


OFFICE OF THE CHIEF PSYCHIATRIST

Practical Implications of the *Mental Health Act 2014*

November 2015


Objectives of this Presentation

- Overview of the changes between *Mental Health 1996* (MHA 1996) and *Mental Health Act 2014* (MHA 2014)
 - Discuss practical implications of the MHA 2014 for private hospitals.
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Update on Progress of MHA 2014

- The *Mental Health Act 2014* is proclaimed and will commence on 30 November 2015


Important Principle

- The MHA 2014 requires clinicians to have increased awareness of appropriate communication and collaboration with patients, families and personal support persons.
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Practice Changes

- The Brief Overview of the *Mental Health Act 2014*: Initial information for Clinicians – March 2015 outlines the main changes.
 - See **Resources** slide at the end of the presentation for training, reference and Helpdesk resources
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Practicable Implications of MHA 2014 for Private Hospitals


- The MHA 2014 requires all clinicians to have increased awareness of appropriate communication and collaboration with patients, families and personal support persons.
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Definition of a Private Hospital/Mental Health Service MHA 2014

- ‘Private Hospital’ has the meaning given in the *Hospital and Health Services Act 1927*, s.2(1).
 - ‘Mental health service’ can include a private hospital but only to the extent that the hospital provides treatment and care to people who have or may have a mental illness (s.4).
 - ‘General hospital’ means a hospital (as defined in the *Hospitals and Health Services Act 1927*, s.2 (1))
 - Private psychiatric hospitals in WA are not Authorised Hospitals. (Ramsay and SJOG provide public beds through a private partnership program).
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What Is The Practical Relationship Between Private Hospitals and the Chief Psychiatrist/OCP Under MHA 2014?

Treatment and care oversight between the Chief Psychiatrist and private hospitals.

- The Chief Psychiatrist is responsible for overseeing the treatment and care of all voluntary patients in a private psychiatric hospital (s.515).
 - The Chief Psychiatrist will prepare Standards and Guidelines as required under MHA 2014 which will be applicable to private hospitals.
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What is the Practical Relationship Between Private Hospitals and the Chief Psychiatrist/OCP under MHA 2014? (cont.)

Review function between the Chief Psychiatrist and Private Hospitals.


- The Chief Psychiatrist may visit a private psychiatric hospital, whenever he or she reasonably suspects that proper standards of treatment and care have not been, or are not being maintained by the mental health service (s.521).
 - Private psychiatric hospitals (inpatient and day hospitals) will be a part of the Chief Psychiatrist's monitoring program.
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What is the Practical Relationship Between Private Hospitals and the Chief Psychiatrist/OCP under MHA 2014? (cont.)


Specific powers of the Chief Psychiatrist relating to treatment and care.

- The Chief Psychiatrist may review any decision of a private psychiatrist about the provision of treatment to an ***involuntary*** patient, either detained in a private general hospital or under a CTO and either affirm, vary, revoke or substitute another treatment decision (s.520).
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How will the Chief Psychiatrist's Standards and Guidelines Impact on Private Hospitals?

- Expectations by private psychiatric hospitals to integrate the Chief Psychiatrist's Standards and Guidelines into hospital policy and practice.
 - The Chief Psychiatrist has accepted the ***National Standards Mental Health Services 2010*** as the broad standards document
 - Chief Psychiatrist Standards- eight standards:
 - Go to www.chiefpsychiatrist.wa.gov.au for copies of the standards
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What Does an Approved ECT Unit Practically Mean?

- Private hospitals that provide ECT must be **approved** by the CP (s.544).
 - The Chief Psychiatrist will undertake a formal visit prior to approval of the ECT service commencing, in line with the MHA 2014.
 - Approval for an ECT service will be based on the Chief Psychiatrist's ECT standards- **updated 2015 edition**.
 - The Chief Psychiatrist also has an existing ECT guide, which has had private psychiatric input- to be updated.
 - There are increased ECT reporting requirements for all private and public ECT services under the MHA 2014.
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Requirements by the MHA 2014 with Regard to Voluntary Children Prescribed ECT

- Children who are voluntary patients must have any prescribed ECT approved by the Mental Health Tribunal (s.195 &.409 – 415).
 - Processes need to be set up between the private hospitals and the Mental Health Tribunal to ensure the MHA 2014 is adhered to.
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What are the New, Specific Areas of Responsibility and Compliance for Private Hospitals Within the MHA 2014?

- Mental health services including private hospitals must make every effort to comply with the Charter of Mental Health Care Principles, which is a rights-based set of principles, when providing treatment, care and support to patients (s.12).
 - Referral to another place can be a private hospital, where the expectation is that the person can be detained and examined within 24hrs (s.26 - 31).
 - If a person is examined in a private hospital by a psychiatrist and referred onto an authorised hospital, the person can be detained and transported by the police and/or a transport officer (s.57 – 63).
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What are the New, Specific Areas of Responsibility and Compliance for Private Hospitals Within the MHA 2014? (cont.)

- A patient can be made an involuntary detained patient in a private general hospital with the approval of the CP. This means that treatment can be provided to this patient in the private general hospital without consent. A report must be sent to the Chief Psychiatrist every 7 days. When the patient has adequately recovered from their physical illness they must be transferred from the GH to the authorised hospital and a transport order can be made to facilitate this (s.64 – 68)
 - Patients' and carers rights as detailed in the MHA 2014 will apply to referred persons and involuntary detained patients in general/psychiatric private hospitals. (part.16)
 - Notification of carers, close family members and other personal support persons should be notified of particular events, such as detaining a patient, making a transport order and discharging a patient (part 9).
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Notifications

- The making of a detention order when a person is referred.
 - The release or revocation order in regard to a detained referred person.
 - The making of a transport order to take a referred person to an authorised hospital or another place, transport orders when revoking a CTO, transferring patients general hospitals and authorised hospitals or between authorised hospitals.
 - Making a person an involuntary detained patient.
 - Making a person subject to a community treatment order.
 - Continuing the detention of a person in an authorised or general hospital.
 - Transferring a person between hospitals.
 - The release of a patient when an inpatient treatment order made via audio visual means is not confirmed.
 - Making a person subject to CTO no longer involuntary
 - Revoking a CTO and making an inpatient order.
 - Releasing of a patient off a CTO.
 - Expiry of an inpatient treatment order.
 - A person absent without leave from a hospital or other place
 - Granting leave from an authorised or general hospital.
 - Extending or varying leave.
 - Cancelling leave.
 - The provision of urgent non-psychiatric treatment.
 - The making or approval of transfer orders under intergovernmental arrangements in other states.
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What are the New, Specific Areas of Responsibility and Compliance for Private Hospitals Within the MHA 2014? (cont.)

- When a person who is of ATSI descent is referred to a private psychiatric/general hospital or detained at a private general hospital the referrer or psychiatrist must, where practicable and appropriate conduct the assessment/examination in collaboration with Aboriginal and Torres Strait Islander MHW or significant members of a person's community including elders and traditional healers (s.50, 81)
 - Use of audio visual means when referring and examining patients in a private general/psychiatric hospital in a non-metropolitan area.
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Leave of Absence from Authorised Hospitals to a Private General Hospital.

- An involuntary detained patient can be given leave to attend at a private general hospital for medical or surgical treatment. The patient remains an involuntary detained patient with all the restrictions to that status.
 - The private hospital needs to make arrangements with the authorised hospital with regards to day to day arrangements (s.105)
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Where are the Specific Areas Where Administrative Requirements Will Be Increased In Private Hospitals?

- Requirement in regards to treatment support and discharge plans regarding detained patients in a general hospital (s.185 – 188).
 - **Physical examination on arrival at a hospital of a voluntary or involuntary patient (s.241) - 12 hours.**
 - When providing emergency psychiatric treatment to a voluntary patient or a referred person a report of the event must be provided to the Chief Psychiatrist (s.202 - 204)
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Where are the Specific Areas Where Administrative Requirements Will Be Increased In Private Hospitals? (cont.)

- Request for a further opinion from an involuntary detained patient in a general hospital or carer in regard to psychiatric treatment (s.182).
 - Provision of urgent non- psychiatric treatment. For involuntary patients detained in a private general hospital any urgent non psychiatric (medical) treatment must be reported to the Chief Psychiatrist. What this means for private psychiatric/general hospitals (s.242).
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Seclusion and Restraint


- In MHA 2014, Seclusion and Restraint as defined by the Act only relate to ***Authorised Hospitals***

Detention for a referred patient may occur in a private hospital, but this is not seclusion or restraint as defined by MHA 2014




Role of Mental Health Advocacy Service

A mental health advocate can when requested, visit or make contact with referred persons and must make contact with involuntary patients detained in a general hospital. For adults the timeframe is 7 days and for children the timeframe is 24 hours. Practically this means staff in private hospitals must understand the role of the mental health advocate and assist them in their work (part 20).




Role of the Mental Health Tribunal

The role of the Mental Health Tribunal pertains to involuntary patients detained in a private general hospital (part 21). Processes need to commence regarding scheduling of reviews at private general hospitals or by use of audio visual means.




Reporting Notifiable Incidents

Notifiable incidents as detailed in s.525, which occur in a private psychiatric/general hospital must be reported to the Chief Psychiatrist (s.526).

- The death of a person wherever it occurs.
 - An error in any medication prescribed which is likely to have an adverse effect on the person.
 - Any other incident in connection with treatment or care which has had or is likely to have an adverse effect on the person.
 - Any unlawful sexual contact with the person by a staff member of a mental health service.
 - Any unlawful or sexual contact with the person by a person who is not a staff member of a mental health service that occurs at a hospital.
 - The unreasonable use of force on the person by a staff member of a mental health service.
 - Any other event that the chief psychiatrist declares by notice in the Government Gazette to be a notifiable incident.
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Functions that Apply to Private Hospitals under the MHA 1996

1. A person can be referred by a medical practitioner or AMHP for examination by a psychiatrist at a private hospital
 2. An involuntary detained patient can be given leave to attend at a private general hospital for general or surgical treatment. The patient remains an involuntary detained patient with all the restrictions to that status. The private hospital needs to make arrangements with the authorised hospital with regards to day to day arrangements.
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Approved Forms- Referral

- 1A Referral
 - 1B Variation of referral

Approved Forms -Detention

- 3A Detention Order
 - 3B Continuation of detention
 - 3C Continuation of detention to enable a further examination by a psychiatrist
 - 3D
 - 3E Order that a person cannot continue to be detained
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Approved Forms- Transport

- 4A Transport order
 - 4B Extension of transport order

Approved Forms CTO

- 5A CTO

Approved Forms Search and Seizure

- 8A Record of search and seizure
 - 8B Record of dealing with seized article
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Approved Forms Emergency Psychiatric Treatment

- 9A Record of Emergency Psychiatric Treatment


Approved Forms ECT

- 13 Statistics about ECT

Forms


- On 30 November 2015, discard all MHA 1996 (and MHA 1962!) forms
 - MHA 2014 Forms will be available on the Chief Psychiatrist website- password not required
 - www.chiefpsychiatrist.wa.gov.au
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Forms

- Remember:
 - Complete the forms- sign, name, date, etc
 - Use the prompts on the back of the forms to remind you about any notifications that must occur
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Resources-

www.chiefpsychiatrist.wa.gov.au

- Clinicians' e-Learning Package
 - 3 hours, certificate, across the MHA2014
 - Referrers' e-Learning Package
 - 1 hour, referral specific
 - Information for Referring Practitioners
 - Hardcopy/online, referral specific, flowchart, Charter
 - Clinicians' Practice Guide (CPG)
 - Reference guide, e-book
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Resources

- Clinicians' Helpdesk
 - **6553 0016**
 - Advice on application of MHA 2014
 - Look at CPG first
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