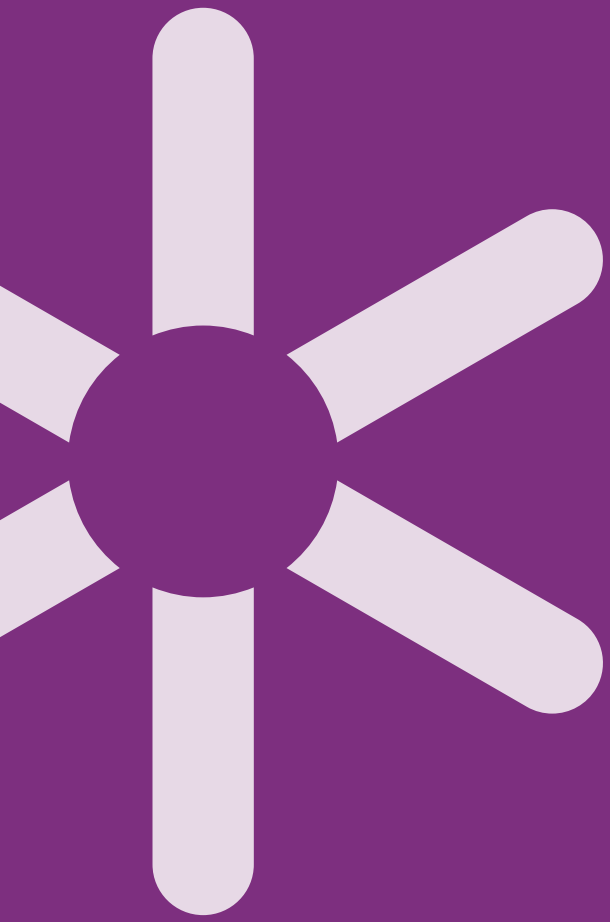
Chapter 3
Previously Identified Issues



> The changes we make here are to make the Act more useful for all involved… to get the best engagement for all stakeholders – consumers, carers and clinicians, so that the experience is as least traumatic as possible, and as most therapeutic as possible, all within that framework of rights

Previously Identified Issues

Since 2015, when the Act first came into operation, various issues have been brought to the Commissions' attention. These issues have either been identified via the post implementation review process, or by a variety of different stakeholders including: private individuals, other government agencies, health service providers, non-government agencies, and the statutory bodies established under the Act.

In this chapter, the issues raised have been grouped into themes with information provided on the relevant section of the Act and the background to the issue (including any suggestions for resolving the issue). A small number of issues do not have a suggestion for amendment.

Comment on any or all of the issues is welcomed.

If you are providing feedback on a Previously Identified Issues in this part:

Please indicate in your response (where possible):

- The issue number identified in the Discussion Paper (eg 3.1);
- Your view on the issue;
- If you think an amendment would assist, what would you suggest? Why have you suggested this?
- If you don't think an amendment would assist, what would you suggest? Could this issue be addressed through policies, procedures, guidelines and/or education?

Theme 1

Consumers

There have been eleven issues raised that come within this category, including the use of restraints in non-authorised hospitals, apprehension and return orders and referral and detention timeframes.

Note: In addition to the issues set out below, please remember that you can make any other comments about provisions relating to **consumers** in the Act.

1.1 Identifying Aboriginal and Torres Strait Islander status on the Approved forms

Section of the Act:
Currently not a requirement under the Act.

Background
The Act does not currently require recording whether a person identifies as Aboriginal or Torres Strait Islander. This has been raised as an issue because the Act sets out additional protections for persons who identify as Aboriginal or Torres Strait Islander (see parts 6 and 13 in relation to the involvement of Aboriginal mental health workers and Elders). The Mental Health Advocacy Service has identified that the provisions are not being complied with and overall Aboriginal or Torres Strait Islander people are not consistently being offered their rights (see footnote 6). This information would encourage and assist mental health services to comply with the Act and assist Mental Health Advocacy Service to provide better follow up to people who identify as Aboriginal or Torres Strait Islander and ensure that their rights are being observed.

This issue relates to the recommendations made through the post-implementation review which were subsequently considered by the Mental Health Data Management Group (Data Management Group) at the Department of Health. The Data Management Group noted that, as a result of the review of the State-wide Standardised

Clinical Documentation, the clinical assessment forms have been updated to include the following information:

- If the patient identifies as Aboriginal or Torres Strait Islander;
- if the patient was offered the involvement of a significant member of the person's community;

if they accepted that offer, or not.

These revised clinical forms are currently used in paper-based formats. These will be integrated electronically into the Psychiatric Services Online Information System.

The Data Management Group identified that there is already information recorded in the mental health online system which allows for the following information to be gathered and reported:

- The number of service contacts delivered by Aboriginal Mental Health/Aboriginal Liaison workers.
- The number and proportion of Aboriginal clients who have contact with community mental health services.
- The number of delivered Aboriginal Cultural Input, Traditional Medicine and Traditional Healer Service Event items by public community mental health services.

An amendment to the Act has been suggested which would require that information on whether a person identified as Aboriginal or Torres Strait Islander be recorded on the Act's Approved forms. There is another view that this issue may already be addressed through operational changes to clinical forms and that this requirement would result in duplication and unnecessary additional administrative tasks for clinical staff.

1.2 Inability to transfer a patient when on a Form 3C – Continuation Orders

Section of the Act: Part 6, sections 55 and 56.

Background

The Act provides for a person to be assessed and referred for an examination by a psychiatrist. In certain circumstances, a person can be detained to allow for the examination to take place, and in addition to this, a continuation order may be necessary to extend the period of detention. Continuation orders allow for a further examination to be made as to whether to treat a person as an involuntary patient. Continuation orders are not always necessary but are allowed under the Act.

The Act does not currently make provision for the transfer of a person on a continuation order to another authorised hospital. A concern has been raised that a person, while on a continuation order at one authorised hospital, cannot be transferred to another authorised hospital.

It has been suggested that the Act should be amended to allow for a person to be transferred between authorised hospitals while on a continuation order. It has also been highlighted that this was not a widespread issue across mental health services.

There is also a view once a person is at an authorised hospital, the examination by a psychiatrist should be completed at that authorised hospital and the person should not be moved around while their status under the Act is still to be determined.

1.3 Apprehension and Return Orders

Section of the Act: Part 7, section 99.

Background

Under the Act, an apprehension and return order is made where a person is absent without leave from a hospital or other place and there is no other safe means to return the person other than to make an apprehension and return order. The person in charge of the hospital (or other place), or a medical practitioner, are currently the only categories of persons authorised to make this type of order.

The Act requires that the person be returned to 'the hospital or other place specified' in the apprehension and return. This wording constrains police, who cannot take the person to any location other than the specified hospital or other place named in the ARO. Concerns have been raised that such a constraint may jeopardise the health of the person apprehended in regional areas who must be returned to a metropolitan mental health service, as set out in the apprehension and return order. For example, this means that, where a long journey is required to return the person to the specified place, the person would not have their mental or physical state reviewed regarding their fitness for transport back to the hospital or other place.

An amendment has been suggested which would allow the police or transport officer to take the person to the nearest hospital for assessment and if necessary, for treatment. However, there are questions around how

any change would operate in practice. For example, what will happen if the place the police want to take the person does not have staff or services that can meet the needs of the person? If changes are made, who should be responsible for ensuring that there is a suitable practitioner and services for the person if they are taken to the new location.

1.4 Restriction on freedom of communication

Section of the Act: Part 16, section 262.

Background

The Act requires services to inform the Mental Health Advocacy Service when an order is made restricting a patient's freedom of communication. However, it does not require a copy of the form documenting the reasons for the restriction to be provided to the Mental Health Advocacy Service. Providing the form would give the Mental Health Advocacy Service the nature of, and reasons for, the restriction.

It has been suggested that the Act should be amended to require that a copy of the form be provided to the Mental Health Advocacy Service. A legislative requirement will create a duty on the psychiatrist or the mental health service to provide the Mental Health Advocacy Service with a copy of the order. Another view is that this issue may have been resolved operationally as the Mental Health Advocacy Service can (by current agreement) access the form through the mental health online system

1.5 Voluntary inpatient rights (including older adult inpatients)

Sections of the Act: Part 16, Division 2, Subdivision 2 – Rights of inpatients generally and section 348.

Background

A concern was raised that older adults are primarily admitted as 'voluntary' patients to locked wards. For example, a person on a guardianship order under the Guardianship and Administration Act 1990 (GAA) may be admitted as a voluntary patient by consent of their guardian who may be a family member but be accommodated in a facility that has locked doors and as a result their freedom of movement is restricted, and they are in effect being detained. There is a concern that the GAA does not afford enough protection to the older adult, in contrast to the Act. For example, there is no independent review of the psychiatrist's decision by the Tribunal. This may also be an issue for other voluntary patients, not just older persons, if they are on a ward that is locked.

There is also concern that in some cases older adults are being held on locked wards with the approval of next of kin without a guardianship order. On the basis of 'least restriction' the person is held on the ward in this manner to the extent that they are 'compliant', but they may not know or fully understand their rights and do not have access to Mental Health Advocacy Service[11] advocates or review by the Tribunal.

It has been suggested that the Act be amended to provide that:

- It be expressly stated that voluntary inpatients have the right to freedom of movement and all that this entails (for example, to have the right to leave); and
- Older adults who are voluntary inpatients in locked wards should be 'identified persons' under the Act so they can also be assisted by the Mental Health Advocacy Service.

A related issue included at Amendment 17: Voluntary Patients in locked inpatient mental health services and it includes the proposed amendment:

- Amend Act to expressly state that regardless of whether a voluntary inpatient is placed in a locked or unlocked ward, a voluntary patient has the right to leave the ward and/or hospital at any time without permission. The proposed amendment could be based on similar wording in the Mental Health Act 2009 (SA).

Note: It would be useful to consider how any amendments would interact with the rights and obligations of a guardian appointed under the GAA.

[11] The definition of a private psychiatric hostel is set out in the Private Hospital and Health Services Act 1927 (PHHSA), which is administered by the Department of Health. Any amendment to the PHHSA sits within the portfolio responsibility of the Department of Health.

1.6 Restraints in non-authorised hospital wards

Section of the Act: Part 14, sections 227 and 228.

Background

This issue stems from discussions during the 2019 consultations with key stakeholders around the use of restraint during naso-gastric feeding of children with eating disorders. These children are treated primarily in non-authorised hospital wards as voluntary patients.

The provisions in the Act relating to the use of restraints only apply to authorised hospital wards and therefore cannot be applied to patients (adults or children, voluntary and involuntary) who may be restrained on wards in non-authorised hospital wards.

The stakeholders consulted in 2019 noted that there was also a broader issue around the use of restraint more generally of children and adults in non-authorised hospitals. Similarly, restraints in emergency departments are not covered by the provisions in the Act.

This issue does not have a suggested amendment. Your comments are welcome.

1.7 Private psychiatric hostel definition

Section of the Act: Private psychiatric hostels are defined in the Act by reference to the *Private Hospital and Health Services Act 1927*. That act defines a **private psychiatric hostel** as:

a. *private premises in which 3 or more persons who —*

b. *are socially dependent because of mental illness; and*

c. *are not members of the family of the proprietor of the premises, reside and are treated or cared for.*

Background

An issue was raised that, as step up/step down services do not come within the category of a private psychiatric hostel, consumers staying in them are not included as 'identified persons for the purposes of having access to the Mental Health Advocacy Service. A concern was expressed that consumers staying in step up/step down services may be just as vulnerable as residents in private psychiatric hostels and therefore should have the same automatic right to advocacy services.

Other types of supported accommodation, however, may also not meet the definition of private psychiatric hostel. For example, the Commission funds a number of services where two people are supported for 24 hours a day 7 days a week due to their complex condition and vulnerability (so are socially dependent and reside at the premises) but because they are less than 3 people in the one premises, they do not meet the definition. This means they do not have access to the Mental Health Advocacy Service advocates nor do they come within the definition of a mental health service and therefore within the jurisdiction of the Chief Psychiatrist.

Other new supported accommodation services are being developed aside from the step up / step down services which also may not meet this definition. Examples include government run (as distinct from private) transitional care supported accommodation services which would not come within the definition because they are not 'private' but the residents are likely to have complex needs and vulnerabilities.

Other views note that step up/step down services are quite different to private psychiatric hostels. For example:

- Step up/step down services are considered short term, transitional accommodation, with the maximum length of stay being 30 days and the average stay 7 – 14 days;
- Consumers are not residents and are required to have their own community accommodation (though this is expected to change in at least one step up / step down that is planned for youth);
- Consumers are required to be socially independent (noting that there are issues around what this means).

It has been suggested that the Act be amended to separately define hostels in some other way to allow for consumers staying in step up/ step down services and other supported accommodation which may or may not meet the definition in the Private Hospital and Health Services Act 1927 to be able to access the Mental Health Advocacy Service in the same way as residents of private psychiatric hostels do (that is, upon request of the person).

1.8 Definition of 'mental health service'

Section of the Act: Section 4.

Background

A 'mental health service' is defined in the Act to include: a hospital that provided treatment or care to people who may have a mental illness; a community mental health service; or any service that is prescribed by the regulations (no services have yet been prescribed). Private psychiatric hostels are specifically excluded in the definition except in relation to the Mental Health Advocacy Service and Chief Psychiatrist, but that definition is said to be outdated and not reflect contemporary services.

Under the Act the Chief Psychiatrist is responsible for the treatment and care of various categories of people including: all involuntary patients and all voluntary patients provided with treatment or care by a mental health service.

Treatment is defined in the Act as meaning the provision of a psychiatric, medical, psychological or psychosocial intervention. Care is not defined in the Act.

In recent years new types of services have been developed to meet the needs of the Western Australian community. While it is possible to have a specific service prescribed by the regulations as a mental health service, a broader issue has been raised to whether new services should be captured by the definition of 'mental health service' for the purposes of the Chief Psychiatrist's oversight.

This issue does not have a suggested amendment. Your comments are welcome.

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

Section of the Act: Part 6, various including sections 28, 44 and 45.

Background

Concerns were raised that there had been occasions where 'back-to-back' forms requiring a mandatory examination by a psychiatrist (form 1A) and detaining people (form 3s) had been completed (i.e. where a referral and detention orders are made and when they expire another set of orders are made). This has resulted in that person's lengthy detention for over 3 days in the metropolitan region, primarily in emergency departments. It is said that the time limits set by Parliament are therefore being rendered ineffective, and in some cases, based on the wording of the Act, the Act may also be being breached where a new detention order is made.

The Act sets out the framework and timeframes as follows:

- Section 44 - A referral for an examination by a psychiatrist remains in force for 72 hours from the time when the referral is made unless the referral is extended under section 45.
- Section 45 – Allows for one extension where the person is outside the metropolitan area.
- Section 28 states that a person cannot be detained for a continuous period of more than 72 hours where the referral is made is in a metropolitan area or 144 hours if the place where the referral is made is outside a metropolitan area. Section 28(11) also states that the person cannot continue to be detained if the referral expires before the person is taken to an authorised hospital or other place.

Other concerns were expressed that a person who needs referral and detention may be put at risk if there was a prohibition on making subsequent referral and detention forms in cases where a person was considered to meet the criteria under the Act and required examination by a psychiatrist. This issue is said to be exacerbated by the lack of available hospital beds and people having to wait days for hospital admission.

This issue does not have a suggested amendment. Your comments are welcome.

1.10 Further Opinions

Section of the Act: Sections 182,183 and 184

Background

The Act recognises that right to obtain a further opinion is an important one and safeguards this right by providing that a person, (or their nominated person, carer, or close family member), may request a further opinion if they are dissatisfied with the treatment that is being provided to them. People on community treatment orders may also request a further opinion on whether it is appropriate for the supervising psychiatrist to continue the community treatment order.

The Act currently requires that the patient's psychiatrist or, in some instances, the Chief Psychiatrist obtain the further opinion 'as soon as practicable' after receiving the request. Further opinions must be given in writing and kept on file. A copy must also be provided to the patient (and to the requesting person if it was requested by a person other than the patient, subject to the patient's consent). If the further opinion has been obtained by the Chief Psychiatrist, a copy must also be given to the patient's psychiatrist. A patient's psychiatrist 'must have regard' to any further opinion that is obtained, including regard for any recommendations made about the provision of treatment to the patient.

If a person is dissatisfied with the further opinion, the Act allows for the matter to be referred to the Chief Psychiatrist. However, the Act also provides for the patient's psychiatrist, or the Chief Psychiatrist, to refuse a request for an additional further opinion if the patient's psychiatrist or the Chief Psychiatrist believes that obtaining an additional further opinion is not warranted.

There have been concerns raised that there are often lengthy delays in obtaining a further opinion and that often the further opinion does not have the appearance of being truly independent of the mental health service where the person was being treated because the psychiatrist providing the further opinion is from the same mental health service.

A Mental Health Advocacy Service report in 2017[12] (and various subsequent Mental Health Advocacy Service annual reports) noted that neither the Act nor the Department of Health's Operational Directive on further opinions were being complied with and that it was difficult to get someone from outside the hospital, where the person was being detained, to prepare the further opinion.

In early 2018, the Department of Health completed an internal Further Opinions Impact Study (Study). The aim of this internal Study was to better understand and evaluate the operational impacts (on health services) of further opinions requested in accordance with the Act. However, the Department of Health's ability to conduct meaningful analysis and produce insights was constrained by data quality issues which were due to inconsistent recording of data by health services. In the end, data sourced from the Mental Health Advocacy Service, together with data obtained through a survey of psychiatrists conducted by the Department of Health, and partial activity data, was used to produce a limited assessment of the impact of requests for further opinions and some of the specific objectives of the impact study were not achieved.

This issue does not have a suggested amendment. Your comments are welcome.

1.11 Treatment, support and discharge plans

Section of the Act: Sections 185,186, 187 and 188.

Background

The Act provides that a person on an involuntary order has a right to be involved in the preparation and review of a treatment, support and discharge plan. Treatment, support and discharge plans must be prepared 'as soon as practicable' after a person is placed on an involuntary order and be reviewed and revised as necessary. The Act also provides that a patient or other interested person can apply to the Mental Health Tribunal (Tribunal) to issue a service provider with a compliance notice for non-compliance with a 'prescribed requirement' of the Act. A prescribed requirement includes ensuring that a patient's treatment, support and discharge plan is prepared, viewed or revised.

During 2017, the Mental Health Advocacy Service conducted an inquiry into treatment, support and

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

discharge plans which was published in 2018[13]. The inquiry concluded that the requirement for treatment, support and discharge plans were not being fully complied with by mental health services. The inquiry noted that a contributing reason for this included that clinicians were unaware of the requirements of the Act. Subsequent Mental Health Advocacy Service annual reports have continued to note poor compliance with respect to treatment, support and discharge plans. In the Tribunal's 2019-20 Annual Report, it was noted that there were no compliance notices issued by the Tribunal. However, the Tribunal did issue 18 recommendations to psychiatrists to review a patient's treatment, support and discharge plan[14] to sure that it fully complied with the Act and the Chief Psychiatrist's guidelines[15].

This issue does not have a suggested amendment. Your comments are welcome.

Theme 2

Personal Support Persons

"Carers, family members and support people are a crucial part of the team, and their perspective is just as important"

Under the Part 2, section 7 of the Act a personal support person includes the guardian or enduring guardian of an adult, the parent or guardian of a child, a close family member, a carer, or a nominated person. This issue relates to rights for personal support persons, and specifically to a psychiatrist's decision not to notify a personal support person.

Note: In addition to the issues set out below, please remember that you can make any other comments you like about provisions relating to **personal support persons** in the Act.

2.1 Decision not to notify personal support person

Section of the Act: Part 9, section 140.

Background

A concern was raised that a decision not to notify a personal support person could have a major impact on a patient and further that they need to be informed, as soon as possible, about their rights.

Section 140(1) of the Act requires that the person responsible for notification of a notifiable event, which are set out in Schedule 2 of the Act, must ensure that, as soon as practicable after the event occurs, that any carer, close family member, or other personal support person of the person is notified.

Sections 142 (1) and (2) of the Act provide that notification is not required if the medical practitioner or authorised mental health practitioner or psychiatrist determines that notification is not in the best interests of the person. In such cases, the person responsible for notification must, as soon as practicable, file a record of the decision and the reasons for it, and provide a copy to the Chief Mental Health Advocate.

It has been suggested that the Act be amended to require notification to the Chief Mental Health Advocate within 24 hours, rather than 'as soon as practicable'. Another view is that imposing a specific timeframe will increase the administrative workload on clinicians.

Theme 3

Children

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 the objects of the Act. In addition, section 303 refers to the importance of protecting the safety of a child while they are a patient in hospital specifically where they are admitted to a service which also admits adults.

[13] https://mhas.wa.gov.au/assets/documents/Treatment-Support-and-Discharge-Plans-TSD-PLANS-Inquiry-final-report-March-2018.PDF
[14] https://mhas.wa.gov.au/assets/documents/Treatment-Support-and-Discharge-Plans-TSD-PLANS-Inquiry-final-report-March-2018.PDF
[15] https://www.mht.wa.gov.au/wp-content/uploads/2020/09/FINAL-MHT-Annual-Report-2019-20-V4.1.pdf

Various issues that have been raised with the MHC that relate to the rights of children under the Act[16]. These include issues such as access to advocacy, reporting obligations in relation to the use of off-label treatment for children and the reporting requirements for children admitted as inpatients to adult mental health services.

Note: In addition to the issues and questions set out below, please remember that you can make any other comments you like about provisions relating to **children** in the Act.

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

Section of the Act: Part 20, section 357.

Background

As part of the post-implementation review recommendations, number 40 stated that the Commission would consider an amendment to the Act requiring the Mental Health Advocacy Service be notified of any child placed on an adult ward.

Through the post-implementation review, a concern was raised that not all children admitted as inpatients receive an automatic visit from an advocate from the Mental Health Advocacy Service. Section 357 of the Act currently requires the Mental Health Advocacy Service to visit or contact all children who have been placed on an involuntary order within 24 hours of that order being made. Services are required to notify the Mental Health Advocacy Service of involuntary children.
Children who are admitted as voluntary inpatients may request contact by the Mental Health Advocacy Service pursuant to a Ministerial Direction under the Act who are then required to visit or make contact within a reasonable time after the request has been made (however notification of the Mental Health Advocacy Service is not mandatory).

It has been suggested that the Act be amended to require mandatory notification to the Mental Health Advocacy Service when a child is admitted as an inpatient to an adult mental health ward, irrespective of whether the child is admitted as a voluntary or involuntary inpatient.

3.2 Restraint of children in non-authorised hospitals

Section of the Act: Not covered in the Act. The suggested amendment is to Part 14, section 227.

Background

A concern was raised about the lack of regulation around the use of restraint during naso-gastric feeding of children who have eating disorders and who are admitted to a general hospital. Most children receiving inpatient treatment for eating disorders are not treated in authorised hospitals but to a general hospital medical ward and most are admitted as voluntary patients.

The Act regulates certain treatments and interventions, including the use of restraint, where that use occurs in an authorised hospital. Section 228 of the Act sets out principles that apply when using restraints. The use of restraint must be carried out in accordance with various requirements in the Act, including requirements around monitoring, recording and reporting. These provisions apply to both adults and children in authorised hospital wards and apply whether those adults and children are voluntary or involuntary patients. They do not apply in non-authorised hospital wards such as general hospitals.

It had been suggested that the Act be amended so that the provisions for restraining a person under section 227 also apply to children receiving treatment for eating disorders in non-authorised hospital wards. However, initial discussions of this proposal raised the related issues of management of eating disorders in both children and adults, as well as the use of restraints more generally for children and adults who are inpatients in a non-authorised hospital. Background information on this issue is available at the footnote below[17].

This issue does not have a suggested amendment. Your comments are welcome.

[16] It was proposed, during the 2019 consultations, that the categories of persons the subject of the Ministerial Direction, and some other categories, should be formally incorporated into the Act as an amendment. These categories of persons may access the Mental Health Advocacy Service upon request. This forms part of the Proposed Amendments discussed in chapter 4.

[17] http://www.nmahsmh.health.wa.gov.au/services/statewide_WAEDOCS.cfm

3.3 Segregation of children from adult inpatients

Section of the Act: Part 18, section 303.

Background

Section 303 is a protection under the Act which requires certain things to occur when a child is admitted to an inpatient mental health service that also admits adults. When considering and applying section 303, the person in charge of the inpatient mental health service must first be satisfied that:

- the mental health service can provide the child with treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual beliefs; and
- the treatment, care and support can be provided to the child in a part of the mental health service that is separate from any part of the mental health service in which adults are provided with treatment and care if, having regard to the child's age and maturity, it would be appropriate to do so.

If a decision is made to admit the child as an inpatient, a written report must be provided to the child's parents which confirms the reasons why the person in charge is satisfied that admission can be done in accordance with the requirements set out in section 303. A copy of the report must be filed, and another copy given to the Chief Psychiatrist.

Youth inpatient mental health units cater specifically for children and young people aged 16 – 24 years. These units have been developed in recent years to better meet the needs of the Western Australian community. As a result, youth inpatient mental health units have some patients who are children (up to 18 years of age), and others who are adults (between 18 – 24 years of age).

In 2019, the Commission and the Chief Psychiatrist looked into the operation of section 303 in relation to these youth inpatient mental health units. This process clarified that section 303 applies to any child admitted to any inpatient mental health service where adults are also admitted. This includes services such as the youth inpatient mental health units. As a result, the Commission and Chief Psychiatrist worked with health service providers to ensure understanding of the reporting responsibilities under section 303 but it was noted that the scope and application of section 303 required clarification and that this would be undertaken through the Review.

The Commission is seeking to consult stakeholders on what amendment, if any, is needed to accommodate initiatives such as youth inpatient mental health units in the Act. For example, the Queensland Mental Health Act 2016 (Qld) expressly excludes child and adolescent units from certain notification requirements similar to that of section 303[18].

One suggestion has been to amend the Act so that youth inpatient mental health units are excluded from being required to comply with section 303 reporting requirements.

3.4 Off-label treatment for children

Section of the Act: Part 18, section 304.

Background

A medication is described as being used for an 'off-label' purpose, if the Therapeutic Goods Administration has not been asked to evaluate the use of the drug for the proposed purpose. This does not mean that the use has been rejected by the Therapeutic Goods Administration. For example, medication approval and registration are often not specifically sought for children, and as a result, children often receive medication that has only been formally approved by the Therapeutic Goods Administration for adults. There are no general requirements to report off-label prescribing in any patient population. These requirements are mandatory for industry (such as manufacturers) and encouraged for prescribers.

The Act currently requires that when an off-label treatment is provided to a child who is an 'involuntary patient'. A record must be retained, and a copy provided to the Chief Psychiatrist. The Act also requires the Chief Psychiatrist to report this information in the annual report.

[18] *Mental Health Act 2016* (Qld), section 231 sets out an obligation to notify the public guardian if a minor is admitted to a high security unit; or an inpatient unit of an authorised mental health service, ***other than a child and adolescent inpatient unit.*** (Our emphasis). A 'child and adolescent unit' means an inpatient unit of an authorised mental health service that provides treatment and care only to minors or young adults. Example – an inpatient unit of an authorised mental health service that admits only minors, or patients between 16 and 21 years.

The Chief Psychiatrist's annual report for 2019-20 noted that: *for the reporting period, there were 13 notifications about children who were involuntary patients and received off-label treatments, which is less than the number of notifications received in the previous financial year. Most notifications were from mental health services in the metropolitan area. The average (mean) age of involuntary children provided with an off-label treatment was 16 years*[19].

At the time the Act was introduced, the rationale for section 304 was that it would ensure that off-label treatment was not provided to children in circumstances where it is not warranted and also to promote transparency[20].

It is noted that health professionals have a responsibility to prescribe the most effective and safe treatment for their patients. As such, off label does not imply an improper, illegal, contraindicated or investigational use. The off-label use of medicines for children and adolescents is a common and important issue for prescribing practice across child and adolescent psychiatry, paediatrics and primary care. There is a need to ensure that clinicians when prescribing off label are doing so in a safe and considered way with consideration of the various clinical guidelines that are available.

There is a view that section 304 does not meet the goal of improving the safety and quality of prescribing of psychotropics to all children and adolescents receiving treatment in Western Australia since section 304 only refers to off-label treatment provided to children who are involuntary patients. It is also the Chief Psychiatrist's view that oversight of off-label treatment provided to children is best achieved through the safety and quality mechanisms of the West Australian Therapeutics Advisory Group and existing standards and guidelines.

It is suggested that section 304 of the Act be revoked.

[19] https://www.chiefpsychiatrist.wa.gov.au/chief-psychiatrists-annual-report-2019-2020/ , page 53.
[20] Explanatory Memorandum to the Act (paraphrased).

Theme 4

Regulation of Certain Kinds of Treatment

Section 192 of the Act describes electroconvulsive therapy as a treatment involving the application of an electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent.

There are two issues that have previously been raised with the Commission that relate to the the use of electroconvulsive therapy under the Act: reporting serious adverse events as part of electroconvulsive therapy statistics reporting requirements in the Act, and applications to the Tribunal regarding electroconvulsive therapy.

Note: In addition to the issues set out below, please remember that you can make any other comments you like about the provisions relating to **electroconvulsive therapy in the Act.**

4.1 Reporting of electroconvulsive therapy statistics

Section of the Act: Section 201.

Background

It has previously been noted that aspects of the reporting requirement under section 201 of the Act creates duplication, as death or serious negative outcomes associated with electroconvulsive therapy are already reported as a notifiable incident to the Chief Psychiatrist, pursuant to section 526 of the Act, in an approved form[21].

It has been suggested that this duplication in the Act be removed by amending section 201.

[21] Form 13, available from the Chief Psychiatrist's office. At the time of writing, Form 13 captures the definition of ***serious adverse even***t as set out in section 201, and further provides explanatory details.

4.2 Application to the Tribunal to use electroconvulsive therapy

Section of the Act: Part 21, Division 6.

Background

In certain circumstances, including where the patient is a child aged between 14 and 18 years and where the patient is an adult who is an involuntary patient (or under the Criminal Law (Mentally Impaired Accused) Act 1996), a psychiatrist may apply to the Tribunal for approval to perform electroconvulsive therapy. Under section 410, the written application must include a treatment plan, including where the electroconvulsive therapy will be provided and the minimum period that it is proposed to elapse between any two treatments (amongst other things).

A suggestion has been made that in addition to the above, the Tribunal should also be required to consider, at the time of the electroconvulsive therapy application, whether the involuntary patient is still in need of an involuntary order (Tribunal may already consider this issue if they choose to. The amendment would require them to consider it).

A further proposal has also been made that the requirements set out under section 410 be removed altogether on the basis that these are clinical considerations that should be left for clinicians to determine. An alternative view is that such matters should have the additional oversight of the Tribunal.

Theme 5

Mental Health Advocacy Service

The Mental Health Advocacy Service provides advocacy services and rights protection to identified persons. The main category of identified persons are those who are detained or subject to an involuntary treatment order under the Act. The Mental Health Advocacy Service is obliged to make contact or visit these persons people within certain timeframes set out in the Act. The focus is to ensure that these people are aware of their rights under the Act.

Various issues that have previously been raised with the Commission that relate to the Mental Health Advocacy Service. There are three issues in this chapter: the first two relate to administrative issues such as how the Mental Health Advocacy Service appoints advocates, and how the Chief Mental Health Advocate delegates powers to senior advocates. The third issue relates to clarifying the term 'financial interest' as it relates to the Mental Health Advocacy Service.

Other categories of 'identified persons' are those who are residents of private psychiatric hostels, and certain categories of children who are voluntary patients. Again, the focus for the Mental Health Advocacy Service is to ensure that these people are aware of their rights under the Act. The Mental Health Advocacy Service does not take the place of other mental health services which provide a range of care and support to people.

Note: In addition to the issues set out below, please remember that you can make any other comments you like about the provisions relating to the **Mental Health Advocacy Service**.

5.1 Engagement of advocates

Section of the Act: Section 350.

Background

Currently, the Act provides that mental health advocates are to be engaged by the Chief Mental Health Advocate under a contract for service, as independent contractors and not as employees. This means, for example, that advocates cannot be paid for leave and must supply their own 'tools'.

In order to assist the Mental Health Advocacy Service with its operations, it has been suggested that the Act be amended:

- to enable advocates to be engaged directly by the Chief Mental Health Advocate on a contractual basis allowing for full-time, part-time and casual contracts; or
- to state that mental health advocates must be appointed by the Chief Mental Health Advocate and leave the Act silent on the contractual terms.

5.2 Chief Mental Health Advocate delegate

Section of the Act: Section 350.

Background

Currently, the Act does not allow for senior mental health advocates to be appointed. In practice, the Chief Mental Health Advocate currently delegates certain advocates with specific functions of the Chief Mental Health Advocate as determined by the Chief Mental Health Advocate. These advocates are then designated as senior mental health advocates. The senior advocate role differs from that of an advocate as they carry out less field work and essentially acts as a deputy Chief Mental Health Advocate.

It has been suggested that the Act be amended to 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 as determined by the Chief Mental Health Advocate'.

5.3 The term 'financial interest'

Section of the Act: Section 373.

Background

Section 373 of the Act provides that a mental health advocate may not provide their functions as an advocate to a person receiving care or treatment by a body or organisation the advocate has a financial interest in. This disqualification extends if a person closely associated with the advocate has a financial interest in the body or organisation.

The term 'financial interest' is not defined in the Act. It has been suggested that this lack of definition creates uncertainty for the Mental Health Advocacy Service. For example, if the term 'financial interest' is construed very broadly, then an advocate would be unable to provide a service to a person who is an inpatient in a mental health ward of a hospital where the advocate's partner is working in another part of that hospital unrelated to the mental health ward.

However, section 373 already provides for certain types of financial interest to be excluded by prescribing them in the regulations, (although none are currently prescribed). The possible solution to this issue may be for the Commission to progress amendments to the regulations exempting certain 'financial interests'.

Theme 6

Mental Health Tribunal

The Mental Health Tribunal (Tribunal) is an independent decision-making body that reviews each involuntary treatment order made by psychiatrists. The purpose of the Tribunal's review is to determine whether the patient needs the involuntary treatment order.

Note: In addition to the issue set out below, please remember that you can make any other comments you like about the **Tribunal** provisions in the Act (or any other aspect of the Act).

6.1 Written reports for hearings

Section of the Act: Will require additional provision in Part 21 – Mental Health Tribunal.

Background

It has been suggested that a requirement be added to the Act to allow the Tribunal to require the treating psychiatrist of an involuntary patient to prepare and submit a written report prior to a Tribunal hearing.

There is another point of view which highlights that psychiatrists (or a clinical person) already usually attend hearings, noting that the Tribunal reported in its annual report for 2019-20 that psychiatrists attended 64% of hearings, and psychiatric registrars attended at 34% of hearings (either with a psychiatrist or alone).[22] There is a concern that requiring the writing of an additional report will impose additional administrative workload on clinicians.

[22] https://www.mht.wa.gov.au/wp-content/uploads/2020/09/FINAL-MHT-Annual-Report-2019-20-V4.1.pdf

Theme 7

Interstate Arrangements

Part 24 of the Act provides for interstate arrangements and agreements with other jurisdictions. Currently, in order for these arrangements to occur the Act requires that 'corresponding laws' be prescribed in the regulations and that there be intergovernmental agreements between the jurisdictions involved before such arrangements can be in place.

Due to each state and territory having their own mental health legislation the solution to this issue is complex. The most cohesive response would be a national one. There is currently work being done nationally to resolve this issue.

7.1 Mutual recognition of mental health orders and interstate arrangements

Section of the Act: Part 24.

Background

As part of the post-implementation review recommendations, number 45 noted that the Commission would progress necessary amendments to allow for interstate arrangements. This aligned with Action 26 of the Fifth National Mental health and Suicide Prevention Plan which commits all Australian governments to improve consistency across their mental health legislation.

To progress post-implementation review recommendation 45, the Commission commissioned a report on interstate arrangements in under the Act and in other jurisdictions (both in Australia and overseas), noting that the Act requires that 'corresponding laws and orders' be prescribed in the regulations and that there be intergovernmental agreements between the jurisdictions involved, before such arrangements can place.

The Report identified that arrangements between states/territories in Australia are particularly complex because each jurisdiction has its own mental health legislation, with each using different terminology and criteria. There are also significant differences between the jurisdictions as to their processes for the interstate movement of consumers on civil mental health orders. In addition, several jurisdictions, including WA, currently do not have operational interstate arrangement, while other jurisdictions did have some arrangements in place, but these were not comprehensive or consistent across jurisdictions. The Report also noted that Queensland and South Australia had reviewed their legislative provisions in this area and removed the requirement for intergovernmental agreements. The Report concluded that interstate arrangements between the states and territories would continue to be fragmented, even for those states and territories, unless a national approach was undertaken to resolve this issue.

Nationally, there has been broad agreement between the states and territories that a national legislative scheme is the preferred approach to mutual recognition of mental health orders.

A National Mutual Recognition Project (NMRP) is now currently progressing this work. The NMRP team is planning to deliver the model legislation to the Health National Council Reform Committee[23] by the end of 2021. It will then be up to individual states and territories to ensure that the model legislation around mutual recognition of mental health orders passes through their own legislative processes.

A related issue included in Chapter 4, Amendment 36: Interstate arrangements for mental health orders includes the proposed amendments:

1. Amend the definition of 'corresponding law' to include a descriptive definition. Currently the definition requires corresponding laws to be declared by the Regulations. This may cause delays when corresponding laws change and can therefore delay interstate movements.
2. Provide a descriptive definition of 'corresponding orders' from other jurisdictions.

[23] Formerly the COAG Health Council.

Theme 8

Audio-visual Communication

Audio-visual (AV) communication can be used by a mental health practitioner to conduct an assessment under the Act.

Note: In addition to the issue and questions set out below, please remember that you can make any other comments you like about the use of **AV communications** under the Act.

8.1 Use of audio-visual communications under the Act

Section of the Act: Sections 48 and 79.

Background

In 2020, and in order to deal with the public health challenges arising from the COVID-19 pandemic, the Mental Health Infection Control Directions (Directions) were issued pursuant to the *Public Health Act 2016*[24]. The Directions require practitioners (including psychiatrists) to use infection control measures when assessing or examining a person for the purposes of the Act. (An assessment may lead to a formal referral for examination by a psychiatrist, and possibly a detention order to allow that examination; while an examination may lead to a person being placed on an involuntary order). Options for Infection control include the wearing of personal protective equipment, physical distancing, physical barriers or audio-visual communication. The practitioner is to determine which infection control measure is appropriate in the circumstances. One of the infection control measures available is audio-visual communication. The Directions also require that where a practitioner is required to self-isolate for any reason, they must use AV communication as the infection control measure when carrying out an assessment or examination. To resolve the conflict between the Directions and the Act (which requires assessments and examinations to be conducted in person, except in non-metropolitan areas), modifications to the Act were made through the *COVID-19 Response and Economic Recovery Omnibus Act 2020*. These modifications to the Act are limited in duration and will cease when the Directions or replacement Directions cease to have effect.

During consultations on these modifications, stakeholders raised the issue that there are a range of other circumstances where AV communication may be necessary when conducting an assessment or examination under the Act. This may include, but is not limited to, situations where there is a shortage of psychiatrists or practitioners in a particular metropolitan area. Requiring face to face assessments and examinations where there is shortage may negatively impact on the timeliness of treatment and care for people.

Other states have statutory provisions which allow for clinicians to use AV communication in some circumstances. For example, the Queensland legislation provides that an assessment or examination may be done using AV if the person doing the assessment or examination considers it clinically appropriate.[25]

It has been suggested that the Act be amended to allow for AV communications to be used for assessment and examination under the Act where it is not practicable to assess or examine the person face to face, and where the use of AV communication would be clinically appropriate. The decision to use AV communication would be at the discretion of the person carrying out the assessment or examination. This should include considerations for including a personal support person (notably one that is culturally appropriate) during the assessment or examination.

[24] The Directions were updated in August 2020, see https://www.wa.gov.au/sites/default/files/2020-09/D19-CHO%20Mental%20Health%20Infection%20Control%20Directions%20%28No.2%29-V4-Final-310820-%28SIGNED%29.pdf

[25] *Mental Health Act 2016* (Qld) s 795.

Theme 9

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

A recommendation made by the WA Parliament Select Committee into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community, Help, Not Handcuffs: Evidence-based approaches to reducing harm from illicit drug use (Select Committee).

9.1 Select Committee - Recommendation 41

Section of the Act: Consideration of how the Act applies in particular situations.

Background

The Select Committee made the following finding and recommendation:

Finding 93: Psychiatrists are interpreting the Act differently, and there is a lack of clarity around how these provisions should apply to people experiencing drug-induced psychosis.

Recommendation 41: The Commission clarify through the statutory review of the Act how and when the Act can be used to detain people experiencing drug-induced psychosis who may not also be mentally ill.[26]

The recommendation requires additional research and work to be done on this issue, noting that evidence given to the Select Committee noted that the Act can already be applied to a person with drug-induced psychosis during those periods when the criteria under the Act was met. However, the competing demands of 'least restrictive alternative' under the Act, also mean that a person cannot be detained or be under an involuntary order once they no longer met that criteria.[27]

This issue does not have a suggested amendment. Your comments are welcome.

[26] https://www.parliament.wa.gov.au/Parliament/commit.nsf/(Report+Lookup+by+Com+ID)/76DC63572B331E7F482584BE00219B5F/file/id.alt.191111.rpf.final.xx%20web.pdf

[27] Above, at pages 162 – 164 which sets out the evidence on which Finding 93, and Recommendation 41 were made.

Theme 10

Clinical Governance Review

This theme sets out a recommendation that was made to the panel conducting the Review of the *Clinical Governance of Public Mental Health Services in Western Australia* (Clinical Governance Review)[28].

10.1 Mental health governance - legislate for Lived Experience partnerships

Section of the Act: Requires new provisions.

Background

In the Clinical Governance Review the panel noted submissions made to it regarding the clinical governance and clinical leadership for mental health services:

Further suggestions to strengthen the genuine representation of people with lived experience were made in the joint submission by WAAMH [Western Australian Association for Mental Health] and CoMWHA [Consumers of Mental Health WA]. This suggested a model of state-wide mental health governance through either new legislation or via amendment of the Mental Health Act 2014 (WA). Key goals of this legislation would be provision of functions similar to the Disability Services Act 1993 (WA). Considerations could include a Ministerial Advisory Council for People with Lived Experience reporting to the Minister for Mental Health, but with a quota to provide for majority lived experience representation (similar to the Disability Services Act 1993) and a new Mental Health Commission Board with a quota to provide for majority representation by people with lived experience.[29]

[28] Clinical Governance Review dated October 2019, published 4 March 2020: https://ww2.health.wa.gov.au/Reports-and-publications/Review-of-the-clinical-governance-of-Public-Mental-Health-Services
For information on the provisions of the *Disability Services Act 1993*, see: https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42879.pdf/$FILE/Disability%20Services%20Act%201993%20-%20%5B04-e0-02%5D.pdf?OpenElement See Part 3 for the provisions relating to the establishment of the Ministerial Advisory Council on Disability.

[29] Ibid, p25.

The Clinical Governance Review did not adopt this submission, but it did make other recommendations which has led to new governance arrangements being introduced for mental health, alcohol and other drug services in Western Australia.

The Mental Health Executive Committee (MHEC), which relates to the public mental health system, and the Community Mental Health, Alcohol and Other Drug Council (CMC), which relates to the community mental health sector, have been established to bring the sector together and strengthen links between community services representatives and Commission policy, planning and commissioning. Both the MHEC and CMC have lived experience representation.

As part of the new governance structure, the position of Chief Medical Officer, Mental Health (CMOMH) has also been created to assist in strengthening the Commission's leadership role across the sector. The CMOMH also plays a key role in the MHEC and CMC. More information about the new governance arrangements which were made as a result of the Clinical Governance Review can be found on the Commission website. A link is provided in the footnote below.[30]

Given that these governance arrangements are still in their early stages, this issue does not have a suggested amendment.

Theme 11

Culture and Spirit of the Act

A person or body performing a function under the Act must have regard to the 15 principles set out in the Charter of Mental Health Care Principles, which state that mental health services must treat people experiencing mental illness with dignity and respect; and that includes respecting their right to make decisions about their own lives. The principles are intended to facilitate recovery from mental illness and for some people, they encapsulate the culture and spirit of the Act. Mental health services and private psychiatric hostels must always consider these principles when they provide treatment, care and support to a person.

Specific questions regarding the Culture and Spirit of the Act:

1. Compared with the 1996 Act, the Act was intended to address the human rights of consumers, families and carers, in the delivery of mental health services. Do you believe that there has been a cultural shift towards addressing human rights since the Act commenced? Why or why not?
2. Are the reporting requirements and forms helpful to ensure that consumers' or their families' and carers' human rights are promoted? If not, why not? Can you state which reporting requirements and forms are useful and which are not?
3. Have the administration and compliance requirements increased? If yes, how is this impacting on the provision of treatment and care to consumers? Can you identify specific reporting requirements and forms that you think are impacting in this way?
4. What is being done well to ensure that the Objects of the Act and the Charter are being met?
5. What needs to be done better to ensure that the Objects of the Act and the Charter are being met? What practical suggestions can you make?
6. What are the barriers to implementing any suggested changes?

[30] https://www.mhc.wa.gov.au/about-us/sector-governance/

11.1 Post-implementation review recommendation

Section of the Act: Whole of the Act.

Background

The final recommendation stated that: *'the Mental Health Commission is 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.'* [31]

The use of the word spirit refers to the general intent or real meaning of the Act. The Holman Review recommended that the Act address the advancement of the human rights of consumers, their families and carers and the Act encapsulates that intent, or spirit through the Objects and the Charter of Mental Health Care Principles.[32]

Stakeholders' feedback to the post-implementation review suggested that there is a tension between the clinicians' compliance with the Act and the spirit of the Act. Specifically, responses to the post-implementation review raised that:

- The administrative obligations on clinicians may impact on their ability to work in the spirit of the Act; and
- Online training programs and Approved Forms appear to be for compliance, rather than for effecting cultural change and working with the spirit of the Act.

Some stakeholders reported to the post-implementation review that the Act has placed an additional administrative workload for clinicians, and as a result had reduced the time available to provide direct clinical care. The additional administrative workload results from more forms, whether for specific purposes (such as for seclusion and restraint) or for other reasons (such as notifications to personal support persons).

Compared to the 1996 Act, the Act contains increased safeguards for consumers and their personal support persons, this includes a level of monitoring which involves notifications and completion of forms. Safeguards are essential and are intended to embody the spirit of the Act, by ensuring consideration of human rights and facilitating collaboration and involvement in treatment and care.

[31] https://www.mhc.wa.gov.au/media/2540/post-implementation-review-of-mental-health-act-2014-final.pdf Recommendation number 48.

[32] Schedule 1 of the Act. Sections 11 and 12 require a person, body and mental health service to have regard to the Charter when performing a function or providing treatment, care and support to patients.