



**SUBMISSION MADE BY THE COUNCIL OF OFFICIAL VISITORS**

to the

**Review of the *Mental Health Act 1996* and  
*Criminal Law (Mentally Impaired Defendants) Act 1996***

in accordance with the *Mental Health Act 1996*, section 215.

**TREATMENT OF PATIENTS**

**Term of Reference**

*“In regards to the operation and effectiveness of the Mental Health Act 1996, consider and have regard to Part 5 and the:*

- 1 Effectiveness and need of Divisions 1 - 9; and*
- 2 Give consideration to alterations and possible additions to Part 5.”*

**Legislation: *Mental Health Act 1996*, sections 104 – 107 inclusive and 113**

**COMMENTARY:**

The *Mental Health Act 1996* makes a number of provisions in relation to the giving of electroconvulsive therapy (ECT) to involuntary patients and mentally impaired defendants in authorised hospitals and other persons. These provisions have raised a number of issues for the Council.

**1 ECT as an “*Emergency Psychiatric Treatment*”**

There are a number of provisions within the Act, which authorise the giving of ECT as an “*emergency psychiatric treatment*” without compliance with the general requirements governing the giving of ECT. Specifically:

- ◆ section 104(2), allows ECT to be given to involuntary patients and mentally impaired defendants in authorised hospitals without the approval of a second psychiatrist; and
- ◆ section 107(2) allows ECT to be given to other persons without their informed consent.

*Emergency Psychiatric Treatment* is defined in section 113 as:

**“113** (1) *In this Division-*

*“Emergency psychiatric treatment” means psychiatric treatment that it is necessary to give to a person -*

*(a) to save the person's life; or*

*(b) to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.*

*(2) Psychosurgery is not permissible as an emergency psychiatric treatment.”*

The Council can not identify any occasion when an opinion from another psychiatrist could not be sought or which would justify the overriding of a voluntary patient’s right to withhold consent. Council is therefore of the view that these provisions should be removed.

**RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996* be amended by removing sections 104(2) and 107(2).

It is recommended that the *Mental Health Act 1996*, section 113 be amended such that electroconvulsive therapy is prohibited as an *emergency psychiatric treatment*.

## 2 Matters for consideration by psychiatrist

Section 105 prescribes those matters that must be considered by a psychiatrist providing an opinion as to whether ECT should be given to involuntary patients and mentally impaired defendants in authorised hospitals under section 104(1)(d).

Specifically the psychiatrist is to consider whether the person has capacity to consent to the treatment. If the person has capacity the psychiatrist is then required to ascertain and have regard to whether or not consent has been given (section 105(c)(i) and 105(c)(ii)).

It is the Council's view that if the person is considered to have capacity to consent and they have reasonably refused such consent that they no longer meet the criteria for involuntary status and therefore should have their status altered accordingly (refer to Council's submission on Criteria for Involuntary Status) and the treatment should not be given. In the case where the person is considered to have capacity to consent and does consent to the treatment they no longer meet the criteria for involuntary status and should have their status altered accordingly.

Further, if it is deemed that person unreasonably refuses consent or lacks capacity the decision to provide ECT should be subject to review by an external review body.

### RECOMMENDATION:

It is recommended that the *Mental Health Act 1996*, sections 105 be amended such that:

- 1 if an involuntary patient or mentally impaired defendant in an authorised hospital is deemed to have capacity to consent to ECT and reasonably refuses such consent (a) their status should be reviewed; and (b) the treatment must not be given
- 2 if an involuntary patient or mentally impaired defendant in an authorised hospital is deemed to lack capacity to consent or unreasonably withholds consent the decision to provide ECT be subject to review by an external review body.

## 3 Monitoring of Use of ECT

It is the Council's view that the use of ECT and compliance with the requirements of the Act governing ECT should be subject to external monitoring and reporting. The most appropriate external body to be charged with this responsibility be it the Board, the Council, or the Office of the Chief Psychiatrist is a matter on which the Council does not have a confirmed view.

## **RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996* provisions governing the use of electroconvulsive therapy be amended to include the provisions that an external body has responsibility to review and report on:

- 1 compliance with the Act's provisions governing electroconvulsive therapy;
- 2 frequency of use electroconvulsive therapy; and
- 3 appropriateness of the intervention.

**Legislation: *Mental Health Act 1996*, section 109**

*“109 An involuntary patient, or a mentally impaired defendant, who is in an authorised hospital, may be given psychiatric treatment without his or her consent.”*

**COMMENTARY:**

The current provisions of section 109 provide that involuntary patients or mentally impaired defendants can be given psychiatric treatment without their consent. There is no requirement to involve the patient in the process.

It is the Council’s view that no matter their status under the Act patients should, as much as is practicable, be consulted and engaged in the decision-making processes concerning their treatment. This aspect is dealt with in more detail under the Council’s submission for Criteria for Involuntary Status, Consent to Treatment (*Mental Health Act 1996*, section 26).

The requirement to consult with the patient is reflected in the Northern Territory *Mental Health Act 2002* provisions, specifically:

*“55. (4) When administering treatment to a person who is an involuntary patient, every practicable effort must be made to involve the person in considering the nature and effect of the treatment and any alternatives that are reasonably available.”*

Further, at section 56 there is a specific requirement for the authorising practitioner (or Tribunal) to be satisfied that:

- “(a) the treatment is in the best interest of the person;*
- (b) the anticipated benefits of the treatment outweigh any risk of harm or discomfort to the person;*
- (c) alternative treatments that would be likely to produce equivalent benefits and with less risk of harm are not reasonably available; and*
- (d) the treatment represents the least restrictive and least intrusive treatment option reasonably available.”*

Whilst provisions are made in sections 95 to 98 of the WA Act governing informed consent there is no subsequent requirement to involve the patient in the treatment decision making process, no matter their status under the Act.

Refer to the Council’s submission for Criteria for Involuntary Status, Consent to Treatment (*Mental Health Act 1996*, section 26).

**RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996*, section 109 be amended to reflect the provisions and requirements of the Northern Territory *Mental Health Act 2002*, sections 55(4) and 56.

**Legislation: *Mental Health Act 1996*, sections 109 and 200**

**COMMENTARY:**

Whereas section 109 authorises the giving of psychiatric treatment to an involuntary patient or mentally impaired defendant in an authorised hospital without their consent, it does not authorise the use of reasonable force to deliver that treatment.

The giving of treatment by its nature may involve the use of some force (e.g. insertion of a needle for an injection). However, the use of force by restraining a patient by holding them down is not part of the treatment.

Where force is necessary, for example to apprehend a person for assessment or a patient who is AWOL, there is a specific provision in section 200 of the Act for police to use reasonable force.

Council considers that provided changes are made to allow greater availability of treatment by consent, then involuntary treatment without consent should also authorise the use of reasonable force to give that treatment.

**RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996*, section 109 be amended so that:

- 1 where involuntary treatment is authorised, reasonable force may be used to give that treatment; and
- 2 documentation of the use of force, including the reason, staff involved, other strategies utilised, be included in the patient's case notes.

**Issue: TREATMENT AND DETENTION - THE ORDER TO DETAIN SHOULD NOT BE AUTHORITY TO TREAT A PERSON WITHOUT CONSENT**

**UNITED NATIONS PRINCIPLE 11**

***“Consent to Treatment***

1. *No treatment shall be given to a patient without his or her consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle.*
2. *Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:*
  - (a) *The diagnostic assessment;*
  - (b) *The purpose, method, likely duration and expected benefit of the proposed treatment;*
  - (c) *Alternative modes of treatment including those less intrusive;*
  - (d) *Possible pain or discomfort, risks and side-effects of the proposed treatment.*
3. *A patient may request the presence of a person or persons of the patient’s choosing during the procedure for granting consent.*
4. *A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. The consequences of refusing or stopping treatment must be explained to the patient.*
5. *A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.*
6. *Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 of the present principle, a proposed plan of treatment may be given to a patient without a patient’s informed consent if the following conditions are satisfied:*
  - (a) *The patient is, at the relevant time, held as an involuntary patient;*
  - (b) *An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 of the present principle, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient’s own safety or the safety of others, the patient unreasonably withholds such consent;*
  - (c) *The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient’s health needs.*
7. *Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 of the present principle, consents on the patient’s behalf.*
8. *Except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may also be given to any patient without the patient’s informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other*

persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the official approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A person representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 of the present principle, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her."

## **Legislation: *Mental Health Act 1996*, section 43, and 109**

### **COMMENTARY:**

Many other jurisdictions do not permit for psychiatric treatment to be given without informed consent where the person to receive the treatment has the capacity to consent (or withhold consent) provided that the consent is not unreasonably withheld.

The National Rights Analysis Instrument Assessment Panel in its report to Australian Health Ministers Council (AHMAC) and National Mental Health Working Group found that Western Australia had only partial compliance (8 out of 20) in this field. In general in its report the National Panel found that Tasmania had the best legislative

practice in regard to informed consent for general mental health treatment. Tasmania scoring full compliance with the UN Principles in this regard under all 5 criteria. Northern Territory legislation rated highly in most areas.

Council is of the view that informed consent, consistent with the relevant UN Principles, is a requirement for the giving of psychiatric treatment to voluntary and involuntary consumers. Once this concept of informed consent is introduced then the order with respect to detention, which now also authorises treatment under section 109 of the Act, must be separated into 2 discrete orders. One to authorise detention and one to authorise treatment after there is consideration given to the issues relating to informed consent. (Refer to the Council's submission for Criteria for Involuntary Status, Consent to Treatment (*Mental Health Act 1996*, section 26)).

In the Model Mental Health Legislation sections 45 to 49 relate to the question of informed consent and matters to be considered before treatment can be given to an involuntary patient. In the Northern Territory Act informed consent is defined in section 7 and matters to be taken into account are contained in section 55(4). General mental health treatment of involuntary patients should be available in no more than two instances:

- a. is likely to cause imminent harm to himself or herself, a particular person or other person; or
- b. is likely to suffer serious mental or physical deterioration

as set out in the Northern Territory legislation.

#### **RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996* be amended such that there be a separation of orders relating to involuntary detention and treatment into two:

- 1 for involuntary status and detention; and
- 2 for involuntary treatment if informed consent to treatment cannot be given or is unreasonably withheld.

**Legislation: *Mental Health Act 1996*, sections 29 – 40, 36 (3), 40 (3), 109, 113**

**COMMENTARY:**

The present scheme of the Act permits the apprehension, transport, detention and assessment of persons referred to an authorised hospital or other place. Treatment (medical and psychiatric) of such persons is not authorised except in emergencies. Emergency psychiatric treatment is provided for in Part 5, Division 7, Sections 113 to 115 inclusive.

**“113** (1) *In this Division-*

*“Emergency psychiatric treatment” means psychiatric treatment that it is necessary to give to a person-*

- (a) to save the person's life; or*
- (b) to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.*

*(2) Psychosurgery is not permissible as an emergency psychiatric treatment.”*

Emergency medical treatment is permissible under the doctrine of “necessity” and specific provision is made under the Criminal Code to protect the providers of such a service. The elements of what would constitute an emergency have been well canvassed in a variety of decided legal cases. Essentially in an emergency (not just an anticipated circumstance) where a person's consent or refusal cannot be determined, consent to necessary treatment is assumed under the law.

It would appear that very often referred persons are given psychiatric treatment without proper authority and in circumstances which do not amount to an emergency.

It is often alleged that the patient has consented to the treatment. However such a claim would negate, at least in part, the criteria for the patient to be made involuntary i.e. section 26(1)(c) could not be met:

*“the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment”* [of their mental illness].

In circumstances where a referred person “consents” to treatment the appropriate course to then follow would be to admit them as a voluntary patient.

That neither psychiatric nor medical treatment can be given to a referred person without informed consent should be set out in unequivocal terms in the Act except in an emergency. Section 7 of the Northern Territory *Mental Health Act 2002* is an example of good legislative practice with a definition of informed consent and the processes involved.

Further, the person is referred to the hospital for assessment, not for treatment and the person does not meet the criteria for treatment without consent as provided in Section 109:

**"109** *An involuntary patient, or a mentally impaired defendant who is in an authorized hospital, may be given psychiatric treatment without his or her consent."*

Given the terms of section 109 there may be no need to specifically proscribe treatment of referred persons however where any treatment is provided there should be some requirement to report such treatment to either the Mental Health Review Board or the Council of Official Visitors or both bodies.

The rationale for such reporting is so that where treatment is given to referred persons there is some mechanism to review or check the process on the provision of such treatment and on the progress of the person past the assessment process.

Such a regime would need to have complementary amendments elsewhere (e.g. section 175's definition of '*affected person*') should be extended to include referred person. (Refer to the Recommendation Two, Council of Official Visitors' submission to the Review of the *Mental Health Act 1996* regarding the operations of the Council).

#### **RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996* specify that treatment cannot be given to a referred person without informed consent.

It is recommended that where any treatment is provided to a person referred for assessment there should be a requirement to report such treatment to either the Mental Health Review Board or the Council of Official Visitors or both bodies.

It is recommended that the appropriate complementary amendments elsewhere in the Act be made to provide for the above (eg Section 175's definition of '*affected person*').

**Issue: MEDICAL TREATMENT MAY BE APPROVED BY THE CHIEF PSYCHIATRIST**

**Legislation: *Mental Health Act 1996*, section 110**

***“Medical treatment may be approved by the Chief Psychiatrist***

**110 (1)** *A person who is in an authorised hospital as-*

- (a) an involuntary patient; or*
- (b) a mentally impaired defendant,*

*may be given treatment, other than psychiatric treatment or treatment referred to in section 108, if it has been approved in writing by the Chief Psychiatrist.*

*(2) Subsection (1) does not limit a power conferred by any other written law by which a person may consent to the medical treatment of another person.”*

**COMMENTARY:**

The Council has identified a number of shortcomings in the present provisions of section 110:

1. Should the *Guardianship and Administration Act 1990* be utilised for approval of all medical treatment for involuntary patients and mentally impaired defendants in authorised hospitals?
2. What is the position if a person has the capacity to consent to medical treatment and refuses to consent?
3. Lack of definition of medical treatment.
4. Sterilisation and Contraception.
5. Delegation of Power to approve and external review provisions.
6. Minors

**1 Should the *Guardianship and Administration Act 1990* be utilised for approval of all medical treatment for involuntary patients and mentally impaired defendants in authorised hospitals?**

The *Guardianship and Administration Act 1990* was established to provide a legislative procedure to enable guardians or administrators to be appointed, as appropriate, on behalf of those adults with a decision making disability. This can include the authority to consent to medical treatment.

The *Guardianship and Administration Act 1990* prescribes a framework which must be applied when guardians are making decisions on behalf of the represented person (refer section 51), specifically that they must act in the ‘best interest’ of the represented person. No such considerations are provided for in relation to section 110 of the *Mental Health Act 1996*.

Given the provisions and safeguards provided in the *Guardianship and Administration Act 1990* it may be argued that there is no place or requirement for the inclusion of section 110 in the *Mental Health Act 1996*. This Act was primarily established to prescribe the framework and requirements for the provision of psychiatric treatment, on an involuntary basis, not the provision of medical treatment.

The framework contained within the *Guardianship and Administration Act 1990* may better serve to ensure that the rights of consumers are respected in an appropriate manner.

An argument against the use of the *Guardianship and Administration Act 1990* has been the delay in having hearings occur to determine whether a guardian is required. This would be of particular concern if medical treatment was required urgently. Section 119 of the *Guardianship and Administration Act 1990* makes provision to deal with such circumstances:

***“Medical and dental treatment***

**119. (1)** *If in the opinion of a practitioner a person presented to him for treatment --*

- (a) is in need of urgent treatment;*
- (b) is incapable of consenting to the proposed treatment; and*
- (c) is at the time of presentation a person for whom a guardian could be appointed under this Act,*

*the practitioner may provide the treatment if the person referred to in subsection (3) consents to it.*

*(1a) A practitioner may provide treatment under subsection (1) without the consent of the person referred to in subsection (3) if in the opinion of the practitioner it is not practicable to obtain that consent.”*

Subsection 3 provides a hierarchy of “nearest relative”, specifically:

***“nearest relative”*** *in relation to a person means the first in order of priority of the following relatives of the person, being a relative who has attained the age of 18 years and is reasonably available at the relevant time –*

- (a) the spouse;*
- (b) a child;*
- (ba) a step child;*
- (c) a parent;*
- (ca) a foster parent;*
- (d) a brother or sister;*
- (e) a grandparent;*
- (f) an uncle or aunt;*
- (g) a nephew or niece,*  
*and for the purposes of this definition –*
- (h) the spouse of a person means both a legal spouse and a person who is not legally married to the first-mentioned person but who lives with that person on a bona fide domestic basis;*
- (i) a brother or sister of a person includes a brother or sister of the half-blood, and a person who was adopted by one or both of the parents of the first-mentioned person; and*
- (j) the elder or eldest of 2 or more relatives described in a paragraph of this definition shall be preferred to the other or any other of those relatives regardless of sex, and no distinction shall be made between relatives of the same age;”*

These provisions appear to address the issue of consent in urgent situations with the possible exception of a small number of consumers who have no “*nearest relative*”.

## **RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996* be amended by deleting section 110 given the provisions of the *Guardianship and Administration Act 1990*.

## **2 What is the position if a person has the capacity to consent to medical treatment and refuses to consent?**

There is a presumption at law that an adult person has the capacity to consent to (and conversely refuse) medical treatment.

Section 110 is open to several interpretations:

- 2.1 A mechanism to authorise medical treatment whether the involuntary patient / mentally impaired defendant in an authorised hospital consents or refuses even though the involuntary patient / mentally impaired defendant has the capacity (i.e. sufficient maturity, wisdom and understanding of the treatment and the consequences of treatment or non-treatment).
- 2.2 A mechanism to authorise treatment where the person lacks capacity to consent or refuse.

There are cases which indicate that this provision will be interpreted by a Court to the absolute minimum level so as to preserve the rights and integrity of the person affected. This is particularly when read in conjunction with section 109 where it is specified the treatment can be given without the patient's consent.

Council has received a copy of a comprehensive legal opinion from the Crown Solicitors Office dated 1 March 2001 by John Young, Deputy Crown Solicitor. The recommendation in that opinion is that section 110 needs to be amended to clarify its intent.

The issue of informed consent must be addressed in relation to this section. Sections 95 – 98 inclusive of the Act provide considerations in relation to informed consent but currently have no relationship to section 110.

Approval under section 110 must not be used to override the decision of an involuntary patient / mentally impaired defendant who has capacity to make decisions regarding medical treatment and refuses such treatment. For example, an involuntary patient in an authorised hospital who is deemed to have the capacity to make a decision regarding medical treatment involving oral medication also has the right to decide not to take this medication. Unless the consumer is subsequently assessed as lacking capacity to make decisions regarding medical treatment and approval sought from the Chief Psychiatrist or delegate, the facility staff do not have

the right to force or coerce the person into taking the medication, not even in the name of "Duty of Care".

Similarly if a Guardian has been appointed to make medical treatment decisions in relation to an involuntary patient / mentally impaired defendant their consent must be sought for any medical treatment, including changes to treatment. Approval under section 110 must not be used to override any such authority under the *Guardianship and Administration Act 1990*.

#### **RECOMMENDATION:**

It is recommended that if the *Mental Health Act 1996*, section 110 provision is retained it be amended to clarify its intent. It is Council's view that the 'intent' should be to the effect that the power of the Chief Psychiatrist to approve medical treatment is limited to those who lack capacity to consent and do not have a Guardian appointed who may consent in their stead.

It is recommended that the *Mental Health Act 1996* be amended to set out the elements which would show the capacity to consent and the essential elements of consent and such provisions already exist in Sections 95 to 98 inclusive.

### **3 Lack of definition of medical treatment**

The Act does not define 'medical treatment'. Although there is no definition in the Act the term has received considerable judicial attention so its meaning from a legal standpoint can be determined, but in any event it is different to 'psychiatric treatment'.

This lack of definition can lead to confusion between the role of this Act and the *Guardianship and Administration Act 1990* in relation to specific treatments, including sterilisation.

#### **RECOMMENDATION:**

It is recommended that if the *Mental Health Act 1996* section 110 provision is retained that it be amended to include a definition of "medical treatment".

### **4 Sterilisation and Contraception**

#### **4.1 Lack of exclusion of sterilisation**

Sterilisation is a very difficult subject. The Model Mental Health Legislation, section 51, proscribes sterilisation as a treatment for mental illness:

*"S 51. A person must not perform on another person as a treatment for mental illness any medical treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out.*

*Penalty: 100 penalty units and imprisonment for 2 years."*

No such prohibition exists in the Western Australian Act. It should be noted that the above prohibition would not prevent the procedure being performed as a medical treatment via authorisation under section 110. If sterilisation is necessary this should be progressed via an application under the *Guardianship and Administration Act 1990*.

The lack of definition of "*medical treatment*" can lead to confusion between the role of this Act and the *Guardianship and Administration Act 1990* in relation to specific treatments, including sterilisation.

### **Case Study:**

(Refer - Council of Official Visitors Annual Report 1998 – 1999, pages 35-36)

Ms E. a young woman had been receiving fortnightly depo provera injections as a contraceptive measure. However, she found the injections unpleasant, believing they were responsible for what she considered to be unnecessary weight gain. She had stated to her consultant psychiatrist that she had no intention of having children and it was her wish to be sterilised. Ms E was an involuntary patient under the Act.

A request was made by the treating hospital for the Chief Psychiatrist to consent to a sterilisation procedure, under section 110 of the Act. No application had been made to the Guardianship and Administration Board for the appointment of a guardian.

The young woman's case was reviewed by an expert committee chaired by the Chief Psychiatrist. An Official Visitor attended to represent the young woman's interests. Prior to the meeting the Official Visitor met with Ms E to discuss and to confirm her wishes. Ms E was adamant regarding her wish to be sterilised, a view that was later confirmed by the Official Visitor at the meeting.

The Council was of the opinion that the issue of consent to sterilisation should be determined by the Guardianship and Administration Board given the specific provisions in the *Guardianship and Administration Act 1990* related to this issue.

Following the panel discussion and receiving subsequent advice the Chief Psychiatrist determined that on this occasion an application should be made to Guardianship and Administration Board for the appointment of a guardian to act on the consumer's behalf and to consider the issue of sterilisation.

Subsequent to this the view was expressed that the approval could have been granted under section 110 of the *Mental Health Act 1996* but this was not the chosen course of action in this case.

## **RECOMMENDATION:**

It is recommended that sterilisation be specifically prohibited in the *Mental Health Act 1996* as a treatment for mental illness.

It is recommended that **if** the *Mental Health Act 1996* section 110 provision is retained that sterilisation be specifically prohibited as a medical treatment which may be authorised under the provisions of that section. If sterilisation is necessary this should be progressed via an application under the *Guardianship and Administration Act 1990*.

### **4.2 Contraception is not excluded nor provided with special consideration.**

Related to the issues of sterilisation is concern regarding the procedures in place for prescribing depo provera as a form of contraception for women. The Council is of the view that contraception does not fall within the definition of 'psychiatric treatment' therefore can not be prescribed or administered under the Act without the individual's consent.

In practice the attitude of staff, on occasions, appears to be paternalistic / maternalistic, based on the notion that the consumer must be protected from her own potential actions or perceived "improprieties". The Council acknowledges that consumers may be vulnerable as a result of their mental state and that a duty of care exists for treating teams, however this does not abdicate the need to respect the consumers' right to make decisions. Associated with this, is the reported perception by some women consumers in secure wards, that if they consent to the depo provera and do not argue, they will be transferred to open wards sooner.

Crown Solicitor's advice was sought on whether the prescription of pharmaceutical contraception falls within the meaning of 'medical treatment' under the Act. The Crown Solicitor's advice was that whilst pharmaceutical contraception does **not** fall within the definition of 'psychiatric treatment' it would be considered, at law, to be medical treatment.

This advice supports the prescribing of pharmaceutical contraception to an involuntary patient or mentally impaired defendant in an authorised hospital without that person's consent if authorised under the provisions at section 110. It also makes it clear that pharmaceutical contraception is not a 'psychiatric treatment' and therefore should not be included as part of the treatment plan in a Community Treatment Order.

## **RECOMMENDATION:**

It is recommended that **if** the *Mental Health Act 1996* section 110 provision is retained that guidelines be developed and / or restrictions put in place governing the

approval of contraception under section 110 to ensure an adequate degree of separation between the prescribing doctor and the authorising psychiatrist.

It is recommended that **if** the power of the Chief Psychiatrist to approve contraception is to be retained it should be limited to those consumers who lack capacity to consent **and** do not have a Guardian appointed who may consent in their stead and is limited to no more than 3 months in which time application can be made for a Guardianship Order.

## **5 Delegation of Power to approve and external review provisions**

The Chief Psychiatrist has delegated the authority prescribed under section 110 to the Psychiatrists in Charge of the authorised hospitals. Such delegation dilutes the responsibility for these decisions and does not provide for an external review of the decisions.

As reported in its 1999 - 2000 Annual Report it is the Council's view that the intention of placing the authority to approve medical treatment for involuntary patients / mentally impaired defendants in authorised hospitals in the Office of the Chief Psychiatrist was to ensure that an external review of decisions regarding medical treatment occurred prior to their implementation. The Council is of the view that this is not seen to be done if, in fact, it is the Psychiatrist in Charge of the authorised hospital where the individual is detained who approves such treatment.

The Council's concerns are not related to the professionalism or competency of the individuals who are in charge of the authorised hospitals. They relate in particular to those types of treatment that may be considered contentious or lifestyle choices, (including contraception); to the intent of the legislation; and to whether, by the delegation of this power without limitations to the Psychiatrists in Charge of the authorised hospitals, this has been circumvented.

Council is of the view that approval for more contentious medical treatments and / or those which relate more to lifestyle choice (eg contraception) should only be made by a guardian appointed with powers in that regard. This provides a significant degree of independence / separation from the prescribing clinicians.

### **RECOMMENDATION:**

It is recommended that **if** the *Mental Health Act 1996* section 110 provision is retained that guidelines be developed and / or restrictions put in place, governing the types of medical treatments that can be approved under the **delegated** authority of the Chief Psychiatrist to ensure an adequate degree of separation between the prescribing doctor and the authorising psychiatrist.

It is recommended that decisions related to medical treatment involving 'lifestyle issues' (e.g. prescribing of contraception to prevent pregnancy rather than treatment for a medical condition) be the sole responsibility of the patient who has capacity to

consent. In cases where the patient lacks capacity that the decisions, other than in an emergency, can only be made by a Guardian appointed with appropriate powers.

## 6 MINORS

The needs and rights of young people require special attention as they are a vulnerable group where conflicting rights and obligations are frequently encountered.

Minors, aged 14 to 17 years, if assessed as having sufficient maturity of thought and perception should be treated in a similar fashion to adults. Where the minor has the maturity and capacity to consent or withhold consent to medical treatment then their wishes should be respected and be determinative of the issue.

Where a minor is under 14 years or has insufficient maturity, perception or capacity or all of these, then their wishes should be taken into account but their legal guardian's decision is determinative, however should be subject to review by an external body if requested by the minor, or their advocate.

Parents of minors may object to the treatment or non-treatment chosen by a mature minor and in order to make the position clear and protect staff when following the wishes of the mature minor, there needs to be appropriate legislative provision.

### RECOMMENDATION:

It is recommended that the *Mental Health Act 1996* in relation to medical treatment of minors have provisions:

- 1 which ensure mature minors aged 14 to 17 years with capacity to consent have the right to consent to medical treatment; and
- 2 where any decisions to provide medical treatment to a minor without that minor's consent be subject to review by an external body on the request of the minor or their advocate.



## Records to be kept

Section 120 of the Act requires in part that:

- “(a) appropriate provision is made for basic needs of the patient, including bedding, clothing, food, drink, and toilet facilities;*
- (b) the patient is observed by a mental health practitioner at regular intervals, as prescribed by the regulations;”.*

There is no requirement for these matters to be recorded. The Council has received complaints from patients who have been in seclusion that they were denied access to drinks, toilet facilities etc. Inconsistent documentation of these being offered or staff responding to consumer requests makes satisfactory resolution of these matters difficult.

Regulation 12 requires that a record is kept of monitoring by medical staff prescribed under section 120(c) and a copy of the report to the Mental Health Review Board (section 120(d)).

### **RECOMMENDATION:**

It is recommended that the recording requirements associated with the use of seclusion, Regulation 12, be amended to include recording of duties performed as required by sections 120(a) and 120(b) of the *Mental Health Act 1996*.

## Reports to the Mental Health Review Board

Section 120(d) of the Act requires:

*“a report of the patient being kept in seclusion is made as soon as is practicable to the Mental Health Review Board.”*

There are no provisions in the Act specifying what action is required of the Mental Health Review Board (the Board) in relation to these notifications. To date the Board has, in its Annual Reports, reported on the number of notifications received. To the Council's knowledge this is the only action taken by the Board in response to receiving these notifications. There is no requirement or process for ensuring that such notifications are forwarded as per this section.

It is the Council's view that the requirement for notification to the Board was to provide for an external review of the use of seclusion. This review should consider as a minimum:

- compliance with the Act's provisions governing seclusion;
- frequency of use;
- circumstances of the use; and
- appropriateness of use

not solely reporting on the number of times notified.

The most appropriate external body to be charged with this responsibility be it the Board, the Council, or the Office of the Chief Psychiatrist is a matter on which the Council does not have a confirmed view.

**RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996* provisions governing the notification of use of seclusion to an external body be retained and amended to include provisions which specify the responsibilities of that body, including to review and report on:

- 1 compliance with the Act's provisions;
- 2 frequency of use; and
- 3 appropriateness of the intervention.

**Legislation: Legislation: *Mental Health Act 1996*, sections 121 – 124 and *Mental Health Regulations 1997*, Regulations 14 - 17**

**COMMENTARY:**

The *Mental Health Act 1996* (the Act) Division 9, sections 121-124 and the *Mental Health Regulations 1997* (the Regulations) regulations 15-17 outline the provision to be complied with when authorising the use of mechanical bodily restraint.

Issues relating to mechanical bodily restraint are many. The report to the Australian Health Ministers Advisory Group on the Application of Rights Analysis Instrument to Australian Legislation at page 16 said:

***“Indicator 10 – Consent to special procedures***

*68. ... Indicator 10 was the Indicator in the Instrument that third least met the requirements in the UN Principles on assessment. The principal difficulty is in the areas of mechanical bodily restraint and involuntary seclusion, as there is a real need for legislative, rather than purely administrative, provisions to prevent abuses occurring.”*

The report of the Application of the Rights Instrument expressed concern about the inclusion of additional grounds to prevent destruction of property. This ground not being in compliance with the relevant UN Principles. Hospitals should have strategies available to prevent destruction of property though, for example, provision of appropriate equipped ward areas. Placing a person in mechanical restraint is far too restrictive an option in what should be a robust and properly equipped environment.

Negative effects and feelings about restraint because of the loss of control over oneself can remain with an individual long after the experience.

Reasons for use are commonly to prevent self injury from falls, prevent wandering and protection of others from intrusive or aggressive behaviour. Some restraints are more intrusive than others, irrespective of the reason they are used.

Following an inspection visit to an authorised hospital in July 1999 Council members became aware of a number of shortcomings in compliance with the legislation relating to the use of mechanical bodily restraint. Subsequently Council’s attention was drawn to ‘Chief Psychiatrist Instruction No. 3 **MECHANICAL BODILY RESTRAINT**’. The Council was of the view that Instruction No. 3 was contrary to the provision of the Act. This view was confirmed by an opinion received from the Crown Solicitor’s Office.

In mid August 1999 the Council wrote to the Chief Psychiatrist advising him of its concerns related to compliance with the legislation associated with the use of mechanical bodily restraint. Further, it requested a withdrawal of the Chief

Psychiatrist Instruction No. 3 and a reaffirming of the need to comply with all aspects of the Act. A response was received from that office in early September 1999 noting the Council's correspondence and promising a "**review in due course**".

In early January 2000 the Council received a copy of correspondence from the Office of the Chief Psychiatrist, dated 6 December 1999, regarding withdrawal of the Instruction No. 3. Examination of the notice highlighted that the Instruction was:

*"now rescinded in its application to **involuntary** patients in authorized hospitals"* (emphasis added).

A further opinion was sought from the Crown Solicitor's Office regarding whether the provisions of the Act in relation to mechanical bodily restraint related to all patients, not only involuntary patients. In addition advice was sought to confirm that an authorisation was required for each application of restraint rather than the provision of an authorisation for "use as required" over a period of time e.g. 6 months.

The advice received in March 2000 confirmed that:

1. the requirements of the Act related to **all** patients in authorised hospitals, irrespective of their status; and
2. all requirements of the Act and Regulations must be complied with for each separate authorisation thus it was not possible to provide a "general" authorisation to apply restraint "as required".

Council recognises that in some cases a form of regular, general, but not too restrictive, restraint is necessary for management of a medical procedure or where a patient is at particular risk of falling. An exclusion from the definition of mechanical bodily restraint already exists for a medical or surgical appliance (section 121).

The present definition of mechanical bodily restraint is very wide and would include a bed with cot sides, a chair with table attached to its arms, or a recliner rocker where that item of furniture is used to prevent unintentional injury to frail patients.

To provide a workable definition Council recommends that the present definition in section 121 have the further exclusion of furniture such as beds and chairs referred to above so that their use would not fall within the provision relating to mechanical restraint provided the degree of restriction was not such as to immobilise the patient's body or limbs.

Council has also identified a difficulty posed by the present legislation where mechanical bodily restraint is approved in an emergency. Regulation 16(b) requires that a medical practitioner be present with for the first 15 minutes an individual is placed in mechanical bodily restraint. Where a senior mental health practitioner orders the restraint in an emergency this provision can not be complied with.

Council recommends that in such a case the medical practitioner is to be in physical attendance as soon as practicable and monitoring each 30 minutes by a medical practitioner is to commence thereafter. Physical attendance and monitoring by a mental health practitioner would be essential in the interim without attendance of a medical practitioner. Application of mechanical bodily restraint on approval of a

mental health practitioner should only be available for a maximum of one application of restraint for no more than 3 hours in any 24-hour period.

Where mechanical bodily restraint is authorised by a medical practitioner the requirements of Regulation 16 should be retained. Regulation 17 should be amended to require full records of all restraints be made in the patient's case notes as well as in a register.

There should be maximum periods for which mechanical restraint may be applied under any particular authorisation.

### **RECOMMENDATION:**

It is recommended that the need to comply with the *Mental Health Act 1996* be clarified.

It is recommended that the *Mental Health Act 1996* section 123 be amended to delete the grounds of "*persistently destroying property*".

It is recommended that the *Mental Health Act 1996* be amended such that a bed with cot sides, a chair with attached table and a recliner-rocker ("tub chair") be excluded from the definition of mechanical bodily restraint where used to prevent unintended injury to a frail patient.

It is recommended that where mechanical bodily restraint is applied in an emergency there be a requirement for a mental health practitioner to physically attend and monitor the patient until attendance of a medical practitioner, as soon as is practicable.

It is recommended that unless a medical practitioner is in personal attendance restraint must be for no more than one three-hour period in a day (24 hours).

It is recommended that all instances of restraint be recorded in the patient's case notes as well as in a register.

### **Reports to the Mental Health Review Board**

Section 124 of the Act requires:

*"The treating psychiatrist is to ensure that a report of the use of mechanical bodily restraint is made as soon as is practicable to the Mental Health Review Board."*

There are no provisions in the Act specifying what action is required of the Mental Health Review Board (the Board) in relation to these notifications. To date the Board has, in its Annual Reports, reported on the number of notifications received. To the Council's knowledge this is the only action taken by the Board in response to receiving these notifications. There is no requirement or process for ensuring that such notifications are forwarded as per this section.

It is the Council's view that the requirement for notification to the Board was to provide for an external review of the use of mechanical bodily restraint. This review should consider as a minimum:

- compliance with the Act's provisions governing mechanical bodily restraint;
- frequency of use;
- circumstances of the use; and
- appropriateness of use

not solely reporting on the number of times notified.

The most appropriate external body to be charged with this responsibility be it the Board, the Council, or the Office of the Chief Psychiatrist is a matter on which the Council does not have a confirmed view.

#### **RECOMMENDATION:**

It is recommended that the *Mental Health Act 1996* provisions governing the notification of use of mechanical bodily restraint to an external body be retained and amended to include provisions which specify the responsibilities of that body, including to review and report on:

- 1 compliance with the Act's provisions;
- 2 frequency of use; and
- 3 appropriateness of the intervention.

**Legislation: No current provision**

**COMMENTARY:**

There may be potential to restrain a patient through medications which is not now subject to detailed external scrutiny. Council suggests consideration of the need to include “chemical” restraint and how the definition may be achieved to permit sedation but not so as to amount to restraint.

**RECOMMENDATION:**

It is recommended consideration be given to inclusion of “chemical” restraint in the provisions of the *Mental Health Act 1996*.

## BIBLIOGRAPHY

### REPORTS

- 2000      ***Application of Rights Analysis Instrument to Australian Mental Health Legislation, Report to Australian Health Ministers' Advisory Council National Mental Health Working Group***; Commonwealth Department of Health and Aged Care, Canberra.
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- 1991      ***Mental Health Statement of Rights and Responsibilities***; Commonwealth Department of Human Services and Health
- 1994      ***MODEL MENTAL HEALTH LEGISLATION Report to the Australian Health Ministers' Advisory Council National Working Group on Mental Health Policy; Volume 1***; Commonwealth Department of Human Services and Health (Released 1995)
- 1991      ***United Nations Principles For The Protection Of Persons With Mental Illness And For The Improvement Of Mental Health Care***; Adopted by General Assembly resolution 46/119 of 17 December 1991

### LEGISLATION

<i>Guardianship and Administration Act 1990</i>	Western Australia
<i>Mental Health Act 1996</i>	Western Australia
<i>Mental Health Act 2002</i>	Northern Territory