The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Western Australian Branch

13 June 2025

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By email to: Ekaterini.blitz-cokis@justice.wa.gov.au

Dear Kathy

Re: Review of *Guardianship and Administration Act 1990* WA

Thank you for the invitation to the WA Branch of the Royal Australian College of Psychiatrists (RANZCP) to make a submission towards the Law Reform Commission's review of the *Guardianship and Administration Act 1990*. We also appreciate the appointment of Dr Noel Collins as the Branch representative to one of the Expert Reference Groups advising the review.

The Branch welcomes the overarching purpose of the review, intended to strengthen compliance with the legislative reforms which shift the perspective on human rights and greater autonomy for persons who lack decision-making capacity.

The RANZCP supports the foreshadowed changes towards language and concepts which better reflect contemporary understandings of disability, decision-making capacity, and supported decision-making for people under guardianship and administration orders.

As experts in mental health, psychiatrists are well placed to comment on aspects of the review which feature in professional practice, including, for example, the use of restrictive practices. However, we note that specialised psychiatric expertise may be required to synthesise the responses to some potentially contentious but important questions raised in the Discussion Paper Vol 2.

Key recommendations

The Branch makes an overarching recommendation that advance health directives and restrictive practices require further discussion in targeted workshops, with participation from experts, including psychiatrists, with relevant medico-legal expertise and complex mental health professional backgrounds, and people with lived experience.

Further, the Branch recommends:

- mandating capacity assessments for advance health directives (AHDs), completed by qualified medical practitioners
- the development of an AHD register as a joint initiative by the Departments of Justice and Health
- an amendment that provides more security for medical practitioners who do not wish to be compelled to provide treatment

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- an amendment allowing provision of any life-saving care to people attempting suicide
- clear definitions of seclusion, and definitions of physical, chemical, mechanical, and environmental restraint
- comprehensive training of all staff working with people in supported decision-making arrangements on de-escalation techniques and deep understanding of differences between treatment and restrictive practices
- legal alignment across disability services, mental health services, and aged care services in the definitions and use of restrictive practices
- a tiered approach to decision-making about restrictive practices depending on the represented person's capacity
- legal safeguards and oversight of any use of restrictive practices particularly when an individual has not given informed consent.

Advance health directives (AHDs)

The review is an opportunity to amend the Act acknowledging that people with fluctuating mental health should have an opportunity to make an AHD requesting a psychiatric treatment if it is needed when their decision-making capacity is diminished, or they are placed under administration orders.

Under the *Mental Health Act 2014* adults are presumed to have capacity, however the Act also requires an assessment of capacity in some circumstances. In our consultations, members have stated that, in practice, the presumption of capacity may not always apply to people with mental illness, and their AHD may not be honoured by medical staff. In those situations, capacity assessments in AHDs for people who are concerned their capacity may come under question in the future would provide clarity and certainty for both represented persons and medical staff who provide treatment and care.
The Branch recommends that a similar requirement for capacity assessment should apply to people under guardianship and administration orders. Preferably, the capacity assessment would be performed by a medical practitioner, and this record would be accessible to any medical practitioner who provides treatment to the represented person.

The Branch believes that there is a need for an operative register of AHDs to ensure safety and quality of mental healthcare provided to the represented person. The register should be developed, and its use made mandatory if an obligation is placed on medical practitioners to check for an operative AHD prior to providing treatment.

The Branch also recommends an insertion of a provision in the Act that a health practitioner cannot be compelled to provide treatment, this would provide greater certainty and protection from criminal and civil liability for practitioners and make the Act more consistent with the legislation in other states such as South Australia and Tasmania.

Treatment decisions

Section 110ZIA of the Act enables a health practitioner to override an AHD if they reasonably suspect that a patient may have attempted suicide and needs treatment. The exception for attempted suicide applies only to urgent treatment, but in some other states, the exemption applies to any life-saving treatment. Importantly, psychiatrists as a profession are committed to preventing suicide whenever possible. The Branch recommends amending the Act to allow crisis support and access to life-saving care for people attempting suicide on guardianship and administrative orders that goes beyond urgent treatment post-attempt.

Our members reported instances where people who lacked capacity to make informed treatment and care decisions for themselves did not receive medical treatment that would

have assisted them. This was seen as being due to the emphasis within disability services on the right of the person with a disability to autonomy, rather than minimising their risk of harm to themselves.

The instances raise definitional questions about when a course of action is considered a treatment versus when it is considered a restrictive practice. For example, members have become aware of people with medical conditions such as Leish-Nyan syndrome and Phenylketonuria, who were considered by disability services to have the right to behave in self-injurious ways by self-mutilating or having a diet that would cause ill-health. Our members reported that providing treatment through medication to prevent self-mutilation was seen as a restrictive practice in the community service context. Similarly, efforts to prevent a person with specific dietary needs consuming items that would injure their health were considered restrictive.

Restrictive practices

The Branch supports efforts to provide clarity and agreement on definitions of seclusion and of chemical, mechanical, environmental, and physical restraint, and better training of all staff so that the distinctions between treatment and restrictive practices are clearly understood. We also support mandatory training in de-escalation techniques managing acute behavioural disturbance and challenging behaviours.

While the Act does not specifically refer to restrictive practices, the guardians appointed under the Act may make decisions about the use of restrictive practices in various settings and under various regulatory frameworks. The Branch is of the view that restrictive practices should only be used to reduce the risk of severe trauma or injury to the person or their families and carers including the staff who provide treatment and care, and only as a 'safety measure of a last resort where all other interventions have been tried or considered and excluded'.

There should be legal safeguards in place when the autonomy of an individual is overridden due to concerns about their lack of capacity and risks of safety/harm and this results in the use of restrictive practices. The safeguards would ensure that these practices are only used when they are the least restrictive alternative and are used for the minimum extent that is required to achieve the outcome, as is in place for mental health under the *Mental Health Act 2014*. We support 'least restrictive' terminology as more appropriate than 'as a last resort' in the context of clinical decision making.

In WA mental health services, the *Mental Health Act* provides a clear authorising framework for the use of seclusion and restraint and sets out the scope for the use of these restrictive practices and external oversight of their use. The *Mental Health Act* also provides for a framework for supportive decision-making where the person lacks capacity and provides for administrative review of the decisions made under the Act by an alternative decision-maker.

An appropriate use of medications to treat mental illness must not be confused with 'chemical restraint'. There is a significant risk that the most unwell people may not receive appropriate treatment because of unwarranted focus on considering side effects of current treatments, such as sedation, as 'chemical restraint'. There is also no clear definition of 'chemical restraint' in any regulatory framework in WA.

We suggest that a similar regulatory approach to Tasmania be adopted for the authorisation of chemical restraint. There, chemical restraint is defined as 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'. Excluded is medication to treat a mental illness or physical condition that may have a sedating effect:

‘chemical restraint occurs when medication is intentionally given to exert control over a patient’s movements or behaviour’.

Some of our members note with concern that statements by some NDIS service providers that they do not use any restrictive practices have the potential to result in perverse outcomes. For instance, on occasions the least restrictive access to treatment is to hospitalise a person because community services will not use any practice seen as ‘restrictive’ in the community service context. In one example, a person with a disability was hospitalised for more than 9 months, and made little improvement, as less restrictive services could not be sourced within the community service setting.

The Branch supports a tiered approach based on the person’s decision-making capacity. If the individual has capacity, then they should be the decision-maker about use of restrictive practices, for example in the AHD. If they have fluctuating capacity or do not have capacity, then the person should be consulted and informed about the proposed use of restrictive practices with a guardian or ‘person responsible’ having the delegated decision-making power. Where there is a potential conflict between the views of the guardian and the person with disability, then we are supportive of powers of review. This might be appointing a delegate who has technical expertise, and/or a panel that can include a person with knowledge of the person with a disability, and people with an understanding of care needs.

We recommend alignment of the system to similar principles in the *Mental Health Act* to ensure there are legal safeguards and oversight of any use of restrictive practices, particularly when an individual has not given informed consent or is deemed as not having capacity and there is an alternative decision-maker.

Thank you once again for the opportunity to contribute to this consultation. The Branch would welcome the opportunity to be involved in the discussion on how authorising restrictive practices can be aligned. If you have any questions about this submission, please do not hesitate to contact Dr Jasmina Brankovich, Policy and Advocacy Advisor, at jasmina.brankovich@ranzcp.org.

Yours sincerely

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Chair, RANZCP Western Australia Branch Committee