Inquiry into the Guardianship and Administration System in Western Australia

Consumers of Mental Health WA

May 2026

Consumers of Mental Health WA

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1. Acknowledgement of Country

Consumers of Mental Health WA proudly acknowledge Aboriginal people as Australia's First Peoples and the Traditional Owners and Custodians of the Land and Water on which we live and work. We acknowledge Western Australia's First Nation's communities and culture and pay respect to Aboriginal Elders past, present and emerging.

We recognise that Sovereignty was never ceded and the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on First Nations communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of First Nations Peoples to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

2. Preamble

2.1 About the respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy organisation independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

2.2 Request for feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work.

Please provide feedback via the contact details on this submission's cover page.

2.3 Language

CoMHWA uses the term 'mental health consumer' and 'consumer' throughout this submission. Mental health consumers refer to people who identify as having a past or present lived experience of psychological and emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity, and choice in how we individually identify. As individuals, we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

CoMHWA endorses the Indigenous Australian Lived Experience Centre's (IALEC) universal definition of lived experience for First Nation communities:

> *A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.*

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples' ways of understanding social and emotional wellbeing.

This definition recognises that there are fundamental differences in how Aboriginal and Torres Strait Islander people experience and define mental health challenges and suicide compared to mainstream definitions.

2.4 About the consultation

Reproduced from the WA Community Development and Justice Standing Committee's webpage on the Inquiry into the guardianship and administration system in Western Australia.

"*The Committee will inquire into and report on the guardianship and administration system in Western Australia. The Committee will investigate how the Public Trustee and the Office of the Public Advocate deliver services to vulnerable people, including how they deliver services in collaboration with other relevant organisations in the health, disability and aged care sectors.*

In particular, the Committee will consider:

1. The organisational capability of the Public Trustee's office and the Office of the Public Advocate to represent and protect the human rights of vulnerable people.

2. The organisational culture of the Public Trustee's office and the Office of the Public Advocate and how this is impacting delivery of services to vulnerable people.

3. The adequacy of mechanisms currently in place to resolve complaints, disputes and allegations.

4. Accessibility of information, including whether the Public Trustee's office and the Office of the Public Advocate provide information to relevant individuals and organisations in a timely, fair and transparent manner.

5. Outcomes experienced by represented persons and their families because of decisions made by the Public Trustee and Public Advocate.

6. Whether current oversight mechanisms are adequate to ensure guardians and administrators are held accountable for their decisions.

7. The role and conduct of the State Administrative Tribunal as far as it relates to the above."

3. Introduction

The *Guardianship and Administration Act 1990* (WA) ("*Guardianship and Administration Act"*), and the institutional administrators operating under it, are now being used in ways never envisaged when the legislation was originally drafted, particularly in relation to mental health consumers. On this basis, CoMHWA seeks a systematic re-imagining of how Western Australia protects people with decision-making challenges. Western Australian mental health consumers deserve a system that functions in line with contemporary understandings of mental health recovery and human rights. This can be achieved by building institutions with a strongly embedded human rights culture grounded in least-restrictive approaches, procedural fairness, autonomy, and the recognition that all people have the right to make choices, even risky or unconventional ones. Organisations must have the capability and culture to recognise that mental health recovery is complex and support alternative understandings of distress, and holistic healing approaches alongside or instead of biomedical models.

If they are to work in ways that realise the human rights of vulnerable people, the Office of the Public Advocate and the Public Trustee need to support those they represent through a process that centres on their goals, dreams and aspirations. This includes ensuring that Aboriginal mental health consumers represented on orders are supported by Aboriginal-led organisations, using culturally safe approaches informed by the Gayaa Dhuwi Declaration and the United Nations Declaration on the Rights of Indigenous Peoples.

The current review of the Guardianship and Administration law, along with this inquiry into the functioning of the system around that law, presents a key opportunity to change. This process of change will be strengthened through hearing and valuing Lived Experience Expertise, and so CoMHWA believes that all reforms, implementation, oversight, and review processes should be co-designed with mental health consumers through lived experience governance and leadership.

CoMHWA welcomes the opportunity to provide feedback to the Community Development and Justice Standing Committee's Inquiry into the guardianship and administration system in Western Australia.

Mental health consumers are more likely than other Western Australians to be subject to laws that remove their human rights to make decisions on their lives, consent to medical treatment, and experience the dignity of taking risks. In our consultations, consumers gave us insight into how the removal or threat of removal of their rights has impacted their lives.

We have drawn on this data, collected over the past two years, to further inform this submission, which includes, but is not limited to:

- Interviews with individual consumers who are currently represented under guardianship orders.

- A focus group was held on 21 May 2024 with CoMHWA members who shared their experiences and stories of being subject to Guardianship and Administration orders. The participants were asked to discuss their experiences with broad topics, including what worked, what didn't work, and what they would do to change the system.
- A meeting on 17 January 2025 of the Consumers of Mental Health Western Australia Aboriginal Lived Experience Advisory Group, which was attended by Aboriginal women and an Aboriginal man, provided feedback on their experiences and the experiences of Aboriginal people with guardianship and administration.
- Ongoing data collection and input from CoMHWA's National Disability Insurance Scheme (NDIS) reference group by its consumer members.
- Ongoing data collection and input concerning the unique experiences of Aboriginal people mental health consumers to CoMHWA's ongoing State Aboriginal Mental Health Network and ongoing consultation undertaken by CoMHWA's Community Engagement Officer for Aboriginal Mental Health and CoMHWA's Indigenous Policy and Research Officer.
- Ongoing data collection and input from CoMHWA's Individual Advocacy and Peer Pathways (service navigation) programs were included in our Preliminary Submission. We have continued to include the perspectives and input of the people working with and advocating for people represented on guardianship and administration orders throughout the drafting process. This is referred to as feedback from Individual Advocates throughout the document.
- Ongoing consultation with mental health consumers in Western Australia on joint priorities for an improved mental health system.
- Consumer representation in relevant settings, including but not limited to: Primary Health networks (WAPHA), WA regional equivalents of the Local Health Networks (regional mental health services under the WA Health Board structure), the Mental Health Commission and the health complaints agency, Health and Disability Services Complaints Office (HaDSCO).

CoMHWA provides responses to the seven areas of consideration listed in the Inquiry's terms of reference under relevant headings below, and includes recommendations for needed action to address issues.

4. Terms of Reference responses

4.1 The organisational capability of the Public Trustee's Office and the Office of the Public Advocate to represent and protect the human rights of vulnerable people

"I don't think it does [have capability]. It doesn't protect us in any way." (CoMHWA Member)

It is the view of CoMHWA that the Public Trustee's office ("Public Trustee") and the Office of the Public Advocate ("OPA") do not presently have the organisational capacity to represent and protect the human rights of mental health consumers, as they are applying a one-size-fits-all approach to people with varied challenges, using legislation that was not designed to ensure the human rights of mental health consumers. We advocate for the Convention on the Rights of Persons with Disabilities to be read through a human rights lens, which centres the consumer at the basis of all decision-making practices. The organisational capacity of the OPA and the Public Trustee to protect the human rights of vulnerable Western Australians is undermined by:

- the disproportionate use of guardianship and administration orders and the disproportionate number of mental health consumers represented on guardianship and administration orders in Western Australia
- lack of resources and infrastructure that would allow for a decision to be made in line with the will and preferences of a represented person
- legislative frameworks based on substitute decision-making that do not align with Australia's human rights obligations under the United Nations Convention on the Rights of Persons with Disabilities[1] ("UNCRPD") and the United Nations Declaration on the Rights of Indigenous Peoples[2].
- the use of coercion through the threat of substituted decision-making orders
- lack of capability to represent and protect the human rights of Aboriginal Mental Health Consumers
- institutional misunderstandings of fluctuating disability and mental health challenges.

[1] United Nations Convention on the Rights of Persons with Disabilities, December 13, 2006, https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

[2] G.A. Res. 61/295, United Nations Declaration on the Rights of Indigenous Peoples (September 13, 2007). https://social.desa.un.org/issues/indigenous-peoples/united-nations-declaration-on-the-rights-of-indigenous-peoples

4.1.1 Disproportionate representation of mental health consumers on orders in Western Australia

"I don't want to be in this system, and I didn't choose to be in this system, and the system has failed so many people." (CoMHWA Member)

Western Australians are placed on Guardianship and Administration at a rate around double that of our peers in ACT, NSW, QLD, TAS, and Victoria. While we cannot provide a clear reason why we are more likely to have our rights suspended than some of our interstate equivalents, we do not believe this is because Western Australians are disproportionately less capable of making decisions than our out-of-state peers.[3] A significant and outsized proportion of the people who are the subject of guardianship and administration orders are identified as mental health consumers. The OPA's annual report shows that the largest group of Western Australians who were represented on these orders are those with mental health challenges at 33% or 1,321.[4] Of these, 84% or 4,055 guardianship orders, include authority to make treatment decisions.[5] The type or total number of psychiatric treatment decisions the OPA made on behalf of mental health consumers is not reported. This lack of data means that it is difficult to get a full picture as to the capability of the OPA to represent and protect the human rights of vulnerable mental health consumers.

4.1.2 Inadequate resourcing

CoMHWA does not believe that, given the current resources of the OPA and Public Trustee offices, guardians and administrators can make decisions in line with human rights obligations concerning ascertaining and acting within the will and preferences of the represented person. Consumers have reported that the person making decisions on their behalf often does not know them by name, does not pick up the telephone when they call, and has never seen where they live or how they live.

The OPA reports that the average cost of providing advocacy and guardianship services for a represented person in 2024 was $1,728.[6] At the time of the calculation, OPA was advertising for decision makers at a level 5 under the PSGOCSA agreement, which is approximately $47 per hour. **A rough calculation suggests that a guardian spends less than 37 hours per year on advocacy and guardianship services.** This

[3] *Australian Adult Guardianship Orders 2022/23*. Australian Adult Guardianship and Administration Council. Retrieved 27 March 2025 from https://www.agac.org.au/assets/documents/Adult-Guardianship-Orders/AGAC-Guardianship-orders-Report-2022-2023.pdf

[4] Office for the Public Advocate. (2025) *Annual Report 2024/25.* Western Australian Government. https://www.wa.gov.au/system/files/2025-11/opa-annual-report-2024-2025.pdf, p. 10.

[5] Ibid 49.

[6] Office for the Public Advocate. (2024) *Annual Report 2023/24.* Western Australian Government. https://www.wa.gov.au/system/files/2024-11/opa-annual-report-2023-2024.pdf, p. 69

calculation does not account for whether overhead costs are included in this amount, as we do not know, but if they are not, then the situation is even more stark.

CoMHWA's individual advocates report that consumers have told them there is often no attention paid by their OPA guardians to the treatment of represented persons on a day-to-day basis. Represented people are often not accompanied by an OPA guardian to health appointments, leaving them in a position where their medication is changed or reviewed without guardian oversight.

4.1.3 Legislative frameworks based on substituted decision-making undermine the capability of the OPA and Public Trustee

The United Nations' Special Rapporteur on Torture states that an absolute ban on all coercive and non-consensual measures, including seclusion and restraint, "should apply in all places of deprivation of liberty, including psychiatric and social care institutions."[7] However, the current legal frameworks make the OPA incapable of protecting consumers from these human rights violations.

Illustrative of this are the ways in which orders that allow for substituted decisions concerning the use of restrictive practices, are used to bypass the safeguards put in place by the NDIS concerning the use of restrictive practices. Service providers require consent from consumers for inclusion of restrictive practices in behaviour support plans, and CoMHWA hears of circumstances in which providers make applications for guardianship orders in order to gain authority to consent to restrictive practices on consumers' behalf.

The Office for the Public Advocates' Annual Report stated that "[at] 30 June 2025, 1,914 (47 per cent) of the 4,055 guardianship orders appointing the Public Advocate included the authority to make decisions regarding restrictive practices, an increase of 33 per cent from 1,441 at 30 June 2024."[8] The OPA states that they believe that they provide accountability for restrictive practices used against represented people in NDIS services: "[t]he increase in guardianship orders including the authority to consent to restrictive practices reflects the increased accountability for service providers in this regard, within both NDIS and residential aged care services."[9] CoMHWA does not believe this is the case, as our members report that their OPA guardians provide very little oversight into these practices, and consumers feel that, rather than being motivated by a drive for greater accountability, NDIS providers are "act-shopping" to bypass the safeguards put in place by the NDIS concerning the use of restrictive practices. The Act and internal

[7] Méndez, J. E. (2013, February 1). *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez* (UN General Assembly Document No. A/HRC/22/53). https://digitallibrary.un.org/record/745862?v=pdf, p. 14

[8] Office for the Public Advocate, *Annual Report 2024/25* (Annual Report, 9 September 2025) https://www.wa.gov.au/system/files/2025-11/opa-annual-report-2024-2025.pdf, p. 49

[9] Ibid.

structures of the Office for the Public Advocate were not designed to interact with the NDIS in a fashion that prioritises the human rights of the represented person.

Substituted decision-making does not facilitate recovery

The legislation that prescribes the best interest test, black-and-white tests of capacity, and the risk-averse practice this creates undermines the capability of the statutory substituted decision makers to act in a manner that aligns with Australia's obligations under Article 16 of the UNCRPD. The medico-legal field has grappled with understanding recovery and the relationship between risk, self-discovery and growth needed for this to take place. His Honour Justice Bell discusses the concept of mental health recovery in relation to the law. "*In the mental health context, 'recovery' is a term of art. It reflects a contemporary understanding of 'health' that is broad — one that requires the social and personal circumstances of the person to be considered and one that is not focused exclusively on preventing and curing illness or disease as such. It emphasises the significance of respecting and promoting patients' self-determination over time and ensuring that patients avoid dependency and institutionalisation*."[10] It has not been the experiences of mental health consumers that this is well understood by those who investigate capacity or administer substituted decision-making through the OPA or Public Trustee, nor are they resourced to carry out this work effectively.

In our submission to the Law Reform Commission, we explained how modern, consumer-aligned understandings of recovery are not supported within a substituted decision-making approach:[11]

> "'Recovery' for people with significant mental health challenges is not a singular model. Broadly, the understanding of recovery is broken into two perspectives. In one group, we have the medical and clinical models that place emphasis on the "reduction of symptoms", compliance with pharmacological treatment plans, and improved medical measures. Consumer-based recovery models are more holistic in nature and focus on person-centred approaches to understanding and treating mental health challenges. The consumer-based model of recovery can include access to and use of medical treatment modalities, but this is not an inherent requirement for recovery.
>
> […]
>
> This aligns with the diversity of views represented by our member cohort concerning their personal recovery. Some members regularly use psychiatric medication and view their medication as a key

[10] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (1 November 2018) [103].

[11] CoMHWA. (2026). *Submission to the Law Reform Commission of WA – Guardianship and Administration Act Review*. https://comhwa.org.au/wp-content/uploads/2025/06/SA-2025-9-GAA-Law-Reform-Commission-of-Western-Australia-Project-114.pdf, p. 39

pillar of their recovery. Some members chose to forgo the medical model of recovery and see their recovery through a spiritual, emotional, healing, or other lens. The combination of the best-interest tests, black-and-white approaches to capacity, and risk-averse organisational practices places a handbrake on exploring recovery outside the medical model."

Implementing supported decision-making is non-negotiable for human rights

The Public Trustee and OPA will not be able to ensure the human rights of vulnerable mental health consumers without the implementation of supported decision-making. This was made clear by the Committee on the Rights of Persons with Disabilities, General Comment No. 1 on Article 12, which states:

"States parties' obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention."

In implementing supported decision-making frameworks, it is essential that supported decision-making is applied consistently across private and public guardianship. Some legislative models provide for supported decision-making only in the circumstances of private guardianship. Mental health consumers from jurisdictions where this has been implemented have reported that this is unsatisfactory for ensuring that the human rights of mental health consumers are upheld. They report that without universal institutional support for supported decision-making, the gap between those with community support and those without widens. This exacerbates the disadvantage that mental health consumers who are isolated from their community due to discrimination or stigma may face.[12]

4.1.4 The use of coercion through the threat of substituted decision-making orders

Consumers have told CoMHWA of experiences of coercion where they have been told that if they do not consent to a restrictive practice or a treatment regime, then an application will be made to remove their decision-making power and put in place a substituted decision-maker. We are aware of this practice happening to mental health consumers in supported housing, hospitals, and/or hostel accommodation. CoMHWA has also heard from consumers who have experienced this from their NDIS providers – coercion which in this context exploits the lack of sophistication in the understanding of highly stigmatised diagnoses and the understanding by consumers that when a person is given a particular diagnosis, often the

[12] VMIAC (2023). *VMIAC Submission to the Independent Review into the compulsory treatment criteria and alignment with decision making laws.* https://www.vmiac.org.au/wp-content/uploads/FINAL_SUBMISSION-to-the-Independent-Review.pdf

discussion about capacity is seen as a forgone conclusion by OPA investigators and the tribunal. During our consultation, one consumer described how an NDIS provider had applied for guardianship orders after she had "asked to be let out of NDIS". She stated that it "feels as though NDIS providers are using it to keep people in services and get NDIS money."

While the OPA itself does not undertake this practice, the threat of being subject to its operations is used to coerce consumers into waiving their rights. In our submission to the Law Reform Commission of Western Australian, we reported:

> "Some mental health consumers have reported to CoMHWA that they wish to end all support from NDIS. During further discussion, it has become apparent that the consumer still wishes to engage support but is unwilling to consent to restrictive practices and has been made aware on that basis that a support provider will make an application for the consumer to be placed under guardianship. Further, it has become clear that consumers can be unaware that they have a choice of providers, can negotiate for different arrangements for restrictive practices during periods of high distress, or can withdraw consent for previously agreed arrangements. Failure to provide supported decision-making in circumstances like this can lead a consumer to abscond or refuse all support. This places a consumer at a much higher risk of harm, abuse, or exploitation."[13]

4.1.5 Lack of capability to represent and protect the human rights of Aboriginal mental health consumers

Aboriginal mental health consumers tell us that the mainstream mental health model, often defaulted to by OPA guardians, does not address the needs of Aboriginal people, and is not aligned with a model based on their understanding of Social and Emotional Wellbeing (SEWB).[14] The OPA and Public Trustee are mainstream organisations, without accountability to Aboriginal cultural leadership. This results in organisations are not capable of supporting Aboriginal people to recover, build capacity and in line with human rights obligations to indigenous people and people with disabilities.

[13] CoMHWA. (2026). *Submission to the Law Reform Commission of WA – Guardianship and Administration Act Review.* https://comhwa.org.au/wp-content/uploads/2025/06/SA-2025-9-GAA-Law-Reform-Commission-of-Western-Australia-Project-114.pdf, p. 84

[14] Dudgeon, P., Rickwood, D., Garvey, D., & Gridley, H. (2014). A history of Indigenous psychology. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed., pp. 39–54). Telethon Institute for Child Health Research / Kulunga Research Network, University of Western Australia;

Commonwealth of Australia. (2017). *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing 2017–2023*. Department of the Prime Minister and Cabinet. https://www.niaa.gov.au/resource-centre/national-strategic-framework-aboriginal-and-torres-strait-islander-peoples-mental

CoMWHA supports the *Gayaa Dhuwi (Proud Spirit) Declaration*[15] which recognises the need for Aboriginal lived experience to define the shift away from paternalistic legal frameworks. Gayaa Dhuwi (Proud Spirit) Australia is the peak body established to create a national plan for culturally appropriate care and suicide prevention for Aboriginal and Torres Strait Islander peoples. Gayaa Dhuwi (Proud Spirit) Australia identifies Aboriginal and Torres Strait Islander's lived experience of distress is significantly different from that of mainstream experiences.

CoMHWA provided to the Law Reform Commission of Western Australia the testimony of Aboriginal mental health consumers concerning their needs; it is important that Committee members also hear these voices. Aboriginal mental health consumers identified their key needs for supported decision-making and other human rights-aligned practices as follows:[16]

> *"Earlier intervention that is centred on the person's wishes is needed."*
>
> *"We need less people doing things "for our own good"."*
>
> *"Because of our lived experience of colonisation, we need Aboriginal Peer workers. Not just "Aboriginal workers" but the right people for the right jobs taking into account cultural protocols of who it is appropriate to share information with. For example between men and women."*
>
> *"Aboriginal people need to be able to have our own healing and make decisions for ourselves."*

An Indigenous Lived Experience Advocate explained the complexity of the situation and the need for Indigenous-controlled administration of the functions of the Act to CoMHWA as follows:[17]

> *"Up North there are very different cultural protocols than Noongar people have. This can create a complex environment which people don't understand. In WA, we have a very diverse kinship system which is made up of Noongar, Yamatji, Wongi, then these break down in into smaller claimant groups. This is a very specialised environment which can be very technical but without the depth of understanding people cannot have the cultural safety required to engage in community or with services."*

[15] Gayaa Dhuwi (Proud Spirit) Australia. (n.d.) *The Gayaa Dhuwi (Proud Spirit) Declaration.* https://www.gayaadhuwi.org.au/gayaa-dhuwi-declaration

[16] CoMHWA. (2026). *Submission to the Law Reform Commission of WA – Guardianship and Administration Act Review*. https://comhwa.org.au/wp-content/uploads/2025/06/SA-2025-9-GAA-Law-Reform-Commission-of-Western-Australia-Project-114.pdf, p. 45

[17] Ibid, p. 37

Given the overrepresentation of Aboriginal consumers in substituted decision-making orders, it is urgent that more appropriate organisational structures are created. Aboriginal mental health consumers and their representatives are best placed to design the guidelines for legislation, policy and organisational standards that will be applied to them. This could be achieved through co-design with Aboriginal and Torres Strait Islander consumers, family/kin and organisations. Without the direct involvement of Aboriginal consumers, their community and representative organisations, it will not be possible to realise the human rights of vulnerable Aboriginal consumers.

4.1.6 Recommendations to build the organisational capability of the Public Trustee's Office and the Office of the Public Advocate

CoMHWA recommends that the Office for the Public Advocate and Public Trustee be appropriately and immediately resourced.

CoHMWA recommends that the state government should subsidise the functioning of the Public Trustee. People who are represented in substituted decision-making orders due to mental health challenges should not be charged fees by the Public Trustee.

CoMHWA recommends that a lived experience expert-led investigation be commissioned by the government in order to understand the complex reasons for the disproportionate use of substituted decision-making orders in Western Australia, including those related to the Office for the Public Advocate and Public Trustee's capabilities to ensure human rights.

CoMHWA recommends that the Office for the Public Advocate and Public Trustee be empowered to represent and protect the human rights of vulnerable people through legislative changes that enshrine supported decision-making as a right, regardless of the represented person's resources or community support. Additionally, we recommend that the Office for the Public Advocate and the Public Trustee be resourced and trained to ensure that represented people have strong support in their decision-making and in expressing their wills and preferences, including understanding fluctuating decision-making capacity, capacity building, and strengths-based supported decision-making approaches.

CoMHWA recommends that changes be made to give the Office for the Public Advocate and Public Trustee the capability to represent and protect Aboriginal mental health consumers' rights under the United Nations Declaration on the Rights of Indigenous Peoples as follows:

- Aboriginal community-controlled organisational structures are created to undertake the functions of the OPA and Public Trustee in line with the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan.
- Aboriginal and Torres Strait Islander consumers, family/kin and organisations and their culturally appropriate representatives co-produce the guidelines for legislation, policy and organisational standards that will be applied to them.

4.2 The organisational culture of the OPA and Public Trustee

In some cases, mental health consumers who had been represented on orders told us they often needed support in making decisions, and when it worked at its best, guardianship or administration had provided that support. However, the black-and-white operation of the current Act, and the organisational culture it facilitates, was not able to recognise their human right to define the direction of their lives. Common themes we heard in our discussions engaging with mental health consumers concerning their experiences of guardianship and administration were shame and self-stigma. The removal of the consumer's decision-making capacity was experienced as infantilising and disempowering. One consumer said:

> *"[The guardianship order] has taken away my own belief that I have capacity to make decisions. I'm always on edge about whether something is my decision or their decision. My decisions are framed as wrong, and get referred to the guardian. She then denies its within her scope." (CoMHWA Member)*

In our submission to the Western Australian Law Reform Commission, we noted:

> "The current system is focused on the harm that may be done by consumers to themselves or others. This way of thinking leads to an overly paternalistic and controlling environment. All humans will need social support to make decisions. This support may come in the form of speaking to a loved one, being provided with information in a language, asking clarifying questions, planning for periods when they have fewer resources or are under higher levels of stress. All humans have fluctuating decision-making capacity and need decision-making support."

The approach embedded within the Act and the organisational culture it creates leads to treating the issue of decision-making capacity and need for support as black-and-white, rather than allowing for fluctuating decision-making capacity, capacity building, or strengths-based supported decision-making approaches. In the words of CoMHWA members who have had experiences being on guardianship orders:

> *'If you don't have a good relationship with your guardian, they can screw you over good and proper. You should be asked by an independent group to check in on how you feel about the guardian…it's hard to reach out on your own. Especially for the CaLD community.' (CoMHWA Member)*

> *"There is such a negative focus, I feel like there could be ways to get to know a person, what they are good at, their strengths. Instead, you feel controlled because of your weaknesses." (CoMHWA Member)*

4.2.1 Organisational cultures that frame mental health challenges or distress in terms of “mental illness” and lack of capacity

Organisational cultural understandings of mental health within the OPA point to stigmatising and biomedical understandings of mental health challenges and distress that include but are not limited to misunderstandings of fluctuating capacity, mental health challenges and the decision-making ability of people with mental health challenges. Indications of this culture are evident in the OPA’s use of the language of “mental illness” in their recent annual reports, and the way that they describe the growth of guardianship appointments as tied to growth in numbers of people in WA who experience mental health challenges. Citing statistics on number of people in WA who may experience mental health challenges, number that may seek mental health assistance through the medical system, and the number of NDIS participants with psychosocial disability, the OPA draws the conclusion that:

> “*Mental illness accounted for the largest proportion of guardianship appointments of the Public Advocate as at 30 June 2024. The growing prevalence of mental illness within the community, coupled with the need for represented persons with mental illness to engage support through the NDIS for better outcomes, particularly those with chronic mental health issues, would seem to indicate growth in the number of guardianship appointments of the Public Advocate for people with mental illness will continue*.”[18]

CoMHWA does not see that number of people with mental health challenges should necessarily correlate with number of people on guardianship order. The OPA does not acknowledge that the vast majority of people with mental health challenges, including those with complex treatment and support regimes, do not have impaired decision-making capacity. This framing is not in alignment with Article 5 and Article 12 of the UNCRPD as it places people with a diagnosis of “mental illness” into a position where they must prove their decision-making capacity to a higher standard than those without a diagnosis. A shift towards differentiating “mental distress” from “mental illness symptoms” across mental health systems and medico-legal spaces, including the culture of the OPA and Public Trustee, would counter stigma around mental distress by facilitating an organisational shift away from defining ways of being and patterns of thought deemed to be outside of the norm as inherently bad.

- “***Mental distress”* can be defined as:** “emotional, social, spiritual, or physical pain or suffering that may cause a person to feel may cause a person to feel strong negative emotions, including but not limited to being apathetic, helpless, sad, afraid, angry, depressed, anxious, or lonely.”

[18] Office for the Public Advocate. (2024) *Annual Report 2023/24.* Western Australian Government. https://www.wa.gov.au/system/files/2024-11/opa-annual-report-2023-2024.pdf, p. 11

- ***"Mental illness symptoms: can be defined as***: "emotions, thoughts, and behaviours identified as stemming from a diagnosable mental illness."

4.2.2 The assumption that those who have been given highly stigmatised diagnoses lack capacity

CoMHWA's individual advocacy team has supported people in their interactions with the OPA as it undertakes its investigative functions, and they have reported that when a person is given a particular diagnosis, the discussion of capacity is often seen as a foregone conclusion. This issue is amplified when a person is given a diagnosis of schizophrenia, schizoaffective disorder, cluster B personality disorders, and others, which we refer to within this submission as "highly stigmatised diagnoses." These diagnoses are more likely to draw high levels of intervention from various medical and state bodies. The organisational culture of the OPA reinforces the current system that provides very little protection against the removal of rights from people with a diagnosis of these conditions. We also note that Aboriginal mental health consumers are more likely to receive these diagnoses.[19] Aboriginal mental health consumers reported that they perceived the greater prevalence of these diagnoses within the Aboriginal mental health consumer cohort was due to implicit bias and systemic racism within the sector.

Mental health consumers and CoMHWA individual advocates report that there is an institutional knock-on effect of a consumer being given a highly stigmatised diagnosis. The chain of events commonly described to CoMHWA plays out as follows: the doctor at presentation assumes that a mental health consumer meets diagnostic criteria, and the Office for the Public Advocate then investigates and concludes that the person has decision-making incapacity based on this diagnosis. These assumptions are then reported to SAT, and a substituted decision-making order is made. This is demonstrated in the treatment of an Aboriginal man who is both deaf and mute, whose published decision in relation to guardianship showed how easy it was for this young man to be given a diagnosis of schizophrenia/schizophreniform disorder.[20]

4.2.3 'Best Interests' decision-making and lack of understanding of recovery in organisational cultures

In a cultural environment shaped by risk aversion and the dominance of biomedical understandings of mental health, the OPA and Public Trustee are unlikely to be able to deliver services that align with recovery as defined by the mental health consumer themselves. Organisational culture has not reflected the shift to the recovery model and understandings of mental health challenges that have influenced

[19] Ogilvie, J. M., Tzoumakis, S., Allard, T., Thompson, C., Kisely, S., & Stewart, A. (2021). Prevalence of psychiatric disorders for Indigenous Australians: a population-based birth cohort study. *Epidemiology and psychiatric sciences*, *30*, e21. https://doi.org/10.1017/S204579602100010X

[20] *K* (2025) WASAT 15, para. 188-201

service delivery in the mental health sector.[21] When the current Act was drafted, and the OPA/ Public Trustee was created to administer the Act, the dominant understanding was that 'mental illness' was disabling, unchanging and complete. Since then, a shift in understanding has highlighted the potential for recovery of consumers, including those who have highly stigmatised diagnoses. For example, "[i]n *contrast to earlier views of schizophrenia as a chronic, debilitating condition with a very poor prognosis, the recovery model assumes that all consumers have the capacity to improve and develop a life distinct from their illness*."[22] The modern goal of interventions is to support consumers to "develop a life worth living."[23] The framing of the 'best interests' tests within the legislation and the organisational culture among substituted decision makers creates a highly risk-averse environment in which there is pressure to act and intervene, which often appears to be in the consumer's best interest when, in fact, it impedes the consumer's long-term recovery outcomes. The risk-averse environment that is embedded in the organisational culture places pressure on guardians to "do something to help" consumers they see as needing some intervention. Yet, this "help" can isolate consumers from finding their paths to recovery through exploring alternatives to the medical model and may lead to significant iatrogenic harms.[24] Iatrogenic effects are often misunderstood and lead to a cascade of interventions, for example: "a *patient begins a prescription of Klonopin and contracts panic disorder literally overnight. The prescribing physician may not recognize the person's condition as an iatrogenic or drug-induced disorder. The doctor, in the rush to find relief for the patient, may declare that the patient has developed panic disorder. And, prescribe more drugs*."[25]

The inability to allow a person to recover on their own terms can impair full recovery and access to different ways of understanding mental distress, including 'psychosis symptoms.' An example of a recovery-based model that does not aim to remove all 'symptoms' but instead sees the voices as part of the whole person is the Hearing Voices Movement (HVM). The bio-medical model identifies the voices heard by some consumers as "auditory hallucinations." Consumers who identify with the hearing voices movement use

[21] Example: National Disability Insurance Scheme. (2021). *Psychosocial Disability Recovery-Oriented Framework* https://www.ndis.gov.au/media/3957/download?attachment

[22] Bellack A. S. (2006). Scientific and consumer models of recovery in schizophrenia: concordance, contrasts, and implications. *Schizophrenia bulletin*, *32*(3), 432–442. https://doi.org/10.1093/schbul/sbj044

[23] Rizvi, S. L., Bitran, A. M., Oshin, L. A., Yin, Q., & Ruork, A. K. (2024). The State of the Science: Dialectical Behavior Therapy. *Behavior Therapy, 55*(6), 1233-1248. https://doi.org/10.1016/j.beth.2024.02.006

[24] The World Health Organisation (WHO) defines "Iatrogenesis" to mean "any noxious, unintended, and undesired effect of a drug, which occurs at doses used in humans for prophylaxis, diagnosis, or therapy." World Health Organization (1972) *Technical Report No. 498: International Drug Monitoring: The Role of National Centres*. Geneva, Switzerland

[25] Ridaeus, D. (2025, June 24). *Iatrogenic Mental Disorders.* Alternative to Meds https://www.alternativetomeds.com/blog/iatrogenic-mental-disorders

"*the term 'hearing voices', which uses ordinary, non-pathologising language framed subjectively*".[26] For many people who hear voices, biomedical interventions that remove the voices do not aid their recovery. The drive to remove 'symptoms' undermines the opportunity to make sense and meaning in their experiences.

Due to the dominance of the bio-medical approach, a consumer's disagreement with diagnosis, treatment decisions, or other psychiatric practices is often seen as evidence of a lack of capacity, pointing to a lack of understanding of recovery approaches as well as undermining consumer choice and consent. As an investigator, the OPA reports to the SAT the findings of their investigations into the capacity of mental health consumers, but the application of the current capacity tests creates a circular logic where the mental health consumers are judged to lack capacity because they disagree with a diagnosis, treatment decisions, or restrictive practices. Consumers find themselves in a legal bind in which they are judged to have the capacity to consent to treatment or practice. However, refusal to consent to the same treatment or practice is used as evidence of a lack of decision-making capacity.

There is an organisational culture of high intervention, where many consumers with highly stigmatised diagnoses are given medications that significantly impair their ability to live a full and productive life due to the highly sedating effects. In our discussions with Aboriginal mental health consumers, they reported distress they feel over family members who are the subject of substituted decision-making orders being left in a "zombie" like state due to what they report as over-medication. Focusing on the drivers of distress is broader than biomedical concepts of symptom management, offering consumers more holistic avenues for recovery and a higher quality of life. These approaches include managing and eliminating drivers of distress, including social prescribing, family violence, homelessness, trauma-related, physical, and/or general health services.

4.2.4 The impact of "colonial load" and racially driven deficit discourse

CoMHWA undertook recent consultations concerning the experiences of Aboriginal people in the mental health system, including those who experience substituted decision making. While the examples given were not all related to the culture of the OPA or Public Trustee, it is important to note that, for consumers, these systems interact with one another, and organisational cultures transfer through one community service, government departments, medical examinations, the court system, and other decision-makers. The following section has been reproduced from the submission made by CoMHWA to the Joint Standing

[26] Dillon, J. (2024, 1 February). ' The Hearing Voices Movement: Beyond Critiquing the Status Quo', *Hearing Voices Network* (Blog) https://www.hearing-voices.org/news/the-hearing-voices-movement/#content

Committee on Aboriginal and Torres Strait Islander Affairs to inform the Inquiry into Racism, Hate and Violence Directed at Aboriginal and Torres Strait Islander People:

> "Both Aboriginal consumers and workers described the additional burden they carry due to the mental health system's failure to understand their cultural obligations. This failure of the system to recognise this burden it creates is an example of how systemic racism and personal biases lead to the routine framing of Aboriginal and Torres Strait Islander people's social and emotional wellbeing and health in terms of a 'deficit discourse' or lack and failure. These systemic blind spots in the structures that produce disadvantage[27] and "the failure by health providers to supply adequate, culturally appropriate services"[28] shift the blame and place responsibility for addressing disadvantage on Aboriginal and Torres Strait Islander people as individuals.[29] As one Aboriginal Mental Health Worker commented:
>
> *"The term "cultural load" should be reframed, the load isn't created by our culture. This should be reframed as "colonial load"."*[30]
>
> Failures to understand cultural context, when combined with mental health stigma, can place Aboriginal consumers at risk of significant harm. Furthermore, biomedical approaches often frame mental health challenges as biological deviations from the 'norm.'[31] These approaches bleed into other interactions that Aboriginal consumers have with systems. Experiences such as wanting to travel to fulfil cultural obligations can be framed by workers as an Aboriginal consumer "failing to understand" or "not having insight into their illness", which can be used as a justification for involuntary treatment. Cultural obligations to store important possessions for family members and kin can be treated by housing workers as "hoarding" and seen as a marker of the Aboriginal consumer "being too unwell to maintain a tenancy". Obligations to care for extended family members and kin are labelled as evidence of incapacity to manage finances and used as evidence

[27] Bond, C. J., & Singh, D. (2020). More than a refresh required for closing the gap of Indigenous health inequality. *Medical Journal of Australia*, *212*(5), 198. https://doi.org/10.5694/mja2.50498

[28] Fogarty, W., Bulloch, H., McDonnell, S. & Davis, M. (2018). *Deficit Discourse and Indigenous Health: How narrative framings of Aboriginal and Torres Strait Islander people are reproduced in policy*, Lowitja Institute. https://www.lowitja.org.au/wp-content/uploads/2023/05/deficit-discourse.pdf

[29] Watego, C., Singh, D., & Macoun, A. (2021). *Partnership for Justice in Health Scoping Paper on Race, Racism and the Australian Health System.* Lowitja Institute. https://doi.org/10.48455/SDRT-SB97, p. 15

[30] Theme of feedback from a joint meeting between the CoMHWA's Statewide Aboriginal Mental Health Network (A network of non-clinical Aboriginal Mental Health Professionals) and the CoMHWA's Aboriginal Lived Experience Advisory Group

[31] Rhodes, L. (2019). The Colonising Effect of Western Mental Health Discourses. *Social Work & Policy Studies: Social Justice, Practice and Theory*, *2*(2). https://openjournals.library.sydney.edu.au/index.php/SWPS/article/view/14182, p. 7

> that the state should manage the finances of the Aboriginal consumer. Failure to grasp the cultural context a consumer is experiencing has the impact of extra labour, as the Aboriginal consumer must explain how community and roles work. This impact is often delivered when a consumer is most vulnerable, such as when they are in involuntary treatment, threatened with eviction or experiencing other significant stressors such as Family Domestic Violence. The vulnerability and external stressors may significantly reduce someone's ability to explain their cultural context. When the individual consumer cannot carry that colonial load, the cultural default and racist conclusions determine the course of their lives, which may result in the suspension of their human rights, including the right to withdraw consent to medical treatment."[32]

We have provided this information to give context to how the current institutions that are charged with assisting vulnerable Aboriginal Western Australians fail to be able to provide an organisational culture that emphasises their human rights as Indigenous People.

[32] CoMHWA. (2026). *Submission to the Inquiry into Racism, Hate and Violence Directed at Aboriginal and Torres Strait Islander People.* https://comhwa.org.au/wp-content/uploads/2026/05/SA-2026-7-Inquiry-into-Racism-Hate-and-Violence-towards-Aboriginal-and-Torres-Strait-Islander-People.pdf, p. 11.

4.2.5 Recommendations to improve the organisational culture of the OPA and Public Trustee

CoMHWA recommends that the organisational culture of the Office for the Public Advocate and Public Trustee change to prioritise the realisation of the human rights of vulnerable people. These organisations need to support the individual through processes that centre on their goals, dreams and aspirations. To facilitate this change, there will need to be legislative guidance and institutional buy-in. We have identified three main areas of organisational culture that need to be addressed:

- guardians and administrators be given guidance and training to be capable of differentiating between “mental illness symptoms” and “mental distress”;
- recognition of consumers’ right to holistic recovery; and
- commitment to building capacity for consumers to self-direct recovery.

CoMHWA recommends that mental health consumers co-design the wording and frameworks for this guidance. CoMHWA recommends that Aboriginal and Torres Strait Islander people co-design models of distress response that are more culturally appropriate than the current decision-making mechanisms.

CoMHWA recommends that the Office for the Public Advocate and the Public Trustee take steps to develop an organisational culture in which supported decision-making is the default and a right available to all represented persons, regardless of the individual's resources or community support.

4.3 The adequacy of mechanisms currently in place to resolve complaints, disputes and allegations

Current complaint mechanisms are not readily accessible or easy to find, and so represented persons often see their only recourse for disputes or complaints concerning a decision to be an application to the State Administrative Tribunal to have the guardianship or administration order revoked. This is unsurprising given that when accessing the Office for the Public Advocate website,[33] there is no mention of a complaints process. When the search term "make a complaint" is entered into the search box at the top, 17851 results appear, and none on the front page refer to making a complaint about guardianship. It takes significant digging to find a facts sheet cryptically named "Public Advocate — Customer feedback and service standards" to find any information on how to make a complaint.

The adequacy of complaint mechanisms is hampered by the current decision-making standard. The Law Reform Commission of Western Australia raised the issue of the best interests standard in *Discussion Paper Volume 1* of their review into the Guardianship and Administration Act 1990 (WA).[34] The LRCWA noted the interpretation of the best interests test by the State Administrative Tribunal was very broad, and we have provided some discussion of these cases.

Current case law states that the decisions made on behalf of a represented person cannot be "informed solely by regard to the guardian's own subjective views."[35] This test gives decision-makers a large amount of latitude. SAT has described the best interests test, which can equally be applied by guardians,[36] as "a very elastic concept and variable"[37], and they write that

> "the legislation should not generally be regarded as intending to supervise guardians or administrators in the exercise of their functions and responsibilities. Decisions made by guardians and administrators should be in the person's "best interests" and while some guidance is given in the legislation it is fundamentally a process of judgment and discretion";[38]

The current broad nature of the test means that there is no effective mechanism or accountability for guardians or administrators. CoMHWA Independent Advocates have spoken to mental health consumers who raised issues with decisions by Public Trustee and OPA that don't take into account them as a whole

[33] Office for the Public Advocate. (2026). *Office for the Public Advocate*. Government of Western Australia. https://www.wa.gov.au/organisation/department-of-justice/office-of-the-public-advocate

[34] Law Reform Commission of Western Australia. (2025) *Project 114, Guardian and Administration Act 1990 (WA), Discussion Paper Volume 1.* Government of Western Australia. https://www.wa.gov.au/system/files/2025-12/lrc-project-114-discussion-paper-vol-1_1.pdf, p. 93

[35] *ED* (2020) WASAT 34, para. 69 citing *GC and PC* (2014) WASAT 10, para. 27

[36] *ED* (2020) WASAT 34, para. 70

[37] *RLB and PMB* (2015) WASAT 64, para. 40

[38] *EP and AM* (2006) WASAT 11, para. 117

person. Represented people are also aware that decision makers have a very broad discretion about the decisions they make due to the current ‘best interests’ standards. Risks for the represented person in making complaints are significant given they are making a complaint against a person who has great power over them. Even if another guardian or administrator is appointed by the OPA or the Public Trustee, respectively, the represented person is aware that this may be someone who works closely with, or has personal interactions with, the person they complained about.

4.3.1 Consumer access to ‘pure advocacy’ services

CoMHWA hears from consumers who are represented persons that retaliation and other punitive or obstructive responses from guardians when they access advocacy services constrain their ability to raise and resolve issues and disputes. In our submission to the Law Reform Commission, we reported:

> “Some mental health consumers report punitive approaches by private guardians in response to mental health consumers seeking independent advocacy services. Including preventing access to friends, restrictions on liberty, instructing support staff not to allow the represented person to purchase items such as cigarettes, and the removal of discretionary spending money.”[39]

> “Mental health consumers have reported that their private guardians have blocked advocates from making enquiries about the financial, personal, medical, and restrictive practice decisions that have been made on their behalf. Advocates have been blocked from making enquiries concerning a guardian’s decisions to remove methods of payment, such as bank cards or online payment information. The use of substituted decision-making power to remove a represented person’s ability to enquire about the potential misuse of resources by their guardian is an absolute misuse of power and should not be allowed to continue.”[40]

The adequacy of complaint mechanisms is further hampered by the conflict role of the guardian as “advocate” as well as that of “decision-maker”. CoMHWA defines that the role of an advocate is to directly represent the expressed views of the person on whose behalf they advocate; this is often called ‘pure advocacy.’ When a substitute decision maker decides what is in the ‘best interests’ of a person, they cannot also be the person’s advocate, as these are distinctly different roles.

CoMHWA recognises that the way that “advocate” is framed within the Act is that a guardian may contact organisations such as service providers, other government departments, employers, etc., to seek that a

[39] CoMHWA. (2026). *Submission to the Law Reform Commission of WA – Guardianship and Administration Act Review*. https://comhwa.org.au/wp-content/uploads/2025/06/SA-2025-9-GAA-Law-Reform-Commission-of-Western-Australia-Project-114.pdf, p. 82

[40] Ibid, p. 50

decision is enacted for a represented person. We do not object to this role for a guardian, as it could involve organising housing, enrolling in education, medical appointments, etc. This becomes a problem when the represented person is in conflict with the guardian in their role as a decision-maker.

We explore later in the document the legislative issues concerning the provision of Electroconvulsive therapy to those unable to consent. Should a mental health consumer be subject to ECT as an involuntary patient, there are significant checks and balances in place, including the right to pure advocacy through the Mental Health Advocacy Service. Guardians are currently the only decision makers empowered by law to force a person to undergo ECT against their will without oversight from the Mental Health Tribunal. Under such circumstances, it is impossible for a guardian to be both a decision maker and an advocate.

4.3.2 Guardian/Trustee attendance at SAT hearings

Guardians and Trustees currently have no obligation to attend the SAT hearings involving the people they are responsible for supporting, despite the profound impact such hearings have on a person's life. Furthermore, CoMHWA has repeatedly heard that OPA guardians are unreachable when the SAT calls, leaving applicants and SAT members in the dark about the rationale for decisions or other matters, which diminishes accountability for the OPA.

One solution to increase accountability in this area would be to require that any future legislation on the processes of Guardianship and Administration mandate that guardians and trustees appear when the person they represent is attending a hearing. Other solutions include making it a policy requirement that the OPA and Public Trustee staff attend each hearing, with an external investigation process if a hearing is not attended, or SAT issuing a standard witness subpoena for the guardian/administrator prior to each hearing.

4.3.3 Recommendations for improved mechanisms to resolve complaints, disputes and allegations

CoMHWA recommends developing a website to provide information and resources for represented people, those subject to applications, and those who have been told they may be subject to applications.

CoMHWA recommends that people represented on orders, who are the subject of an application, or have been told they may be the subject of an application for orders, have access to free legal representation and individual advocacy in all forums where decisions are being made concerning their lives, to help avoid and resolve complaints, disputes, and allegations.

CoMHWA recommends that Guardians should not have the right to block or obstruct a represented person from accessing advocacy services.

4.4 Accessibility of information in a timely, fair and transparent manner

There is currently very little information available to people about guardianship or administrative orders, including their rights to advocacy, self-advocacy, and capacity building. The OP's published resources are currently available to those seeking information on performing the functions of guardianship or administration, or on planning for the future. As our above discussion concerning information about complaint pathways makes clear, what information is available is difficult to access.

One of CoMHWA's individual advocates noted how chaotic the guardianship system can be in relation to the activities and understanding of the person under orders, their health service providers, and other related organisations:

> *"No one knows the exact nature of the orders they are under. One client does not believe they have a guardian, even though they absolutely do. They are not aware of the limits and scope of what orders constitute. There is often confusion about what HSPs [health service providers] need to send, and what the scope of guardianship entails. Who actually has the orders is often unclear." (CoMHWA Individual Advocate)*

One consumer has had significant issues with the interactions between herself and other service providers due to the guardianship order she is currently under. The consumer reports that she has tried to obtain legal support regarding a housing and tenancy issue, and one organisation she spoke with said that they "would take it on, but wanted to speak with the guardian first, and wouldn't do it without this. [But the] guardian says it's not within her scope." There is no clear information about what the consumer can ask of her guardian regarding advocacy, nor what the orders mean in practice for her.

Seeking information from the OPA about processes, without involving or alerting the assigned OPA guardian, has proved difficult. One consumer described calling the OPA line for information about having orders reviewed or revoked, but was refused this information because they did not want to identify themselves or risk alerting their OPA guardian to their enquiries. The consumer then sent an email to OPA seeking general information about the process for reviewing an order, but didn't receive a response. The email was about reviewing an order. For information to be accessible, there must be the ability to provide and clarify it on a confidential basis.

4.5 Outcomes experienced by Represented Persons and their families because of decisions made by the Public Trustee and OPA

CoMHWA undertook a series of consultations that included individual discussions, broad focus groups, and specific group discussions with Aboriginal mental Health consumers. We also spoke with individual

advocates who provide pure advocacy for mental health consumers represented on guardianship and administration orders.

A key concern expressed by our focus group participants was the enormous impact that guardianship can have on their autonomy, self-worth and their ability to pursue a life that is meaningful to them. A critical facet of this concern is overzealous guardians denying the dignity of risk to those under their care, refusing to allow choices that general members of the public have the right to participate in. Other members noted the prevalent lack of capacity building and consultation about the choices that impact their everyday lives. Finally, our individual advocates spoke of the profound and infantilising impact that a guardianship order can have on everyday life and socialising for those placed under them. Some represented people reflected that they needed short-term support, but the length of time they were under orders significantly impacted their lives:

> *"The length of time that guardianship can happen for is crucial. If you get stuck too long, you lose confidence." (CoMHWA Member)*

4.5.1 Mental health stigma and systemic racism

In our submission to the Law Reform Commission, we raised that;

> "Aboriginal mental health consumers communicated deep distress about the lack of recognition of their family supports and the assumption that the OPA will do a better job looking after their interests[…] Aboriginal mental health consumers reflected that the narrow biological definitions of "family" as understood by mainstream Australia did not correctly identify the people who are the closest emotionally, most financially supportive, or able to articulate the will and preference of the consumer."[41]

When Aboriginal mental health consumers with highly stigmatised diagnoses are under guardianship orders, the guardian may default to making decisions that rely almost solely on the view of the medical treatment teams. Aboriginal mental health consumers stated that these decisions often contain significant cultural and systemic biases, which means Aboriginal mental health consumers are inappropriately or over-medicated with sedating medications.

[41] CoMHWA. (2026). *Submission to the Law Reform Commission of WA – Guardianship and Administration Act Review*. https://comhwa.org.au/wp-content/uploads/2025/06/SA-2025-9-GAA-Law-Reform-Commission-of-Western-Australia-Project-114.pdf, p. 23

"Professional people are making personal decisions from a professional position of power. They are using their personal biased opinion to treat Aboriginal people. We get the same treatment because of stigma rather than being seen as individuals." (Aboriginal CoMHWA Member)

"Doctors look at Aboriginal men and assume they are dangerous just based on how they look." (Aboriginal CoMHWA Member)

4.5.2 Lack of capacity building

The impact of having a guardian with a suitable practice for the person under orders was gestured to in the following comment from one of our members, who noted how a guardian they had experience with did not adopt a strengths-based approach to their care:

"There is such a negative focus, I feel like there could be ways to get to know a person, what they are good at, their strengths. Instead, you feel controlled because of your weaknesses." (CoMHWA Member)

This concern over being understood through objectified deficits and weaknesses was mirrored in the comments CoMHWA gathered about issues of autonomy more generally.

A lack of financial and employment skills development for people under the care of the OPA or Public Trustee was a recurring concern we heard from our members who told us that guardianship did not adequately prepare them for an independent life in the future. These members wanted help to make decisions and help to understand the processes involved, they found that all too often their guardians simply made decisions for them without explaining the rationale and systems involved:

"I was very young when I went under guardianship, and I feel like it didn't help me prepare to be an adult." (CoMHWA Member)

"After I got off the orders, I had no idea how to manage my money so these things being arranged made it harder for me. I wanted someone to help me do it, rather than just do it for me." (CoMHWA Member)

Because guardians play such an important role in the lives of the people they help support, the relationship between guardians and those under their care can be hugely impactful.

"I worked a lot in the prison system, and not a single time in many, many years did I see a single guardian visit. Good guardians could change these young lives. Knew a 15-year-old who wanted to be a bricklayer. Got him an apprenticeship, and he is now a qualified bricklayer and doing well, but all he

needed was a little bit of support. Guardian made no effort to support this young man. All many of these young people in incarceration just need a little boost." (CoMHWA Member)

Some of our members felt that there should be options for those under orders to prompt a review of their appointed guardian if they feel as though they are not being listened to or are receiving substandard care:

> *"You feel like you have lost control when you get a guardian… It's critical to emphasise how important picking the right guardian for the person is. There should be a feedback form each year where people can request a new guardian if they think that they could have a better fit." (CoMHWA Member)*

4.5.3 Denial of dignity of risk

Many of the members we spoke to felt they were not afforded the dignity of risk, despite being entitled to make potentially dangerous personal choices, just as any other member of the community is. Examples of such risky activities might include activities such as tobacco smoking. As one member wrote:

> *"Any decisions you make about your money are turn into simple good or bad decisions. You can't ask for money simply for cigarettes for example." (CoMHWA Member)*

The denigration of the right to the dignity of risk was also highlighted by CoMHWA's individual advocates, who noted that suspending this right was a restrictive practice that is often all too easily approved. They highlighted how easy it appeared to be to get restrictive practices put in place without appropriate deliberation about this decision to suspend a person's rights. They expressed concern that there was insufficient oversight into the approval of restrictive practices, and noted that, as a consequence of this overuse, people were often alienated from the system providing them with care:

> *"Preventing or restricting access to cigarettes is a restrictive practice and requires tribunal approval. If you open the door to restrictive practices, then the permission for these practices is open for everyone. It seems to be far too easy to get approval for restrictive practices, there needs to be more oversight, consultation with the individuals. It alienates people from the process and is deeply counterproductive." (CoMHWA Individual Advocate)*

Beyond this imposition on the right to the dignity of risk, our individual advocates spoke of their experiences with people under guardianship who had lost a great deal of sociality due to the onerous obligations of being under the care of the Public Trustee. Principally, this social disruption was caused by inherent delays in being able to contact the trustee to make their funds available at short notice:

"There is the concern with delays in receiving funds. A person I work with now can't go for drinks with friends on a Friday... He has to call an administrator to ask, and then will get the money on Monday or Tuesday. You have to accommodate and plan days ahead if you want a remotely normal life... Not just socialising, but also missing out on items for sale etc." (CoMHWA Individual Advocate)

Within all our consultations, it was reported that people would get far better outcomes if supported decision-making were introduced. Supported decision-making would help ensure that people under guardianship orders do not feel as isolated from the systems that determine their day-to-day lives, and that their desires, concerns, and meaningful activities are heard and understood by the guardians tasked with caring for them. The issue was summarised by a CoMHWA individual advocate:

"Guardians need to advocate, explain their decisions, and actually do supported decision-making." (CoMHWA Individual Advocate)

4.5.4 Lack of communication and consultation

Communication and consultation between guardians/trustees and represented people affect the quality of decisions and can lead to significant adverse outcomes. The difficulty in communicating with guardians and trustees was a common source of anger and frustration for many of our members, who described how these difficulties led to terrible experiences and severe confusion about what was happening in their lives. One issue we frequently heard was guardians making decisions for those in their care without any communication or consultation. Beyond this egregious disregard, other members noted their fear when making requests, as well as the lack of explanation for decisions to which they were informed. If the OPA and Public Trustee are to work effectively to facilitate the human rights of those represented on orders, developing and resourcing consistent, accessible modes of communication between guardians and those under orders will be an essential step. Concerningly, for many of our members, their issues with communicating with their guardians related to very general and basic questions that were completely unaddressed:

"I wish the process was explained to me earlier and better." (CoMHWA Member)

"Guardians need to be more proactive about reaching out to the people that they care for." (CoMHWA Member)

"Never been asked by the guardian what would I like, what would I like to see. I am never asked: 'is this working, what can I do better?'"(CoMHWA Member)

“What am I going to do? The guardian is supposed to be acting in my best interest, but how can she know when she never talks to me?”(CoMHWA Member)

“The person I was caring for had so many difficulties in contacting their guardian, they felt like it was impossible.” CoMHWA Member

An additional factor complicating communication between guardians and those under orders is the power imbalance and the sense that this communication will escalate a situation. As one member wrote:

“I felt like I couldn’t contact my guardian if I was in trouble or something bad was happening, because it would look bad for me and make the situation worse.” (CoMHWA Member)

Another member noted their distress and the frustration they felt when their public trustee was changed without any effort at communicating this fact to them:

“I had a public trustee, and they didn’t communicate to me that my public trustee was changed. I emailed the address and then suddenly there was a different person responding.” (CoMHWA Member)

The issues arising from poor communication between guardians and represented people can affect the understanding people under orders have of the system they are enmeshed in. CoMHWA’s individual advocates noted some of these consequences of poor communication:

“There is a lack of understanding about what a guardian or trustee can actually do. The people under orders don’t know what they can actually request, how reviews work, or the specific nature of the orders.” (CoMHWA Individual Advocate)

CoMHWA’s individual advocates also noted how communication difficulties with guardians can impact on other services used by people under guardianship, and spoke of their experiences with members who struggled to be able to make GP appointments due to having a trustee:

“Communication with guardians is challenging at the best of times. But think of the stress of having to ask for some of your money in advance because you need see a doctor… there are just so many barriers to easy access.” (CoMHWA Individual Advocate)

This story also highlights an ongoing problem in which GPs refuse to see people under guardianship or administration because they know they will not be paid promptly; the fact that GPs are instituting this policy indicates a recurring, systemic issue in which public trustees and guardians do not respond quickly enough to meet the person's needs.

"I had to request any medical interventions through my guardian, which was very inconvenient, and made it impossible to arrange quick visits" (CoMHWA Member)

Communication was also cited by these individual advocates as an essential skill that good and effective guardians possess, describing what good communication looks like in the following comment:

"The best guardians have clients who know their name, they answer the phone when they should be able to be contacted. If they have taken the time to go out and meet the person under orders [it makes] a huge difference... Without communication it can be hugely disempowering for the person under guardianship." (CoMHWA Individual Advocate)

It is also important to acknowledge that, though not mandated in the Act, there are guardians working presently who do adopt the spirit of supported decision-making in their practice. This disconnect between good, ethical interpersonal care on the one hand, and the legislated systems of guardianship described in the Act on the other, was captured by the following feedback from one of our members:

"I liked my guardian, but the systems of guardianship did not make me feel supported, only the people in the system did." (CoMHWA Member)

4.5.5 Fees charged by the Public Trustee

CoMHWA members reported significant distress over the decision to charge fees to those under administration orders, who feel that they are effectively paying for the privilege of having their rights suspended by the State, as their quotes illustrate:

"My neighbour was very, very unwell, and guardianship really made her health much worse. Once the situation was resolved, she got better. They were also charging her a lot of money, which she found particularly difficult." (CoMHWA Member)

"The fees that are charged are very high, and they need to make sure that you can contact them easily." (CoMHWA Member)

They were unaware of the costs associated with being placed on administrative orders and of the delays in having them lifted once their decision-making capacity improved, leaving them significantly worse off financially, as illustrated by this feedback from CoMHWA members on their experiences of being represented by the public trustee:

"Maybe 2 years after I got a trustee, I asked them where my money went. I had no idea that I was paying for the public trustee themselves. It felt very odd that I had to ask to find this out." (CoMHWA Member)

“A year into being under administration orders, I asked to see a breakdown of how my money was spent. They showed it to me…but you shouldn’t have to ask, they should tell you”. (CoMHWA Member)

Currently, the Public Trustee is self-funded, which means that some mental health consumers are subsidising the Public Trustee's work more broadly. CoMHWA feels that this cannot be allowed to continue.

4.6 Whether current oversight mechanisms are adequate to ensure guardians and administrators are held accountable for their decisions

CoMHWA has heard from our members of the difficulties of navigating other institutions while under guardianship. Sometimes these institutions were explicitly related to guardianship orders, such as engaging with the State Administrative Tribunal to have orders removed or adjusted. Other comments spoke to the challenges when navigating making a complaint about a guardian, or engaging with adjacent services while under guardianship orders. Some members felt that they did not trust either the Office of the Public Advocate or the Public Trustee, and noted that they wanted a dedicated complaints/feedback body that was independent to prevent poorly administered orders from negatively impacting people:

“Give the individual an opportunity for feedback. This needs to be given to an independent body... It [guardianship] is supposed to help people and not damage them further.” (CoMHWA Member)

Current oversight mechanisms for decisions made concerning mental health consumers under these orders do not embed lived experience governance. As such, CoMHWA feels they cannot fulfil obligations under Article 4.3 of the UNCRPD, which obliges States, in the “*development **and implementation** of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities,”* to *“closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations*.” [emphasis added]. The National Mental Health Consumer and Carer Forum provides a detailed framework of the lived experience governance model that frames lived experience governance as a form of stewardship that ensures organisational culture remains centred on those who they are designed to serve.[42] In our Submission to the Law Reform Commission of Western Australia, we noted the need for a distinct change in the oversight of organisations that can impact the human rights of mental health consumers. We noted, “[t]he lived experience governance model expressed within the Lived Experience Governance Framework has been

[42] Hodges, E., Leditschke, A., Solonsch, L. (2023). *The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All.* Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, p. 12-13

created for implementation within the mental health providers and the governance models that apply within that industry. However, the model is applicable and transferable to the oversight mechanisms that are implemented in any area where the human rights of mental health consumers must be safeguarded."[43]

Even in contexts where civil penalties exist, traditional oversight mechanisms designed to protect the human rights of mental health consumers tend to favour those empowered by the current system, and have demonstrated a hesitancy to use civil penalties to protect those who are disempowered within the system.[44] For example, the Victorian Mental Health Commission is a traditional oversight authority that has failed to use its enforcement power, as despite over 14,000 complaints being made to the organisation over 9 years, the Commission has failed to issue a single compliance notice.[45] A recent audit of the Australian Human Rights Commission complaints management processes noted, "[c]*omplaints handling is not demonstrably fully effective. The Commission has not met its key performance indicator for conciliating complaints in each of the three most recent years and a greater proportion of complaints are being terminated or discontinued*."[46]

4.6.1 Oversight related to Electroconvulsive Therapy

In Australia, Electroconvulsive Therapy ("ECT") is a highly regulated and historically controversial treatment therapy.[47] The *Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2024,* outline the oversight and protections for ECT treatment of patients who are "involuntary" under the *Mental Health Act 2014* (WA) ("*Mental Health Act").*[48] These protections do not apply to mental health consumers under guardianship orders if their guardian consents for them to receive ECT. Due to a legal gap, a patient under a guardianship order whose guardian has given consent to treatment is legally defined as "voluntary" and "consenting" for the purposes of the *Mental Health Act,* even if the consumer does not

[43] CoMHWA. (2026). *Submission to the Law Reform Commission of WA – Guardianship and Administration Act Review*. https://comhwa.org.au/wp-content/uploads/2025/06/SA-2025-9-GAA-Law-Reform-Commission-of-Western-Australia-Project-114.pdf p 53.

[44] Katteral, S. (2023). Resolving mental health treatment disputes in the shadow of the law: The Victorian experience. *Australian Dispute Resolution Bulletin*, *2023* (September), p. 20-22

[45] Ibid, p. 20

[46] Australian National Audit Office (2025). *Management of Complaints by the Australian Human Rights Commission* (Auditor-General Report No. 24 2024–25). Australian Government. https://www.anao.gov.au/work/performance-audit/management-of-complaints-the-australian-human-rights-commission, p. 6

[47] Wilson, K., Purushothaman, S., & Kolur, U. (2022). Psychiatric advance directives and consent to electroconvulsive therapy (ECT) in Australia: A legislative review and suggestions for the future. *International Journal of Law and Psychiatry*, *85*, 101836. https://doi.org/10.1016/j.ijlp.2022.101836

[48] Chief Psychiatrist of Western Australia, *Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2024, March 2025 version (2.2).* Western Australian Government. https://www.chiefpsychiatrist.wa.gov.au/standards-guidelines/guidelines-ect/, p. 27

want this treatment. No data are reported on the frequency, nature, or circumstances of the consent given for ECT use by either private or public guardians.

Public and private guardians do not have the resources, specialist health or medical expertise to assess whether electroconvulsive therapy is necessary, what alternatives are available, and the impact of the provision of ECT on a person without their consent. There is more oversight of a highly qualified psychiatrist when they administer ECT to a person under the *Mental Health Act* than a lay guardian under the *Guardianship and Administration Act*. CoMHWA raised this issue in our submission to the Law Reform Commission of Western Australia review into the *Guardian and Administration Act 1990* (WA). Unfortunately, this is a legal gap that falls between the *Mental Health Act* and the *Guardian and Administration Act.* The Law Reform Commission of Western Australia commented "[w]hile we are of the view that consideration should be given to requiring ECT to have the same statutory decision-making mechanisms as sterilisation and termination of pregnancy, we do not make a recommendation to this effect. This would involve a review of the MHA's provisions, which is beyond the Commission's Terms of Reference." CoMHWA hopes that the broader scope of this inquiry can lead to prompt action to close this gap in legislative oversight of this practice.

4.6.2 Oversight related to restrictive practice

We have discussed above the growing role of service providers in applying for Guardianship orders and its link to the use of restrictive practices. The current functioning of guardianship in WA fails to protect vulnerable mental health consumers against this harm.

The current standard formulation of orders relating to restrictive practice is extremely broad.[49] There is no obligation under legislation, OPA guidelines/public policy, or standard orders to collect data on what, when, and how these restrictive practices are used, on efforts to minimise their use, or on alternatives that were considered. This stands in direct contrast with other legislation that allows for these practices, such as the Mental Health Act.

Opt-out advocacy services are currently the practice for mental health consumers who have been subject to seclusion or restraint under Victoria's *Mental Health and Wellbeing Act 2022*.[50] It is appropriate that similar services are provided for those who have similar practices used while on guardianship orders.

[49] Example: *K* (2025) WASAT 15, para. 52-53

[50] *Mental Health and Wellbeing Act 2022* (Vic) s. 43

4.6.3 Recommendations to ensure guardians and administrators are held accountable for their decisions

CoMHWA recommends that decision makers be formally trained in supported decision making and human rights as they apply to the exercise of power over represented persons. Decision makers should sign agreements stating they understand how to implement their responsibilities, including to uphold the human rights and support the decision-making capacity of the represented person.

CoMHWA recommends that public and private guardians should be subject to regular accountability measures, including auditing, in the following areas:

- How they have engaged in supported decision making.
- How they have supported the represented person's access to culturally relevant practices.
- How they have determined the will and preferences of the consumer and how they have supported the represented person's will and preferences.
- What activities have been undertaken to build capacity for independence and decision-making.
- What treatment decisions have been made on behalf of the consumer.
- What restrictive practices have been authorised.
- If coercive practices have been used.

Moreover, this data should be maintained and made available to the public through regular reporting mechanisms.

Electroconvulsive therapy

CoMHWA recommends that immediate action be taken on the legislative gap between the Mental Health Act and the Guardianship and Administration Act that allows for a guardian to decide that a mental health consumer receive electroconvulsive therapy with no oversight from any tribunal. Furthermore, we recommend that electroconvulsive therapy not be administered to any person against their will and preferences.

CoMHWA recommends that lived experience governance, and where applicable, Aboriginal lived experience, be embedded into all spaces where the Act is administered, including but not limited to oversight of the operations of the OPA, auditing of guardianship and administration, and inclusion in the SAT decision-making processes.

Restrictive Practice

CoMHWA recommends that higher levels of accountability be exercised regarding the restrictive practices. This would start by collecting data on where, when, and how restrictive practices were

used. Each time restrictive practices are used, the OPA guardian should be responsible for:

- Collecting data on what restrictive practice was used, and this should be published annually in a report similar to that of the Chief Psychiatrist;[51]
- Visiting the represented person to see what supports are needed after the incident;
- Speak to staff about cause of the incident and what is being done to prevent the further use of restrictive practices; and
- View the file to ensure that the incident is correctly documented and that relevant regularity notifications have been made by the service.

CoMHWA recommends that the use of restrictive practices against represented people should trigger a notification to an opt-out advocacy service. So, the represented person may have someone to conduct non-legal, consumer-directed advocacy on their behalf regarding the issue.

[51] Office of the Chief Psychiatrist. (n.d). *Seclusion and Restraint.* Western Australian Government. https://www.chiefpsychiatrist.wa.gov.au/good-practice/monitoring-reporting/seclusion-restraint/

4.7 The role and conduct of the State Administrative Tribunal as far as it relates to the above

4.7.1 Experiencing a SAT hearing

A Consumer's Perspective on a SAT Hearing in 2025

> *"At the initial SAT hearing, no one told me what was going on. SAT was not very accessible or approachable. I was just told to rock up – didn't know where I was going and was very unwell at the time. It's like a maze, there is a lot of security. You just have to sit down and hope for the best. You have to address them in a certain way[…] It's a courtroom. It's very isolating and it's very much all focused on you. Even when you have to go there and just sit there and not speak, it's very intimidating. I was overwhelmed. It's very triggering. Not person-centered. It was scary as hell! I was really upset after the hearing, and I just ran away […] I worry about people who don't realise there are things out there that they can access. If they aren't telling me and I'm pushing, then no one is being given info! They don't make easy-read versions, nothing is accessible. Nothing is explained. Don't know where to look, don't know you HAVE to look."*

It is important to recognise that the SAT is, for those placed under Guardianship or Administrative Orders, one of the very few mechanisms that can provide oversight and accountability and represents a critically important safeguard to prevent against harms to represented persons in this system. It is therefore imperative that the processes of the SAT are structured to *maximise accessibility* for those under orders, and that, when determining a matter, the SAT should engage with concerns in a holistic and contextualised fashion rather than operating strictly according to legal obligations in rendering a decision.

The dysregulation and disruption experienced by consumers during the SAT processes are legally recognised as a specific basis for denying review.[52] However, little attention is paid to the consequences caused by the processes during hearings, including how dysregulation resulting from the processes impacts a person's ability to self-advocate or articulate themselves. One consumer stated that they had been dysregulated during the hearing, and this led SAT to make the conclusion that they lacked capacity:

> *"At the initial SAT hearing, no one told me what was going on. No one told me not to speak up, if I hadn't said anything […] I would not have guardianship." (CoMHWA Member)*

[52] For Example: *RK* (2022) WASAT 112, para. 38

This was different for another consumer who had support from an individual advocate. Individual advocates have a broader scope than legal advocacy alone. The advocate described the impact that preparation, advocacy for disability, and the strong support they provided had on the outcomes:

> *"In preparation for the appeal hearing, James (not his real name) told the advocate he was worried that becoming distressed or angry could be misinterpreted by the Tribunal. Together, they developed a plan to manage his emotions during the hearing. The advocate wrote to the Tribunal in advance, explaining the emotional impact of the process and requesting that short breaks be allowed if needed.*
>
> *At the appeal hearing, James clearly demonstrated how his circumstances had changed and that he understood his finances and the consequences of his decisions. When he became overwhelmed, the hearing was paused, allowing James to step outside and be supported by his wife and the advocate before continuing." (CoMHWA Individual Advocate)*

We have discussed above the difficulties those with private guardians have experienced when they have been subjected to abusive behaviours from their guardians. The issue is compounded by the difficulty of navigating access outlined above, as well as the contextual issue of proximity when complaints automatically defer to a conciliation approach, where the guardian will be informed of this complaint and, in some cases, will have the opportunity to adversely impact the person under guardianship in retaliation for raising this concern.

4.7.2 Accessibility of the SAT

The established pathway to register applications for review of orders to the SAT, namely the "ECourt" system.[53] The ECourt system is extremely difficult to navigate for many people living with a psychosocial disability. At the time of this submission, many of the formats to provide documentation links on the SAT webpage are broken and do not function. CoMHWA Individual Advocates have experienced the Tribunal recommending that people use the 'Have your say' section to upload documents as a workaround. The pathways for contacting the SAT are in dire need of improvement to ensure that their processes and oversight can be accessed without requiring represented persons to overcome unnecessary barriers. This is especially important for facilitating the review of orders and other concerns that may be held by those who themselves are under orders. We believe that the SAT should operate in accordance with the Australian Guardianship and Administration Council's ("AGAC") guidelines for Australian tribunals to maximise a

[53] State Administrative Tribunal. (2023). *Guide for Self-Represented Persons (from filing to enforcement).* Western Australian Government. https://sat.justice.wa.gov.au/_files/Guide_for_Self-Represented_Persons.pdf

person's participation in guardianship proceedings.[54] The implementation of these guidelines should be co-designed with mental health consumers, and oversight of implementation should include lived-experience governance to ensure that unforeseen issues are quickly identified and resolved.

CoMHWA believe that there could be more done to ensure that communication with represented persons attending the SAT is conducted clearly and equitably. To this end, we believe that the Act should allow for the appointment of a 'communication partner' to assist a person to navigate proceedings. In this context it is appropriate that people with lived experience of guardianship would be well placed to be trained to provide support and advocacy for those under guardianship orders. Communication support should, at a minimum, align with the NJC Communication Bill of Rights, and the Developmental Disability WA easy-read version of the Communication Bill of Rights to best support those under orders to have their preferences for communication respected.

Additionally, the procedures and processes of SAT hearings can often be intimidating for those under orders to navigate, requiring formalities and titles to be observed as well as being undertaken in settings that emphasise power imbalances through their arrangement. CoMHWA's advocates have reported positively about the ability of SAT members to accommodate the needs of those people they have represented, including eschewing titles and formalities. This resulted in a represented person feeling comfortable enough to attend a hearing in person. We need to reshape SAT processes so that the person who is the subject of the hearing is central to the process, and is provided with advocacy to help communicate their preferences about how to best engage in hearings to the SAT prior to these proceedings.

4.7.3 Formulation of orders

Effectiveness of orders

The current focus of SAT hearings is often oriented around the necessity of orders, and does not consider whether the order has been effective in achieving its purpose. This issue is especially prevalent in situations where a person has been appointed a public advocate from the OPA.

CoMHWA's individual advocates, who often work with people under guardianship orders, have described concerning situations where a review of orders by the SAT revealed that a public advocate had not been in contact with the person they represent in 6 months, leading to a lack of support as a previously utilised service provider had changed their business. In the hearing, the SAT were focused on deciding whether

[54] Australian Guardianship and Administration Council. (2019). *Maximising the Participation of the Person in Guardianship Proceedings: Guidelines for Australian Tribunals.* https://www.agac.org.au/assets/documents/Guidelines/AGAC-Best-Practice-Guidelines-2019.pdf

orders were still required, and did not comment or act upon the very obvious ineffective management of the guardian with this person.

CoMHWA suggests that future assessment for the need for continued orders should include, as a part of order reviews, a requirement for the SAT to comment on and note whether the orders have been *effective* for a particular represented person. Assessing effectiveness should involve consideration of three key factors in how an order is being administered, namely the degree of communication between the Guardian and represented person, the timeliness of communication and actions by the guardian, and the alignment between the guardian's actions and the will and preferences of the represented person. To clarify, the noting of the effectiveness of orders considered by members of the SAT would not be a process involving subsequent direct actions or determinations, but rather a method of ensuring accountability around the management of orders for represented persons that could be considered in future SAT determinations, as well as other avenues such as complaints to relevant bodies such as the OPA.

Blanket approval of restrictive practices

> *The "Guardianship [Order] doesn't say anything about mental health and psychosocial at all – it's dangerous, it's very broad." (CoMHWA Member)*

The current process for approving restrictive practices has left many people under orders with lasting harm, stemming from the blanket nature of this process and the practice of post-hoc approval of restrictive practices when these have been used without approval. As it stands, the approval for a Guardian to be able to authorise restrictive practices is unspecified in relation to the kind of restrictive practice that is being considered.

We have heard of people under orders who have had their guardians empowered to use restrictive practices because they may require a single tablet of lorazepam when feeling agitated, and the current bifurcated process means that this gives their guardian wholesale permission for all restrictive practices, rather than in the context of a specified permission to employ medication in particular circumstances. This is deeply concerning and has the potential to facilitate unethical and inappropriate treatment of represented persons. It is CoMHWA's view that future Guardianship and Administration Acts should delineate restrictive practice approval into separate categories to ensure that the human rights of represented persons are upheld to maximal possible degree.

In our submission to the Law Reform Commission of Western Australia, we reported consumers' concerns about how orders are drafted and that they do not align with the least restrictive principles, as follows:

> "Consumers are reporting to us that the current way orders are structured means that Orders are far broader than they need to be. When Orders are currently written, they allow for the

> substitution of decision-making across a broad platform, i.e., “medical decisions” or “restrictive practice”. This can lead to serious unintended consequences for the represented person. An example may be that a consumer may agree at a Tribunal hearing that they would like assistance to quit smoking. They may agree that it would be helpful to have their Guardian be able to instruct support staff not to purchase cigarettes on their behalf. The ability to direct staff in this fashion is defined as “restrictive practice”. The consumer then finds that an order is made that authorises a Guardian to consent to any type of restrictive practice on their behalf.”

This reflects the wish that many people with decision-making challenges have for support to reach their goals and improve their lives. SAT orders should be tailored to emphasise this support rather than creating blanket authority.

4.7.4 Recommendations concerning the role and conduct of the SAT

CoMHWA recommends that the person who is the subject of the hearing should be central to the process. The represented person's will and preferences should determine, to the greatest possible extent, who is eligible to be a party to proceedings and the preferred manner and settings to inform how proceedings are conducted.

CoMHWA recommends that SAT processes should allow for the appointment of a 'communication partner' to ensure that a person understands and is understood during proceedings.

CoMHWA recommends that the SAT should operate in accordance with the Australian Guardianship and Administration Council's guidelines for Australian tribunals to maximise a person's participation in guardianship proceedings.

CoMHWA recommends that communication support should, at a minimum, align with the NJC Communication Bill of Rights, and the Developmental Disability WA easy-read version of the Communication Bill of Rights to best support those under orders to have their preferences for communication respected.

CoMHWA recommends that people with lived experience of guardianship would be well placed to be trained to provide peer support and advocacy for those under guardianship orders as they navigate the processes.

CoMHWA recommends that the practice of making blanket orders that authorise "restrictive practices" should end and that Orders should delineate restrictive practice approval into separate categories to ensure that the human rights of represented persons are upheld to maximal possible degree

CoMHWA recommends that people who are the subject of applications or who are represented under the Act should have access opt-out legal representation and individual advocate services in any decision-making forums, including all Courts, Tribunals, and other legal forums, where decisions are made concerning their lives.

CoMHWA recommends that as a part of order reviews, a requirement for the SAT to comment on and note whether the orders have been *effective* for a particular represented person. Assessing effectiveness should involve consideration of three key factors in how an order is being administered, namely the degree of communication between the Guardian and represented person, the timeliness of communication and actions by the guardian, and the alignment between the guardian's actions and the will and preferences of the represented person.

CoMHWA recommends that guardians and trustees be mandated to appear when the person they represent is attending a hearing.

5. Conclusion

In conclusion, CoMHWA calls for urgent, systemic reform of Western Australia's guardianship and administration frameworks to better protect the human rights, autonomy, and dignity of mental health consumers and Aboriginal and Torres Strait Islander peoples. Central to these reforms is the transition from substituted decision-making to supported decision-making as the default approach, supported by adequate funding, culturally safe practices, and comprehensive training for guardians, trustees, and decision-makers. Within the agencies and tribunals, there is a need for stronger accountability, oversight, advocacy access, and lived experience leadership across all levels of the State Administrative Tribunal, the Office of the Public Advocate, and the Public Trustee. The work we have undertaken on this issue has given us a unique understanding of how mental health consumers experience guardianship and administration orders, their interactions with the OPA and Public Trustee, their lived experience of facing tribunal hearings concerning their rights, and their wishes for support with decision-making that does not alienate them from directing their own lives. To this end, CoMHWA has focused on ensuring that the views of our members with experience of guardianship have been central to the formation of our recommendations.

6. List of recommendations

6.1 The organisational capability of the OPA and Public Trustee

CoMHWA recommends that the Office for the Public Advocate and Public Trustee be appropriately and immediately resourced.

CoHMWA recommends that the state government should subsidise the functioning of the Public Trustee. People who are represented in substituted decision-making orders due to mental health challenges should not be charged fees by the Public Trustee.

CoMHWA recommends that a lived experience expert-led investigation be commissioned by the government in order to understand the complex reasons for the disproportionate use of substituted decision-making orders in Western Australia, including those related to the Office for the Public Advocate and Public Trustee's capabilities to ensure human rights.

CoMHWA recommends that the Office for the Public Advocate and Public Trustee be empowered to represent and protect the human rights of vulnerable people through legislative changes that enshrine supported decision-making as a right, regardless of the represented person's resources or community support. Additionally, we recommend that the Office for the Public Advocate and the Public Trustee be resourced and trained to ensure that represented people have strong support in their decision-making and in expressing their wills and preferences, including understanding fluctuating decision-making capacity, capacity building, and strengths-based supported decision-making approaches.

CoMHWA recommends that changes be made to give the Office for the Public Advocate and Public Trustee the capability to represent and protect Aboriginal mental health consumers' rights under the United Nations Declaration on the Rights of Indigenous Peoples as follows:

- Aboriginal community-controlled organisational structures are created to undertake the functions of the OPA and Public Trustee in line with the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan.
- Aboriginal and Torres Strait Islander consumers, family/kin and organisations and their culturally appropriate representatives co-produce the guidelines for legislation, policy and organisational standards that will be applied to them.

6.2 The organisational culture of the Public Trustee's Office and the OPA

CoMHWA recommends that the organisational culture of the Office for the Public Advocate and Public Trustee change to prioritise the realisation of the human rights of vulnerable people. These organisations need to support the individual through processes that centre on their goals, dreams and aspirations. To facilitate this change, there will need to be legislative guidance and institutional buy-in. We have identified three main areas of organisational culture that need to be addressed:

- Guardians and Administrators be given guidance and training to be capable of differentiating between "mental illness symptoms" and "mental distress";
- Recognition of consumers' right to holistic recovery; and
- Commitment to building capacity for consumers to self-direct recovery.

CoMHWA recommends that mental health consumers co-design the wording and frameworks for this guidance. CoMHWA recommends that Aboriginal and Torres Strait Islander people co-design models of distress response that are more culturally appropriate than the current decision-making mechanisms.

CoMHWA recommends that the Office for the Public Advocate and the Public Trustee take steps to develop an organisational culture in which supported decision-making is the default and a right available to all represented persons, regardless of the individual's resources or community support.

6.3 The adequacy of mechanisms currently in place to resolve complaints, disputes and allegations.

CoMHWA recommends developing a website to provide information and resources for represented people, those subject to applications, and those who have been told they may be subject to applications.

CoMHWA recommends that people represented on orders, who are the subject of an application, or have been told they may be the subject of an application for orders, have access to free legal representation and individual advocacy in all forums where decisions are being made concerning their lives, to help avoid and resolve complaints, disputes, and allegations.

CoMHWA recommends that Guardians should not have the right to block or obstruct a represented person from accessing advocacy services.

6.4 Oversight and accountability

CoMHWA recommends that decision makers be formally trained in supported decision making and human rights as they apply to the exercise of power over represented persons. Decision makers should sign agreements stating they understand how to implement their responsibilities, including to uphold the human rights and support the decision-making capacity of the represented person.

CoMHWA recommends that public and private guardians should be subject to regular accountability measures, including auditing, in the following areas:

- How they have engaged in supported decision making.
- How they have supported the represented person's access to culturally relevant practices.
- How they have determined the will and preferences of the consumer and how they have supported the represented person's will and preferences.
- What activities have been undertaken to build capacity for independence and decision-making.
- What treatment decisions have been made on behalf of the consumer.
- What restrictive practices have been authorised.
- If coercive practices have been used.

Moreover, this data should be maintained and made available to the public through regular reporting mechanisms.

6.4.1 Electroconvulsive Therapy

CoMHWA recommends that immediate action be taken on the legislative gap between the Mental Health Act and the Guardianship and Administration Act that allows for a guardian to decide that a mental health consumer receive electroconvulsive therapy with no oversight from any tribunal. Furthermore, we recommend that electroconvulsive therapy not be administered to any person against their will and preferences.

CoMHWA recommends that lived experience governance, and where applicable, Aboriginal lived experience, be embedded into all spaces where the Act is administered, including but not limited to oversight of the operations of the OPA, auditing of guardianship and administration, and inclusion in the SAT decision-making processes.

6.4.2 Restrictive practice

CoMHWA recommends that higher levels of accountability be exercised regarding the restrictive practices. This would start by collecting data on where, when, and how restrictive practices were used. Each time restrictive practices are used the OPA guardian should be responsible for:

- Collecting data on what restrictive practice was used, and this should be published annually in a report similar to that of the Chief Psychiatrist;[55]
- Visiting the represented person to see what supports are needed after the incident;
- Speak to staff about cause of the incident and what is being done to prevent the further use of restrictive practices; and
- View the file to ensure that the incident is correctly documented and that relevant regularity notifications have been made by the service.

CoMHWA recommends that the use of restrictive practices against represented people should trigger a notification to an opt-out advocacy service. So, the represented person may have someone to conduct non-legal, consumer-directed advocacy on their behalf regarding the issue.

6.5 The role and conduct of the State Administrative Tribunal

CoMHWA recommends that the person who is the subject of the hearing should be central to the process. The represented person's will and preferences should determine, to the greatest possible extent, who is eligible to be a party to proceedings and the preferred manner and settings to inform how proceedings are conducted.

CoMHWA recommends that SAT processes should allow for the appointment of a ‘communication partner’ to ensure that a person understands and is understood during proceedings.

CoMHWA recommends that the SAT should operate in accordance with the Australian Guardianship and Administration Council’s guidelines for Australian tribunals to maximise a person’s participation in guardianship proceedings.

CoMHWA recommends that communication support should, at a minimum, align with the NJC Communication Bill of Rights, and the Developmental Disability WA easy-read version of the Communication Bill of Rights to best support those under orders to have their preferences for communication respected.

CoMHWA recommends that people with lived experience of guardianship would be well placed to be trained to provide peer support and advocacy for those under guardianship orders as they navigate the processes.

[55] Office of the Chief Psychiatrist. (n.d). *Seclusion and Restraint.* Government of Western Australia. https://www.chiefpsychiatrist.wa.gov.au/good-practice/monitoring-reporting/seclusion-restraint/

CoMHWA recommends that the practice of making blanket orders that authorise “restrictive practices” should end and that Orders should delineate restrictive practice approval into separate categories to ensure that the human rights of represented persons are upheld to maximal possible degree

CoMHWA recommends that people who are the subject of applications or who are represented under the Act should have access opt-out legal representation and individual advocate services in any decision-making forums, including all Courts, Tribunals, and other legal forums, where decisions are made concerning their lives.

CoMHWA recommends that as a part of order reviews, a requirement for the SAT to comment on and note whether the orders have been *effective* for a particular represented person. Assessing effectiveness should involve consideration of three key factors in how an order is being administered, namely the degree of communication between the Guardian and represented person, the timeliness of communication and actions by the guardian, and the alignment between the guardian’s actions and the will and preferences of the represented person.

CoMHWA recommends that guardians and trustees be mandated to appear when the person they represent is attending a hearing.

12 / 275 Belmont Avenue, Cloverdale WA 6105
9258 8911 | admin@comhwa.org.au | ABN: 95 581 286 940

www.comhwa.org.au