which the consumer (and their family/ carer) has been involved in.

LEA also raises the issue of rTMS and whether now is the time for this to be provided for within this review of the Act given rTMS has been approved under certain criteria, for use with an applicable MBS item number. We believe it is timely to consider its inclusion.

Amendment 26 - Provide for a transcript of oral reasons delivered during a Tribunal hearing to suffice as compliance with a request for reasons

As the proposed amendment is currently written, it implies an oral version of the Tribunal's decision would be sufficient. LEA agrees the transcript should suffice as written information and the person should not have to go through any EOI process to obtain this transcript.

What change to the Act do you think is required

We recommend clarity around the wording of this proposed amendment.

Amendment 27 - Enable the Tribunal to correct any clerical mistakes, accidental errors, omissions, miscalculations, or defects of form, contained in its decisions or reasons

What change to the Act do you think is required

We agree; however, notification of any corrections must be provided to the consumer.

Part 23

LEA agrees with all amendments in this section.

Other Matters not addressed elsewhere

1. Recovery-oriented practice

Our respondents (consumers and family/carers) spoke of the treatment and care they (or their loved ones) received while held under the Act. Most reported a stabilisation based upon high levels of anti-psychotics (some reported they felt this was means to control behaviour), crisis management and stabilisation of symptoms rather than a focus on recovery skills for consumers which were based upon an individual's needs. One interviewee shared this harrowing experience:

"My distress from the revolving door- new locums every 3-4 months. Over 1 Year I saw 5 psychiatrists. Every time the medication changed. I was weaned off one and changed to another- requiring a hospital stay each time. I got to the place where I stopped listening. You don't understand the torture that goes into these medication changes."

From our respondents there was a view that over-medicalisation of mental health issues without taking heed of the necessity for providing consumers and carers with resources, education and

recovery-oriented practice will continue to be of detriment to individuals living as well as possible in the community and leading fulfilling lives.

LEA strongly supports true consumer centred/led care which takes a holistic approach to recovery.

"I was at the hospital every day and asking what was happening. There wasn't a lot happening, and nothing I could do. At the time I was thinking, he's safe, they're obviously doing some sort of therapy, and now what's next"

"Treatment tended to be a 'holding pattern' using medication and little genuine recovery work on the wards."

Peer Support is recognised as a necessary, cost-reducing, and evidence-based practice for recovery-oriented services (both consumer and family/carer peers). Respondents spoke of the power of lived experience and its ability to guide people through the experiences of involuntary treatment. There has been some success with the use of peer workers in Emergency Departments for those presenting with mental health issues. The uptake of peer workers within our inpatient units is still limited in scope, and LEA suggests the review of the legislation might include access to a peer worker for all consumers, families, and carers. This would progress the genuine choice required for people to succeed in their recovery.

2. Conflicting Opinions between Doctors

We heard people speak of being referred for assessment under a Form 1A, only to have a different psychiatrist disagree, and in some cases discharge a person without any treatment, support, or follow-up. While we would concur, this is in line with "least restrictive means", the completion of the 1A can lead to ongoing consequences for an individual.

"!!! So, one Psych says he is a risk - another says he is fine except he is jealous of other people and that fits in with his diagnosis"

"When you're under the control of a single psychiatrist- it's so wrong there's too much control and power for one person to write a 1A."

LEA has a focus on the private sector, however, we heard people speak of this from two angles:

- a) An individual in a private hospital being referred for assessment, despite there being no decline in their mental health or change to risk.

"She was placed under forms despite having had no change in risk"

- b) An individual being refused hospitalisation in a private hospital after they had been placed under a form 1A and had lived well for a long period of time. This has led to consequences for that man and his family.

"The (Private) hospital wouldn't take him because he had been on a 1A prior, even though the psychiatrist assured he was not a threat, no one would take him. It's like a little cross against his name forever."

Contact

LEA has been pleased to provide this Submission for consideration. We would welcome the opportunity for further clarification on any points raised and Lorraine Powell would be the first point of contact for you.



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Appendix One

Survey questions:

LEA MH Act submission- survey questions

Are you completing this survey as a:

Consumer

Carer/ Family member

Both

Survey questions

1. Were you placed under any of the following: (please tick all that are relevant to you)

Been involuntarily admitted (Admitted to hospital even though I didn't want to go there and told I couldn't leave without the doctor's permission - Form 6A)

Placed under a Community Treatment Order (CTO) (Told by the mental health service that I had to receive treatment and medication from them, even if I didn't want to see them- Form 5A)

Been held for assessment (Was taken to a community mental health clinic or hospital emergency department for assessment of my mental health, even though I didn't want this - Form 1A, 2 or 3A).

2. I received a copy of the form/s from the mental health service describing the reason for being held involuntarily

- Yes
- No
- Can't remember

3. Did you receive a copy of your rights under the Act

- Yes
- No
- Can't remember

4. Did you receive a copy of the Charter of Mental Health Care Principles

- Yes
- No
- Can't remember

5. Were your rights and the Charter given to you and explained in a way you could understand?

- Yes
- No
- If no- what would have helped

Please comment:

6. Do you believe your rights were respected and upheld?

- Yes
- No

Would you like to tell us more about what happened?

Please comment:

7. Did you have mixed experiences regarding your rights with different workers?

- Yes
- No

Please comment:

8. Was there any type of worker who was better at ensuring your rights were upheld? (ie nurse, psychiatrist, psychologist, other)

Please comment:

9. Did you understand where you could go to for help in understanding and upholding your rights?

Yes

No

10. If yes, did you access help?

Please comment:

11. If yes, where did you go?

Please comment:

12. Often, people are placed under the Act after attending an emergency department (ED).

Did you go to an ED?

Yes

No

13. How long were you there for?

Please comment:

14. How were you transported to the inpatient unit?

Personal vehicle

Police

Ambulance

Transport service

Other – please comment

15. Were things explained to you in a way you could understand at each step in your experience?

(please tick those relevant to you)

being taken to ED

Yes

No

N/A

assessment whilst there

- Yes
- No
- N/A

transfer to and arrival in inpatient unit

- Yes
- No
- N/A

16. Is there anything which would have made your experience better?

Please comment:

17. When a person is being held involuntarily for an assessment/ examination, there is a requirement that this happens within the first 72 hours (3 days) (form 1A). Did you:

Receive a copy of the form?

- Yes
- No
- Can't remember
- N/A

Receive an assessment within the 72 hours?

- Yes
- No
- Can't remember

If you didn't, how long did it take?

Please comment:

Did the doctor/ psychiatrist do the assessment in

- Person
- Over the phone
- Video conference or teleconference?

Please tell us about the experience

Under the Act, you have a right to request a second (further) opinion. Please tell us:

18. Did you request a second opinion?

Yes
No

19. If you also receive care from a private practice clinician/ psychiatrist/psychologist, were you able to have them included in this process?

Yes
No
N/A

20. If you requested a further opinion, how was that arranged and how long did it take?

Please comment:

21. Did you have trust and confidence in that second opinion?

Yes
No

22. Did anything change from the result of that second opinion?

Yes
No
what and/ or why? Please comment:

23. Is there another way you think a second/ further opinion could be obtained- how?

24. The Mental Health Act 2014 (Act) (s.185) states that any involuntary patient, or any person under a community treatment order (CTO) is required to have a treatment, support and discharge plan (TSD Plan).

25. Did you know there was a TSD Plan for your care?

Yes
No
Can't remember

26. Were you and/or your family/ carer included in the development of your plan?

Yes
No

27. Were your views and opinions included in the plan?

Yes
No
Partially (to some extent)

Please comment:

28. How long did it take for you (and your carer) to be aware of your TSD plan?

- Immediately
- Within a day
- 2-3 days
- longer

29. Was your TSD plan reviewed every three months?

- Yes
- No
- Don't know

30. Did you receive a copy of your TSD plan?

- Yes
- No
- Can't remember

31. Did other people who support you/ services you attend get involved in your TSD plan?

- Yes
- No
- Some
- All
- Don't know

32. Anything else you would like to tell us about your treatment support and discharge plan?

Please comment:

33. For many people, their ongoing mental health support is provided in the community, either by a private Doctor/ therapist/ psychologist or their GP, or both.

Tell us about how the involvement and communication between the team who has/ is treating you under the involuntary treatment order happens with your community-based practitioner.

Please comment:

34. Do you think you had enough time with the clinical staff to talk about things that were worrying you?

- Yes
- No

35. Do you have any other thoughts on the WA Mental Health Act and how it works or doesn't for you?

What is being done well, what would you like to see done differently, and what do you think supports or blocks changes?

Please comment:

36. For some, being placed under an order is a positive experience, or there are some positive experiences people have while being treated involuntarily.

Please tell us about something that was done well and you would like to see more of.

37. Do you have any other comments about the Mental Health Act 2014 review?

Please comment:

Thank you that now concludes this survey, BUT

Would you like to be interviewed by phone or zoom to discuss issues related to the WA Mental Health Act? (If so, Lorraine Powell LEA's Director and WA coordinator would speak with you)

No

Yes (please provide your name and email address below)

Would you like to enter the draw to win a \$50 gift voucher, please provide your details below:

Demographics

I live in:

WA

Outside of WA but I have been placed under the WA Act

Are you located in:

Metro

Rural

Remote

What is your Age range?

Under 16

16-25

26-32

33-40

55 and over

Gender identification

Male

Female

Non-binary

Other

Do you identify as Aboriginal or Torres Strait Islander origin?

Yes

No

Cultural background

What language do you mostly speak at home?

Again- thank you so much for your contribution- it is deeply appreciated. We also respect that this survey may have given rise to some anxiety or distress and encourage you to seek support if you need it. Here are some contacts:

Queerspace <https://www.queerspace.org.au/>

Beyond Blue <https://www.beyondblue.org.au/>

Lifeline 13 11 14

WellMob <https://wellmob.org.au/>

Sane Australia <https://www.sane.org/peer-support>