



**CHIEF PSYCHIATRIST**  
of Western Australia

# Chief Psychiatrist's Guidelines

As required under Section 547 of the Mental Health Act 2014

**December 2015**

## Acknowledgement

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## Message from the Chief Psychiatrist

The Mental Health Act 2014, requires the Chief Psychiatrist to be responsible for overseeing the treatment and care to a range of users of mental health services. As Chief Psychiatrist, I am required to discharge that responsibility by publishing a series of eight guidelines (ref. MHA 2014 sec. 547) pertaining to the following;

- (a) making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order;
- (b) making decisions under section 26(3)(a) about whether or not a place that is not an authorised hospital is an appropriate place to conduct an examination;
- (c) ensuring as far as practicable the independence of psychiatrists from whom further opinions referred to in section 121(5) or 182(2) are obtained;
- (d) making decisions under section 183(2) about whether or not to comply with requests made under section 182 for additional opinions;
- (e) the preparation, review and revision of treatment, support and discharge plans;
- (f) the performance of electroconvulsive therapy;
- (g) compliance with approved forms;
- (h) ensuring compliance with this Act by mental health services.

Guidelines in this context, is to be a basic reference point seeking to consistently leverage safe and quality care for the benefit of consumers and carers. It is the responsibility of services to consider this set of guidelines.

As Chief Psychiatrist, I value the skill and commitment of Mental Health Service Staff. They, together with the central role of consumers and carers in shared decision making, represent the greatest assets available to Mental Health Services.

From time to time, as appropriate, I may publish guidelines for other purposes relating to the treatment and care of persons who have a mental illness.

The guidelines complement and must be read in conjunction with the existing relevant documents such as the Chief Psychiatrist's Standards for Electroconvulsive Therapy. While these guidelines have statutory relevance for Mental Health Services as defined by the MHA 2014, I commend these guidelines to the broader mental health sector for consideration.



**Dr Nathan Gibson**  
**CHIEF PSYCHIATRIST**

**30 November 2015**

## Chief Psychiatrist's Standards and Guidelines Working Group (CPSGWG)

The CPSGWG was established to develop the Chief Psychiatrist's Standards and Guidelines as required under Section 547 of the Mental Health Act 2014 (the Act).

The purpose of the Guidelines and Standards is to assist in the development and implementation of appropriate practices and to guide continuous quality improvement in mental health services. They focus on:

- Ensuring there is consumer and carer involvement;
- The principles underpinning service delivery;
- Meeting the expected standards of communication and consent; and
- Monitoring and governance.

The CPSGWG membership was comprised of:

- Mental health professionals;
- Consumers;
- Family and carers.

The consumer and carer representatives on CPSGWG, while acting as individual experts, were members of wider networks including:

- Consumers of Mental Health WA (CoMHWA);
- Carers WA;
- Children of Parents with a Mental Illness (COPMI);
- Mental Health Carers Arafmi; and
- Health Consumers' Council.

There was also representation from the Lived Experience Advisory Group (LEAG) and the Mental Health Bill Implementation Reference Group (MHBIRG).

The process and context for the development of the Standards and Guidelines was:

1. The development of the Guidelines specified in Section 547(1) of the Act;
2. The development of the Standards and required under Section 547(2) of the Act.
3. The National Practice Standards for the Mental Health Workforce (NPSMHW) and the National Standards for Mental Health Services (NSMHS) have had significant national consumer and carer input into their development and these Standards have been accepted by the Chief Psychiatrist.
4. There was appropriate consultation by CPSGWG with individuals and relevant bodies external to the Group to further refine the Standards and Guidelines developed by CPSGWG.

## **Guideline (a): Making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order (s. 547(1)(a))**

### **1. S.24(3) A decision whether or not a person is in need of an inpatient treatment order or a community treatment order must be made having regard to the guidelines published under section 547(1)(a).**

1.1 This Chief Psychiatrist guideline is made in accordance with section 24(3) and in relation to making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order.

1.2 Involuntary status can only be imposed on a person if the person meets the criteria for being made an involuntary patient either in an authorised hospital, or in certain circumstances and with the approval of the Chief Psychiatrist in a general hospital or in the community under a Community Treatment Order (CTO). While the criteria for involuntary detained status and CTOs are slightly different reflecting the differences of purpose of involuntary status, in the major elements they are similar.

### **2. Criteria for involuntary treatment order**

2.1 The clinician needs to be aware that if even one criterion is not fully met then the person cannot be made an involuntary patient.

2.2 The decision of whether a person should be made an involuntary patient become particularly difficult when making judgements regarding degrees of risk or whether a person has capacity.

2.3 The Mental Health Tribunal when conducting a review will consider whether all the criteria are met and are obliged to discharge an order if even one criterion is not fully met.

### **3. (1) A person is in need of an inpatient treatment order only if all of these criteria are satisfied:**

#### **3.1 Criteria 1 is-**

(a) that the person has a mental illness for which the person is in need of treatment;

##### **3.1.1 Section 6 provides a definition of mental illness-**

*(1) A person has a mental illness if the person has a condition that —*

*(a) is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and*

*(b) significantly impairs (temporarily or permanently) the person's judgement or behaviour.*

3.1.2 This definition is similar to the previous Mental Health Act and reflects a decision based on the observations of identified behaviours rather than on a specific diagnosis.

- 3.1.3 In regard to referrals the Medical Practitioner or Authorised Mental Health Practitioner (AMHP) only needs to suspect that the person has a mental illness noting that the issue of diagnosis is a matter for a psychiatrist. However, even a suspicion cannot be based entirely on the views of others or on the person's medical record, there must be evidence based on the personal assessment by the Medical Practitioner or AMHP which leads them to suspect the person may have a mental illness.
- 3.2 Section 6(4) requires that-  
*A decision whether or not a person has a mental illness must be made in accordance with internationally accepted standards prescribed by the Regulations for this subsection.*
- 3.2.1 The implication of this requirement is that the condition observed can be ascribed to specific diagnosis of particular mental illnesses described in '*internationally accepted standards*'.
- 3.2.2 The standards prescribed by the Regulations are the International Classification of Diseases (ICD-10), Chapter 5, Mental and Behavioural disorders, published by the World Health Organisation- access online at <http://www.who.int/classifications/icd/en/bluebook.pdf> and the Diagnostic and Statistical Manual (DSM-5) published by the American Psychiatric Association- access online information <http://www.dsm5.org/pages/default.aspx>
- 3.3 Section 6(1)(a) describes conditions characterised by a number of different types of disturbance which all indicate the presence of a possible mental illness.
- 3.3.1 Disturbance of thought or perception may indicate a type of psychotic illness such as schizophrenia.
- 3.3.2 Disturbance of mood and volition may indicate a mood disorder such as depression or mania.
- 3.3.3 Disturbance of orientation or memory may indicate an organic disorder such as dementia.
- 3.3.4 However section 6(1)(b) notes that just having a condition characterised by those behaviours is insufficient to decide that the person has a mental illness. What is additionally required is that the condition significantly impairs either temporarily or permanently the person's judgement or behaviour.
- 3.3.5 The clinician needs to inquire into the details of the person's life to see what changes have occurred which significantly impact on aspects of the person's day to day activities. Are they making poor judgements about self-care or their relationships with others? Are they behaving in ways that are out of character and may be placing them at risk from themselves or others?
- 3.3.6 Information needs to be sought from the person, others such as family members who may have vital information, the views of other health professionals and in documents such as the person's medical record.

- 3.3.7 The word significant indicates a particular degree of impairment which needs to be reached. If the decision is that there is only slight impairment there may not be the grounds to decide that what is being observed is a mental illness.
- 3.3.8 Whether the impairment is temporary or permanent is less relevant as either can lead to a decision that the person has a mental illness.
- 3.3.9 Some mental illnesses such as an episode of mania can arise very quickly and with treatment dissipate quickly. Other illnesses such as anorexia or dementia may have longer gestation and some organic illnesses are deemed to be permanent.
- 3.4 The Act provides for a number of behaviours which in themselves or combined with other behaviours in this list would not indicate a mental illness. However there may be a behaviour in this list such as *'the person being sexually promiscuous'* which combined with other disturbances of thought and volition could perhaps indicate a manic episode in a person with bi-polar disorder. Just because one or more of the behaviours exhibited is in the list of exemptions does not mean that other behaviours are not relevant in deciding whether the person has or does not have a mental illness.
- 3.4.1 The list of exemptions is as follows-
- (a) *the person holds, or refuses or fails to hold, a particular religious, cultural, political or philosophical belief or opinion;*  
While holding or refusing to hold a particular belief is not in itself indicative of a mental illness it is recognised that delusional beliefs can often centre on a religious or political theme. Therefore the extent to which the belief is irrational or unusual and is impacting on the person's life can indicate that this is a delusional rather than a rational belief. This may be a contentious area where the psychiatrist does not share the view of the person and more enquiries may be required to determine that the belief is delusional and therefore indicative of a mental illness rather than just being eccentric.
- 3.4.2 (b) *the person engages in, or refuses or fails to engage in, a particular religious, cultural or political activity;*  
This elaborates from the previous exemption recognising that from a particular belief system there may be an engagement with an activity which may or may not indicate a possible mental illness. For example a person handing out political pamphlets may not in itself indicate a mental illness however if this is being done in a manner out of keeping with accepted behaviour or as an elaboration of a delusional belief then while the person may believe they do not meet the criteria of mental illness from a clinical perspective the criteria may be met.
- 3.4.3 (c) *the person is, or is not, a member of a particular religious, cultural or racial group;*  
This exemption recognises that people may identify with a particular group and such identification is not in itself an indication of mental illness. However, at times when a person is mentally ill they may be inclined to behave in ways that are not in keeping with their usual behaviours and family and friends may explain this change of behaviour within a mental illness framework. The clinician's task is to gather information from a variety of sources including family members, carers and people from the patient's community, which would provide supporting evidence one way or the other. At times a person



from a different cultural or racial group may behave in ways that an ethnocentric clinician may find strange or bizarre when in reality the person is behaving within cultural norms. It is important when assessing a person from another cultural or racial group not to misinterpret behaviour because the clinician does not have experience in working with people from that cultural or racial group. Obtaining information from other members of that cultural or racial group is vitally important before making a decision that the person is suffering from a mental illness.

3.4.4 *(d) the person has, or does not have, a particular political, economic or social status;*

This exemption emphasises that the person's social standing in itself is not a factor when determining whether the person has a mental illness. For example just because a person's lifestyle such as eating a particular diet or refusing to work is very different from the norm perhaps reflecting a particular social status, that does not mean that the person is suffering from a mental illness. Many people have different values and customs without a judgement being made that they are experiencing mental illness and the task for the clinician is to differentiate these different behaviours from behaviours indicative of a person experiencing mental illness.

3.4.5 *(e) the person has a particular sexual preference or orientation;*

This exemption indicates that choosing to be gay, bisexual or transgender are not in themselves indications of mental illness. For example a gay man may be in conflict with his parents because of his sexual choices which could impact on his mood. His sexual preference and the conflict it causes may then be relevant to a diagnosis of depression but it is the resulting mood disorder which is significant not his sexual preference.

3.4.6 *(f) the person is sexually promiscuous; or*

*(g) the person engages in indecent, immoral or illegal conduct;*

These exemptions emphasise that how a person decides to lead their life from a moral perspective is not in itself relevant to whether a person has a mental illness. People may choose to lead their lives in ways that the clinician may find distasteful, decadent or immoral, and those life style choices do not indicate the presence of a mental illness. However there may at times be a dramatic change in a person's sexual behaviour which may be indicative of a mental illness and the clinician's task is to work out whether a change from a previous way of living is within the parameters of normality or indicative of a mental illness such as a mania.

3.4.7 *(h) the person has an intellectual disability;*

At times the behaviour of a person with intellectual disability may be misinterpreted as indicating mental illness and the clinician needs to ascertain the causes of the behaviour. Further information from a family member, carer, personal support person, guardian or staff at the Disability Services Commission (DSC) may indicate that what is being observed is an exaggeration of the types of behaviour associated with the intellectual disability. DSC workers may at times be confused as to whether the behaviour indicates a mental illness or the exacerbation of behavioural symptoms associated with intellectual disability and may quite reasonably request a mental health assessment. It should be understood that at times people with an intellectual disability may suffer from depression or psychosis (akin to a dual disability) and require mental health intervention.



3.4.8 (i) *the person uses alcohol or other drugs;*

*(3) Subsection (2)(i) does not prevent the serious or permanent physiological, biochemical or psychological effects of the use of alcohol or other drugs from being regarded as an indication that a person has a mental illness.*

This exemption is problematic as there are significant co-morbidity issues between mental illness and use of alcohol and other drugs. The wording is significant as is subsection (3). A person may use alcohol and drugs and in their intoxicated or withdrawing state appear to be presenting with symptoms of mental illness such as hallucinations and disordered thinking. These symptoms may then be misinterpreted as indicative of mental illness when in fact they directly relate to either the intoxication or the person withdrawing from an intoxicated or drug dependent state.

For example the symptoms of amphetamine intoxication or the symptoms of alcohol withdrawal both mimic symptoms of psychosis. The Act provides for an examination to be extended for up to 72 hours from the time of receipt in order to delay the decision as to whether the person's behaviour is due to the use of alcohol or other drugs or mental illness or even a combination of the two disorders. If it is merely the former the person should not be made an involuntary patient as they do not meet the criteria for mental illness.

However, subsection (3) recognises that some of the serious or permanent symptoms of alcohol and drug use such as depression, mania or dementia may all indicate that the person may also have a mental illness. For example it is well recognised that alcoholism or petrol sniffing may cause brain damage (dementia) which may require mental health intervention.

3.4.9 (j) *the person is involved in, or has been involved in, personal or professional conflict;*

At times the behaviour of persons involved in conflicts can be extreme or out of character and an external observer such as a family member or a professional colleague may feel that they indicate a mental illness. An extreme or over-reaction may be interpreted as a mental illness when it might just be to the way a person expresses themselves or an example of a particular personality trait. The best interpretation of current behaviour is past behaviour and if a person is acting grossly 'out of character' it might be indicative of a mental illness rather than just a behavioural reaction. Being in conflict can exacerbate emotions to a level which seem to be unreasonable, however before deciding that the behaviour is indicative of a mental illness a full exploration of the genesis of the conflict and the way the person usually reacts needs to be explored.

3.4.10(k) *the person engages in anti-social behaviour;*

There are cultural and historical links between mental illness and anti-social behaviour which can lead to misinterpretation of anti-social behaviour as indicative of a mental illness. When a person commits an anti-social act such as an assault or criminal act and it is out of character for the person to behave in that way, an assumption may be made that the behaviour is indicative of a mental illness rather than a type of personality which resorts to anti-social behaviour. There are particular symptoms of mental illness such as delusional beliefs which may lead to anti-social acts and which are clearly a result of a mental illness. However, at times a person who commits an anti-social act or a family member or legal representative may attribute the behaviour to suffering from a mental illness when in fact it is the result of a personality trait

or way of managing a problem and not related to suffering a mental illness. Being able to attribute a reason or motivation for a behaviour can be complex and components such as the person's previous history including a forensic history, whether the behaviour is out of character or what explanation the person and family give are all relevant in determining whether this exception is relevant.

3.4.11 (i) *the person has at any time been —*

*(i) provided with treatment; or*

*(ii) admitted by or detained at a hospital for the purpose of providing the person with treatment.*

This exception ensures that a person cannot be made involuntary patient just because they previously received treatment or were admitted or detained at a hospital for a mental illness. There needs to be some current and significant evidence that the person is presently suffering from a mental illness. There may be a temptation for clinicians to view a person's behaviour through the lens of their mental health history and make assumptions about their behaviour just because previously they have received treatment for mental illness. This exemption makes it clear that that is insufficient evidence that the person needs to be referred or made an involuntary patient on this occasion.

#### **4. Criteria 2-**

***25(1)(b) that, because of the mental illness, there is —***

***(i) a significant risk to the health or safety of the person or to the safety of another person; or***

***(ii) a significant risk of serious harm to the person or to another person;***

4.1 Having established that the person has or is suspected to have a mental illness requiring treatment a judgement needs to be made as to whether because of their mental illness the person is placing their own or another person's health or safety at risk or there is significant risk of serious harm to the person or other people. Even if a person has a mental illness requiring treatment there are no grounds to refer the person or make them an involuntary patient unless this and the other criterion are met.

4.2 The clinician needs to use standardised or equivalent contemporary risk assessment tools and guides, that are appropriate to age and context, which support clinical judgement and clinical decision making and inform a shared management plan. While the CP endorses a role for actuarial tools and the Department of Health has policies regarding risk assessment and management tools, it must be noted that actuarial risk assessment tools are of limited predictive value on their own.

Note that even though a person may score as a high risk they may still be provided with treatment and care as a voluntary patient. There will be situations where a person is at high risk but can demonstrate that they have capacity and therefore cannot be made an involuntary patient.

4.3 Risk in mental health is the likelihood of an event happening with potentially harmful outcomes for self and others and is divided into 4 categories

- a) Risk to self
- b) Risk to others
- c) Risk from others
- d) Risks from systems or treatment



Risk to self includes-

- a) attempted suicide;
- b) self-harm including repetitive self-injury;
- c) self-neglect;
- d) absconding and wandering (which may also be a risk to others);
- e) drug (illicit and prescribed) and alcohol intoxication, misuse or withdrawal;
- f) lack of recognition and treatment for physical health conditions such as eating disorders and medical conditions such as diabetes mellitus, delirium, organic brain injury, epilepsy; and
- g) quality of life risks such as risk to dignity, reputation, social and financial status.

Risk to other includes-

- a) violence and aggression;
- b) sexual assault or abuse;
- c) harassment;
- d) stalking or predatory behaviour;
- e) property damage including arson;
- f) being a public nuisance; and
- g) reckless behaviour that endangers others such as drink driving.

Risks from other includes-

- a) physical or sexual abuse or assault;
- b) emotional harm or abuse;
- c) harassment;
- d) financial abuse; and
- e) neglect.

Risk from systems or treatment includes-

- a) adverse or side effects of medication;
- b) inadequate assessment;
- c) poor follow-up;
- d) premature discharge;
- e) ineffective care;
- f) welfare risks such as debts; and
- g) homelessness.

- 4.4 From a legislative perspective it is the self-harm and risk to others which are paramount when deciding whether a person should be referred or made an involuntary patient.
- 4.5 A risk assessment is the gathering of information and analysis of what might happen from the behaviours identified. It is essential to understand what are the specific risk factors for an individual, for example from a perspective of trauma informed care, and in what situations they might occur. To do a good risk assessment you need to link historical information to current circumstances, though the clinician cannot base their decision just on historical information and risk assessment and management of the risk go hand in hand.

- 4.5.1 A risk assessment can be separated into 6 components:
- a) What happened- *for example the patient discovered with rope in the garden expressing ideas of self-harm and brought to an Emergency Department;*
  - b) What the patient tells you- *I am very distressed and depressed and the voices are annoying me;*
  - c) Observing their behaviour- *patient looks sad and restless and responding to unseen voices;*
  - d) Asking others like family members and carers what they have noticed- *patient has become more miserable, talking about hurting himself and complaining about nasty voices;*
  - e) Is there a history of these symptoms- *patient had a mental health assessment 6 months ago but there was no follow-up;* and
  - f) Doing some tests- *such as the Risk Assessment and Management Plan- SMHMR 905 or the CAMHS Risk Assessment Form.*
- 4.5.2 Structured Clinical Judgement (SCJ) is a method using all 6 sources of information especially your clinical knowledge and not just depending upon questionnaires. A Risk Assessment and Management Plan in itself should not determine a decision in risk management but it can be one part of a SCJ assessment.
- 4.5.3 There are a number of issues which will assist in a good risk assessment and include:
- a) Access to accurate records, particularly the person's medical file;
  - b) Having time to do the assessment properly understanding that the decision you make may ultimately result in the person becoming an involuntary patient;
  - c) The patient being able to communicate with you for example speaking the same language and if they come from a CALD (culturally and linguistically diverse) background getting the assistance of an interpreter and for people with hearing impairment an Auslan or similar interpreter;
  - d) The patient not being confused, for example because of a medical condition such as delirium, or intoxicated which may lead to misinterpretations;
  - e) Getting additional information from a family member, carer or friends;
  - f) When the patient has had feelings like this in the past how have they been managed;
  - g) If there has been a previous self-harm episode what follow-up was provided;
  - h) Exploring a range of issues such as thoughts, mood, plans, intent, impulsivity, means or methods of self-harm, losses, stressful events, supports and medical and psychiatric history ;
  - i) What is the patient's views on how to manage their problems, make things better;
  - j) The clinician feeling physically safe and confident while conducting the assessment; and
  - k) Talking it over with another health professional.
- 4.5.4 Managing risk includes:
- a) Devising a plan, including a back-up plan the purpose of which is to translate collective decisions into actions where there is an allocation of individual responsibilities for the patient, family members, carers or friends,

health staff and at times other government and non-government bodies.

This includes completion of the Triage Form SMHMR 900;

- b) The plan should clearly identify the times and dates for reviewing the assessment and management plan;
- c) If the risk is low or moderate then a safety plan needs to be drawn up;
- d) If the risk to the health and safety of the patient is high then referral under the Act needs to be considered;
- e) Note that even if the Act is used a patient's mental state can change over time especially if given treatment and the referral process can be revoked;
- f) At times even patients with high risk can be managed without the use of the Act if there is an element of cooperation from the patient and a willingness to comply with treatment;
- g) The risks that are present when a patient is intoxicated may be confused with risks present in a patient who is mentally ill and risks presented only by intoxication should be managed within a general health setting.

**5. (c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself.**

- 5.1 Capacity issues are discussed in Chapter 2 and a task for the clinician is to determine whether a person does or does not demonstrate that have the capacity to make a treatment decision.
- 5.2 Demonstrating capacity is different from eliciting capacity. The clinician may try to elicit capacity by applying a capacity test such as the MacArthur Competence Assessment Tool for Treatment (MACCAT-T) or the Capacity to Consent to Treatment Instrument (CCTI), however if the patient does not cooperate with the clinician applying the test it may not be possible to determine whether the person has capacity or not. In those situations the onus falls on the clinician, making him or her responsible for determining capacity
- 5.3 Demonstrating capacity is different from eliciting capacity and places some responsibility on the patient to demonstrate that they have capacity. If they fail to do so, for example by refusing to communicate or undertake the capacity test then they have not demonstrated capacity and could be made an involuntary patient if all the other criteria are met.
- 5.4 Within these broad parameters clinicians must take a pragmatic and measured approach with enough flexibility to determine that capacity has been demonstrated without on every occasion insisting on conducting a formal capacity test. In many cases capacity or lack of capacity will be self-evident and while any documentation must justify the decision taken, a formal test will not always be required.
- 5.5 Capacity to consent to treatment may be viewed differently from other types of decision making such as consenting to a financial transaction, initiating a relationship or consenting to an operation. Even patients who have very reduced capacity may be able to make minor treatment decisions, for example accepting a medication such as Paracetamol for a headache. The greater the impact the medication will have on the patient the greater the degree of demonstrated capacity that may be required. Patients may imply consent by their actions such as accepting a tablet into their hand however there are limits to implied consent and it is at times used to avoid determining capacity.



- 5.6 While capacity in a general sense is a complex matter which includes the type of decision being made; how the decision will impact on the patient; whether a reasonable person in a similar circumstance would consent to a specific treatment; the degree of impairment and the views of family members; within the Act a decision has to be made one way or the other. Does the person demonstrate capacity or is capacity not demonstrated? This decision is required in order for the criteria of involuntary status to be met or not met. At times a patient may lack capacity but does not meet any of the other criteria for involuntary status and even though the patient may be quite impaired there may be insufficient grounds to make them an involuntary patient.
- 5.7 A patient may have the capacity to make a decision about treatment but still refuse the treatment which may not, as far as the clinician can determine, be in their best interest. For example a patient may accept they have a depressive disorder with suicidal ideation but only be willing to take herbal medication. However, despite the risk, if a patient demonstrates capacity they cannot be made an involuntary patient.

**6. (d) that, treatment in the community cannot reasonably be provided to the person;**

- 6.1 This criteria only applies to a situation where a patient could be made an involuntary detained patient. If it is possible to provide the treatment even as an involuntary patient in a community setting then the CTO option should be considered. The reasons why a person may not be able to be provided with treatment in the community include:
- a) the possibility that the acuity of the illness may be so severe that only inpatient care will ensure the health and safety of the patient;
  - b) the patient may be so physically impaired, for example because of an organic disorder, that inpatient care is required;
  - c) the degree of supervision the patient needs may not be available if for example the patient lives in a remote community;
  - d) a mental health service is unavailable either temporarily or permanently to be provided in the community the person lives in for example because the community is very remote.
- 6.2 In order for the person to meet this criteria the clinician needs to consider the impact of the mental illness on the person as well as the community resources available. At times it may seem contrary to human rights that a person is made an involuntary detained patient because a mental health community service is not available, and while every effort should be made for such a service to be provided the overarching needs of the patient in relation to health and safety are paramount.

**7. (e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order.**

- 7.1 The principle of 'less restriction' applies in a variety of ways in the management of a person with mental illness. In this context it is the environment in which the treatment is provided which is under scrutiny. If a person can be given adequate treatment in a less restrictive setting such as the community or in an open rather than a secure ward as a voluntary patient then this criteria may not be met.
- 7.2 All of us have the human right of freedom of choice and movement so removing that freedom should only be done when it is clear that there is no less restrictive way of managing the person's treatment and care other than making them an involuntary

detained patient. Claiming that a voluntary patient can be cared for in a locked ward as a less restrictive option is not in the spirit of the Act.

- 7.3 Any voluntary patient in an Authorised Hospital which is locked must have the ability to leave the ward when they want to unless the matters referred to in section 582 apply which provides protection from liability when detaining a person with mental illness.

**8. The criteria for making a CTO are similar to making an Involuntary Detaining Order except for these additional criteria-**

***S.25(2(b(iii)))- a significant risk of the person suffering serious physical or mental deterioration; and***

***S.25 (2(d))- that treatment in the community can reasonably be provided to the person;***

- 8.1 The significant risk of deterioration criteria emphasises the essential difference between involuntary detaining orders and CTOs. While the same criteria apply the threshold for the risk issues in regard to a CTO is lower which therefore allows for treatment in the community rather than in an Authorised Hospital. It also recognises that CTOs should be kept for those patients with a more long-lasting or chronic illness where there is evidence that treatment is required for lengthy periods of time and the symptoms of the illness more intractable.
- 8.2 At times people with a more chronic illness while they can live in the community may need to have treatment regularly even as an involuntary patient at times and the reason for the CTO is concern that if they did not receive the treatment there is a significant risk of serious deterioration. So while the risk may not be immediate the criteria may still be met.
- 8.3 Patients should only be put on a CTO if treatment in the community can reasonably be provided. If because of geography or extreme resistance it is not really possible to provide treatment in the community then this criteria is not met. Even though a CTO is an involuntary order if there is absolutely no cooperation between the patient and the treating team then there may be no purpose in placing the patient on a CTO. Some patients may be so adamantly against the CTO that there is no other option than attempting to treat the patient as a voluntary patient and when necessary as an involuntary detained patient.

**9. Decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order**

- 9.1 In making a decision to refer a person or make them an involuntary patient all the criteria must be met.
- 9.2 The criteria may not always be met to the same degree of certainty but due consideration must be given to all the criterion as any review by the Mental Health Tribunal will give weight to all the criteria.
- 9.3 While it is necessary to provide some details on the forms (Referral Form 1A/ Order for assessment of voluntary patient Form 1A/ Inpatient Treatment Order Form 6A/ Continuation of involuntary status order Form 6C/ Community Treatment Order Form 5A), more detail and reasons for the decision need to be made in the patient's medical record.

9.4 When any involuntary order is continued, all of the criterion must again be considered and the order can only be continued and extended if all the criteria are met.

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**Review Date:** 12 months from the date of commencement

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## **Guideline (b): Making decisions under section 26(3)(a) about whether or not a place that is not an authorised hospital is an appropriate place to conduct an examination.**

1. The medical practitioner or Authorised Mental Health Practitioner (AMHP) has when referring a person for examination by a psychiatrist the option of referral to an Authorised Hospital or a place that is not an authorised hospital but where there is a psychiatrist available to conduct an examination.

1.1 The choice of destination, which can also be where the person is being assessed by the medical practitioner or AMHP, reflects a number of variables and options.

1.2 These variables include-

### 1.2.1 Access to an Authorised Hospital

There are a number of authorised hospitals, usually part of a general hospital in Western Australia. However currently there are only 4 authorised hospitals in non-metropolitan areas. Given those limitations a referral to an Emergency Department (ED), a general hospital, a mental health or general health clinic, a nursing post or a private hospital may be a preferred option.

### 1.2.2 Availability of a psychiatrist to conduct the examination

While all Authorised hospitals have access, even out of hours, to a psychiatrist there are a number of places in the state where a psychiatrist is either not available or not available at the time of referral. At times, and depending on the acuity of the patient, a referral can be delayed or a person detained at a place awaiting the arrival of a psychiatrist. This option is particularly useful if it is felt that it would be detrimental to a patient to remove them from their community or even their home and transport them to an authorised hospital. Examinations can also in non-metropolitan areas be conducted by Audio-Visual (AV) means and that allows a referred person to remain at the place of assessment or a place that is not an authorised hospital for that AV examination to occur (see Addendum 7 regarding use of AV means).

It is the responsibility of the referrer to ensure that having decided to refer a person to a place that is not an authorised hospital that a psychiatrist is available to personally attend or in relation to non-metropolitan areas can conduct an examination by AV means. This entails contacting the place the person is being referred to before the person is transported to inform them of the referral so that a psychiatrist can be made available to conduct the examination. If it is clear that no psychiatrist will be available within the time frame, which is 24 hours from the time of receipt, though in non-metropolitan areas that can be extended by a further 48 hours, then alternatives should be considered such as referral to an authorised hospital or another place where a psychiatrist is available. At times these arrangements can be conducted while the referred person is being transported as the Act provides for a change of destination after the person has been referred and transportation commenced.

### 1.2.3 Physical condition of the referred person

If it is clear to the referrer that the referred person has physical health problems, such as consequence of an overdose or self-harm or effects of anorexia, which could pose a significant risk in transporting the person to an authorised hospital, then the person could be referred to a general hospital for examination by a psychiatrist who could make the person an involuntary detained patient in a general hospital with the approval of the Chief Psychiatrist. The same issues about the availability of a psychiatrist to conduct the examination apply.

### 1.2.4 Acuity of the referred person

While the criteria for referral are quite broad the main reason to use legislation is to manage significant risk. At times a referred person might be so mentally unwell that they pose a serious and imminent risk to themselves or others and urgent action is required to reduce that risk. While emergency psychiatric treatment ( Form 9A) can be delivered which could reduce the problem of acuity, where the person is best treated and where the person should be referred to become important safety issue for the patient and staff. Authorised hospitals are the preferred place to manage high risk patients; however even some authorised hospitals in non-metropolitan areas would have difficulty in managing high risk patients because of staffing or environmental issues. Referral should not be made to places where it is clear that a high acuity patient could not be managed safely. At times temporary management can occur such as when a patient is managed in an ED while awaiting transport to an authorised hospital, but longer term care will require the skills of mental health clinicians in an authorised hospital.

### 1.2.5 Dislocation from community or family

Referral of a person to be examined by a psychiatrist always has to some extent a negative effect on the patient and possibly carers and family. While management of risk and safety concerns are paramount, consideration should also be given to the effects of dislocation from community or family. This may be especially relevant to children, or referred persons in non-metropolitan area or who are of Aboriginal or Torres Strait Islander descent or who come from a CALD community and have a limited understanding of English. In these circumstances the referrer will need to look at how to reduce the negative impact of dislocation while ensuring treatment is provided. This may involve more consultation with carers and family members or significant people from the person's community such as elders or traditional healers. The criteria of 'least restriction', is particularly relevant in these situations and every effort should be made to bring these issues into consideration when making a decision as to where to refer the person.

## 2. Referral to other places

### 2.1 There are a number of places that are not an authorised hospital where a person can be referred to and include-

- a) an ED;
- b) a general hospital;
- c) a non-authorised mental health hospital including private hospitals;
- d) a community mental health or general health clinic;
- e) a nursing post particularly in remote areas of the state; and
- f) in appropriate circumstances a place of residence such as a residential home, hostel or where a person is living.

- 2.2 Intentionally the variety of places of where a person can be referred to is wide so as not to exclude a place where it is appropriate for the examination to be conducted. However, referral to a place of residence would be exceptional and proper justification for that decision be required and documented.
- 2.3 The overarching issue is safety for the referred person and others including staff. An option may be convenient but if it is not safe then it should not be chosen.
- 2.3.1 For example the community mental health clinic may be seen as a very convenient place as it is staffed by mental health clinicians and perhaps even the person's case manager, but if the staff will have difficulty containing a acutely ill person in that environment then it would be preferable to refer the person directly to an authorised hospital or an ED where treatment can be provided.
- 2.3.2 However, where there are other less restrictive ways then those options should be explored. For example there may be an elderly Aboriginal patient in a remote community with significant physical health problems where the most appropriate place of examination could be there home.
- 2.3.3 The psychiatrist seeing a person in their home has the option of placing the patient on a CTO, referring them onto an authorised hospital or making no order.

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**Review Date:** 12 months from the date of commencement

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## **Guideline (c): Ensuring as far as practicable the independence of psychiatrists from whom further opinions referred to in section 121(5) or 182(2) are obtained.**

1. This only applies to involuntary patients detained in an authorised or general hospital or on community treatment orders, or mentally impaired accused detained in an authorised hospital.
2. Independence of psychiatrists
  - 2.1 There are varying degrees of independence and the pathway chosen to identify who should conduct the further opinion depends on a number of factors including the wishes of the patient or other person who requested the further opinion, what further opinion services are available, how long a person is prepared to wait for that further opinion to be provided and whether there are costs involved and who should meet those costs.
  - 2.2 In order to provide as much choice as possible a wide view of 'independence' is promoted. This can range from a further opinion being provided by a psychiatrist from the same service as the treating psychiatrist which may be seen as the least independent to a further opinion from a private psychiatrist for a cost which could be seen as the most independent.
  - 2.3 The most important factor is patient choice, following the patient or person who requested the further opinion being provided with as much relevant information as possible. The relevant information should include waiting times for examination depending on whether a psychiatrist from the hospital or service presently caring for the patient provides the further opinion compared to a psychiatrist from another service providing the opinion. While from a practical perspective arranging a further opinion from within a service might be easier the Act stipulates that the examination should as soon as practicable regardless of who is providing the further opinion.
  - 2.4 If a psychiatrist from another service is preferred the patient should be made aware what that implies as to when the examination will occur and where. For involuntary detained patients it is usual for the psychiatrist to travel to where the patient is, however that does not preclude special arrangements whereby the patient can visit a psychiatrist in their rooms or at another hospital. For patients on CTOs it would be usual to conduct the examination at the mental health clinic however this does not preclude the patient attending where the psychiatrist is or the psychiatrist visiting the patient at their residence. For patients in non-metropolitan areas the examination can be conducted using Audio visual (AV) means.

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**Review Date:** 12 months from the date of commencement

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## **Guideline (d): Making decisions under section 183(2) about whether or not to comply with requests made under section 182 for additional opinions.**

### **1. Further requests**

- 1.1 A patient or the person who requested a further opinion may, having received the further opinion report, remain dissatisfied and wish to have a further opinion from another psychiatrist or the Chief Psychiatrist.
- 1.2 The patient or the person who requested the further opinion has the right to request a further opinion.
- 1.3 The request can be written or oral and should indicate why the person remains dissatisfied and what preferable outcome they wish to have.
- 1.4 Unlike the first request for a further opinion, the treating psychiatrist or Chief Psychiatrist has the option of refusing to progress the request if he or she feels that the request for a further, further opinion is not warranted.
- 1.5 However, if there are good reasons to allow for a further opinion the treating psychiatrist or the Chief Psychiatrist may progress the request similar to the first request.
- 1.6 The patient or others have the right to request for a further opinion at least once in every episode of care.

### **2. Why a further opinion may not be warranted**

- 2.1 If the further opinion was provided very recently and nothing has changed with regard to the treatment plan a further request may not be warranted.
- 2.2 If a further opinion has been provided from a request by the patient and then a further request is made from another person who is entitled to make a request a further request may not be warranted.

### **3. Why a further opinion may be warranted**

- 3.1 Dissatisfaction with the further opinion psychiatrist and the way the examination was conducted may lead to a view that a further opinion is warranted.
- 3.2 If the treatment issue the subject of the request was not addressed in the report a further opinion may be warranted.
- 3.3 If there have been substantive changes to the condition of the person and/or the treatment plan a further request may be warranted.
- 3.4 If any adverse effects which were the subject of the initial request have exacerbated, a further request may be warranted.
- 3.5 If there is new concern about treatment since the completion of the report, a further request may be warranted.



- 3.6 If the patient or the carer believe their views were not sufficiently heard during the process, a further request may be warranted.
- 3.7 If there has been a change in the way treatment is delivered for example from the patient being an inpatient to being on a CTO.

#### **4. Response to a further request**

- 4.1 There should never be automatic refusal to a further, further opinion.
- 4.2 Due consideration should always be given as whether further opinion is warranted and this should entail a discussion with the treating psychiatrist.
- 4.3 If it is decided that a further opinion is not warranted the psychiatrist needs to provide reasons for that decision and the patient and the person who requested the further opinion if not the patient must receive a copy of the reason for that decision.

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**Review Date:** 12 months from the date of commencement

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## Guideline (e): The preparation, review and revision of treatment, support and discharge plans.

To ensure that treatment, support and discharge plans are prepared and reviewed in the most inclusive, collaborative and timely manner with all appropriate stakeholders.

This Guideline should be followed in conjunction with the following Chief Psychiatrist's Standards:

- Care Planning Standard
- Consumer and Carer Involvement in Individual Care Standard
- Physical Health Care of Mental Health Consumers Standard
- Transfer of Care Standard.

### 1. Introduction and purpose

The Mental Health Act 2014 (Act) (**s.185**) states that any involuntary patient or mentally impaired accused patient admitted to an authorised hospital, or any person under a community treatment order (CTO) is required to have treatment, support and discharge plan.

The importance of creating and reviewing a treatment, support and discharge plan as early as possible with the appropriate people cannot be overstated. The completion and review of the plan is to provide coherent and consistent support for the patient. The plan should be developed using shared decision making and an overarching focus on recovery (**s.7**). The plan outlines how the patient will be treated whilst under a treatment order, and how the support and treatment will continue following discharge. The creation and regular review of these plans is now a requirement in the Mental Health Act 2014.

The clinical team is to consider the wishes of the patient to the extent that is practicable. This includes any Advance Health Directive or terms of enduring power of guardianship made by the patient. Reasons not to follow these wishes must be documented as noted in the MH Act 2014. (**s.179**)

Involving the person experiencing mental illness in their treatment plans and decisions allows the person more control and self-determination. This assists the person to participate actively in their own self-care to adapt to and live with their mental illness and recovery.

Meaningful engagement between the treatment team, the patient and their personal support persons when the plans are being developed and reviewed creates a positive and engaging relationship. This therapeutic relationship is one of the most significant factors in improving treatment outcomes for people experiencing mental illness.

### 2. The Mental Health Act 2014

2.1 The treatment, support and discharge plan must outline the treatment and support that will be provided to any involuntary patient or mentally accused patient admitted to an authorised hospital or whilst under a treatment order in the community (CTO). (**s. 186**)

2.2 Additionally, the discharge plan must outline the treatment and support that will be provided to the patient following discharge from the authorised hospital or from the CTO. (**s.186**)

- 2.3 The patient's psychiatrist must ensure that the treatment, support and discharge plan is prepared as soon as possible after the patient is admitted into the hospital or once the CTO is made. **(s. 187)**
- 2.4 The patient's psychiatrist must also ensure that the following people are involved in the creation of the plan when appropriate:
- 2.4.1 The patient - who must always be involved (this also applies to a patient who is a child). Where a patient is temporarily unable, or is unwilling, to be fully involved in the process, repeated valid attempts will be required to engage the patient in dynamic, meaningful and individually relevant planning. These attempts must be documented.
  - 2.4.2 If the patient is a child or required to have a guardian (or any person authorised by law to consent on person's behalf) then these people must be involved in the development of the plan and also require a copy of the plan.
  - 2.4.3 The patient's personal support persons (Unless it is not appropriate to supply this information due to risks or concerns under sections 269(1), 288(2), 292(1)).
  - 2.4.4 The psychiatrist must take a number of reasonable steps to ensure that the patient's personal support persons are contacted and included – and these steps must be filed in the clinical notes if the contact attempts are not successful.
  - 2.4.5 If the patient is of Aboriginal or Torres Strait Islander descent, then significant members of the patient's community (including elders and traditional healers) and Aboriginal or Torres Strait Islander mental health workers must be consulted and included wherever possible. (s.189)
  - 2.4.6 If the patient is from a culturally and linguistically diverse population, every effort must be made to address any language and cultural issues that may negatively impact on the person's ability to be consulted in developing treatment, support and discharge plans. This may involve including interpreters or members from the patient's community to assist with the development of the plans.
  - 2.4.7 The psychiatrist should also ensure that any other appropriate persons or bodies (organisations) are involved in the treatment, support and discharge plans – for example the psychiatrist will involve relevant community clinical and other mental health services to ensure collaboration and support for the person on a CTO or for someone about to be discharged from an authorised hospital.
  - 2.4.8 A record of the plan, involvement of any persons above and a record of attempts made to contact the personal support persons must be filed in the person's clinical notes. **(s. 188)**
- 2.5 The physical health treatment needs of the patient should be considered when developing the plans and included in the treatment plans if there are physical conditions which need to be monitored or addressed.

### **3. The National Standards for Mental Health Services 2010**

The National Standards for Mental Health Services 2010 (NSMHS 2010) reinforce the actions required by the Act.

*Extracts from the NSMHS 2010:*

10.4 Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to consumers and their carer(s).

10.4.5 The mental health service conducts a review of a consumer's treatment, care and recovery plan when the consumer:

- requests a review
- declines treatment and support
- is at significant risk of injury to themselves or another person
- receives involuntary treatment or is removed from an involuntary order
- is transferred between service sites
- is going to exit the MHS
- is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.

### **4. Completion and Recording of treatment, support and discharge plans**

4.1. Treatment and support plans are to be reviewed at least every 3 months, as described in the National Standards for Mental Health Services 2010. If this is not reasonable or possible, then the reason must be explained clearly in the clinical notes.

4.2. Copies of the treatment, support and discharge plan are to be given to patient, and their personal support persons.

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**Review Date:** 12 months from the date of commencement

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## **Guideline (f): The performance of electroconvulsive therapy (s. 545(1)(f))**

The Chief Psychiatrist takes as the Guideline for the performance of electroconvulsive therapy (ECT) as the following document: [\*The ECT Guide: The Chief Psychiatrist's Guidelines for the use of Electroconvulsive therapy in Western Australia 2006\*](#) (the Guideline).

It is noted that this Guideline acknowledges the Mental Health Act 1996. Notwithstanding, the Guideline remains a useful and safety-focussed clinical guide and the contextual references remain valid.

There will be a further developmental process to update this Guideline relative to practice and current statute, but until that time this existing Guideline remains.

## Guideline (g): Compliance with approved forms

To ensure that approved forms are completed, recorded and filed correctly and are delivered to the appropriate staff, agencies, patients and personal support persons in a timely and efficient manner and in accordance with the Mental Health Act 2014 (Act). Approved forms are not to be used as a replacement to recording Notifiable Events (**s.138 to 145**).

### 1. Introduction and Purpose

The completion of the approved forms is a legal requirement for clinicians who are performing functions under the Act. These legal requirements support and uphold the rights of patients and personal support persons as outlined in the Consumer and Carer Involvement Standard. (**s. 545, s.546**)

### 2. For clinicians

- 2.1 The clinician should always practice with regard to the intention behind the Act and Charter of Mental Health Care Principles using approved forms to support treatment as stated in the CPG: Ethical and legal practice.
- 2.2 It is the responsibility of all clinicians who perform functions under the Act to become familiar with the approved forms and their applications prior to using them.
- 2.3 Clinicians must ensure that all relevant clinical and legal information is clearly documented in the patient's clinical record – including date, time, name, designation and signature of the clinician.
- 2.4 When referring and transferring patients between services – clinicians must ensure the approved form and any other relevant information has been received and confirmed by the accepting service - before the (referral) transfer occurs.
- 2.5 Clinical justification for decisions made under the Act must be recorded and documented in the clinical record and on Approved Forms when required.
- 2.6 The approved forms must be readily identifiable and clearly legible within the clinical record and recorded using black ink.
- 2.7 Clinicians must ensure that the original of each completed approved form is placed in the clinical record.
- 2.8 Clinicians must ensure the patient and personal support persons, if required, has been given a copy of the completed approved form.
  - 2.8.1 Appropriate services are to be engaged with to ensure that the patient and personal support persons understand the content of the approved forms in a format or language they understand.

### 3. Services which use approved forms

- 3.1 Each service must have clear internal processes that ensure clinicians are completing and complying with all requirements on the approved forms as per the Act.

- 3.2 The service is to have regular audits and the provision of education on legal requirements regarding but not limited to the completion of the approved forms. This is to include specific requirements for metropolitan, non-metropolitan locations, children and adolescent patients and mentally impaired accused patients.
- 3.3 The service must have internal processes that regularly check patient's clinical records are being adequately maintained and appropriate information and approved forms are included.
- 3.4 Services must ensure that staff follow the known process for approved forms to be sent to Office of the Chief Psychiatrist, the Mental Health Advocacy Service and the Mental Health Tribunal within the legislated time.

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**Review Date:** 12 months from the date of commencement

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# Guideline (h): Ensuring compliance with the Mental Health Act 2014 by mental health services

To ensure that mental health services and their staff are compliant with all aspects of the Mental Health Act 2014 (Act).

## 1. Introduction and Purpose

- 1.1 Compliance with legislation is critical, it is reflective of adherence to clinical standards and it is essential that mental health services have appropriate processes in place to ensure that this is observed.
- 1.2 Compliance also requires adhering to the overarching ethos of the Act which is found in the Objects of the Act (s.10) and the Charter of Mental Health Care Principles (Act, Schedule 1). The intention of the Act is to:
  - Provide the best possible treatment and service to people experiencing mental illness
  - Provide a service which upholds and protects the basic human rights of people experiencing a mental illness
  - Provide the service in the safest but least restrictive environment
  - To treat all people experiencing a mental illness with dignity, equality, courtesy and compassion
  - To include the patient, and their personal support person in decisions and planning regarding their treatment and care
  - To optimise the safety of the person experiencing mental illness as well as the community.

## 2. Agencies which check Compliance with the Act

There are various agencies which share responsibility for oversight of compliance with the Act. They all perform various compliance checks to detect when the Act is not being enacted as per legal requirements. They are:

### 2.1 *Chief Psychiatrist*

The Chief Psychiatrist is responsible for overseeing the standards of treatment and care of all involuntary patients, all voluntary patients of a mental health service, mentally impaired accused persons detained in an authorised hospital and those referred under the Act for an examination by a psychiatrist.

Please refer to Chapter 11 of the Clinical Practice Guideline (CPG).

### 2.2 *The Mental Health Tribunal*

Mental Health Tribunal (The Tribunal) is an independent statutory body established under the Act. The Tribunal has the authority to review a number of decisions made by psychiatrists that affect a person's rights, voluntary or involuntary status and other restrictions on a person's freedom.

Please refer to Chapter 9 of the Clinical Practice Guideline (CPG).



### 2.3 *The State Administrative Tribunal (SAT)*

If a person has had a review by the Tribunal, and the person, or the treating psychiatrist, or anyone who, in the opinion of SAT has an interest in the matter, is not satisfied with the concluding decision, they can apply to the SAT for a review of that decision.

Please refer to Chapter 10 of the Clinical Practice Guideline (CPG).

### 2.4 *Mental Health Advocacy Service*

Mental Health Advocacy Service (Advocacy Service) provides an identified person (as defined in the Act, part 20, section 348) with access to information about their rights and provides support to the person in exercising those rights. This is generally achieved by providing the identified person with access to a mental health advocate who will also support the person in pursuing complaints where necessary and can support the person to request and attend a review by the Tribunal.

Please refer to Chapter 8 of the Clinical Practice Guideline (CPG).

## **3.0 Mental Health Services**

- 3.1 The mental health service has a responsibility to ensure that all staff are provided adequate training and information to allow them to conduct functions under the Act.
- 3.2 The mental health service must ensure that processes are developed and implemented which support functions under the Act and are known to clinicians and administrative staff.
- 3.3 The mental health service must cooperate and support investigations undertaken by the above bodies to allow continuous improvement and changes to occur.

## **4.0 Clinicians**

- 4.1 Clinicians who perform functions under the Act have a responsibility to ensure that they are familiar with and comply with the Act.
- 4.2 Clinicians must undertake appropriate education or information sessions regarding the Act, including E-learning and face-to-face education.
- 4.3 Clinicians must be aware of their specific responsibilities in relation to their organisational role regarding the Act.
- 4.4 Managers have a responsibility to ensure processes are in place to record and report all activity relating to the Act i.e. processing of forms.

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**Review Date:** 12 months from the date of commencement

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