



Government of **Western Australia**
CHIEF PSYCHIATRIST

Clinicians' Practice Guide to the Mental Health Act 2014

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Disclaimer: Clinicians' Practice Guide to Mental Health Act 2014

The Mental Health Act 2014 commences on 30 November 2015. The Clinician's Practice Guide (CPG) provides information for clinicians related to the legislation.

There will be regular updates to the CPG to ensure accurate and practical legal/clinical translation.

Currency or accuracy of printed or downloaded copies of the CPG cannot be guaranteed. The correct and updated version of the CPG will be located on the Chief Psychiatrist's website.

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Preface

The *Mental Health Act 1996* has been in force since 13 November 1997. It replaced the 1962 Act and introduced into legislation bodies such as the Mental Health Review Board, an independent tribunal to review involuntary status, less restrictive treatment options such as Community Treatment Orders to facilitate essential treatment external to a hospital, and a new part of the Act dedicated to patient's rights.

As required by section 215 of the *Mental Health Act 1996*, a review of the legislation was completed in December 2003 by Professor D'Arcy Holman, and in October 2004 the government of the day accepted the majority of the recommendations of the review. The drafting of a new Mental Health Bill commenced in September 2005.

One election commitment of the present government was to table a new Mental Health Bill in Parliament and this was achieved by the publication of a draft Consultation Bill in 2011 and a Green Bill in November 2012.

In the development of the Consultation and the Green Bill there was extensive consultation with patients¹, carers, clinicians, interested others and the Department of Health. To assist the progress, an expert group provided advice in 2010. Gregor Henderson, a mental health expert from Scotland, and Professor Terry Carney, law professor from New South Wales, provided recommendations regarding systems of quality assurance and the establishment of the Mental Health Review Tribunal.

Community and stakeholder input into the Consultation and the Green Bill has shaped the *Mental Health Act 2014* (Act), which I believe is exemplary legislation providing for the rights of people with mental illness, within a framework enabling optimal treatment and care.

The process to bring this Act into fruition has been extensive and I would like to thank the many people from within the Mental Health Commission, the Department of Health and Parliamentary Council as well as patients, carers and interested others who have all contributed to this substantial step forward in mental health reform in Western Australia.



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¹ The Guide refers to "patients" when it means people who are, or appear to be, experiencing a mental illness. This use of the term is not a recommendation that the term "patient" should be used in practice in preference to other terms such as "consumer", "clients" or similar. It is simply a reflection of the terminology used in the Act itself.

Purpose of the Clinicians' Practice Guide

The *Mental Health Act 2014* (Act) sets out the legislative processes in regard to the way mental health patients in Western Australia (WA) are cared for and treated. While the Act applies to some voluntary patients it is primarily relevant to a small number of people experiencing mental illness who, because of the seriousness of their mental illness and issues in compliance with treatment, need to be made subject to involuntary status.

The vast majority of mental health care is provided on a voluntary basis and, except for a few matters, the Act is silent on how that care and treatment is delivered. However, there are many other policies, procedures, codified standards and research information that provide guidance on good practice and evidence-based care and treatment. The Clinicians' Practice Guide (CPG) provides information and links to such other sources where relevant.

This CPG is one of a set of legislative guides and is specifically written for mental health clinicians and other health staff who may need to use the legislation when providing treatment and care.

While essentially the CPG is about the Act and what clinicians should be aware of when applying legislative processes, it strives to be more. Legislation needs to be understood, interpreted and placed in the context of personal experience. While explaining what the legislation intends, the guide also explores the issues clinicians should keep in mind and what best practice indicates when applying the Act. The CPG has been subject to extensive consultation and feedback and legal and legislative review.

Mental health care is complex and while legislation provides a set of rules which must be applied, how those rules are interpreted and impact on patients, carers, families and communities depends greatly on the approach clinicians take.

Essentially when managing complex matters clinicians should act in a patient centered and recovery focused way. While it provides legal pathways of managing treatment and care situations, at the heart of the Act is how clinicians interact with and relate to patients and others. This should be in the best interests of the patient and with the overall aim of providing treatment with the least restriction on the person's freedom of choice and movement.

The purpose of the CPG is to clearly explain what is in the Act, suggest how it should be interpreted and outline practices clinicians should adopt when performing a function under the Act. It is also about placing the Charter of Mental Health Care Principles at the forefront when delivering care and treatment.

Ethical and legal practice underlying the Act

Mental health services and the clinicians who work for the services are expected to comply with the Charter of Mental Health Care Principles, the Objects of the Act, and Guidelines and Standards published by the Chief Psychiatrist. There is also an expectation that when clinicians are performing functions under the Act they do so from an ethical and legal position. In relation to the legislation, ethical and legal practice has three pillars:

- procedural fairness for consumers²
- accountability by clinicians
- inclusion of family members, carers and other support persons.

Applying these three pillars when performing functions under this Act ensures not only that the requirements of the Act are met, but also that the human rights of people experiencing mental illness are promoted.

Procedural fairness

While the Act provides direction on some of the processes clinicians will undertake when applying the legislation, there is no guarantee of procedural fairness. It is not possible to map and track every aspect of clinician and patient interaction to ensure all processes and decisions are fair. It is up to each individual clinician to perform their tasks in such a way as to ensure a substantial element of fairness when applying the Act.

Procedural fairness works on the concept that if a patient perceives that he or she has been treated in a procedurally fair way then they are more likely to be satisfied with the outcome. If a person does not believe they have been heard or if they believe they have been treated unfairly they are more likely to be resentful and uncooperative. Procedural fairness is required by law regardless of the relationship between the patient and the clinician, however a relationship based on trust and confidence will enhance the process.

The CPG aims to provide pathways to assist the clinician in applying procedural fairness but cannot scope every circumstance the clinician will be faced with. What may be needed is the filter of personal experience: *'If this was happening to me or a person I cared for, what would I like to happen?'*

Accountability

There is an expectation when a clinician performs any function under the Act that there are good clinical and legal reasons for performing that function. All actions taken need to be supported by the imperatives of good and safe practice as well as clinical accountability.

² Drew, N. (2014) Living and learning together: principled practice for engagement and social transformation in the east Kimberley region of Western Australia in Rinehart, R.E., Barbour, K.N., Pope, C.C., eds. *Ethnographic Worldviews*: Springer Link: chapter 7 – pp 77-91

Accountability is more than justifying a particular action, it is accepting responsibility and believing that whatever is done is morally and legally correct and in the best interests of the patient. It is being able to review the action and state that, given the particular circumstances at the time, the correct investigations were made, the right questions were asked, important information was accessed and the right decisions made. Many sections of the Act require clinicians to be accountable for the processes they undertake and the decisions they make.

In the risk averse environment we work in, clinicians may feel that the expectation on them to make reasonable decisions in line with the legislation and good practice can be extremely difficult given that risk management is an imprecise science and the factors influencing decision making are constantly changing. It is within that framework that clinicians need to acknowledge consequences for their actions, use a shared decision making process with patients and their families whenever possible, and have sound reasons for using their clinical judgement in making decisions and documenting the process.

Inclusion

A clinician does not make decisions in a vacuum. While clinical information and education are important, the inclusion of other people such as relatives, parents, carers and nominated persons in the decision making process is essential.

The Act emphasises the importance of consulting with a range of people who are important to the patient. For Aboriginal people, this includes consultation with elders, traditional healers and significant people from the patient's community. Failure to include important people is not only against the principles in the Act but can lead to important information being overlooked.

Clinicians can at times be concerned that time spent contacting and consulting carers and concerned others can detract from time spent with the patient on their care and treatment. However, the Act emphasises that caring for people who are experiencing mental illness is a joint enterprise between clinicians, the patient, and important people in the patient's life and inclusion is a fundamental principle underlying the legislation. Other people in a patient's life can bring invaluable insights and information which can enhance patient care and add significantly to the clinical picture.

Objects

The purpose of any legislation needs to be articulated and Part 3 of the Act provides details of the Objects of the Act.

10(1)(a) to ensure that people who are experiencing mental illness are provided with the best possible treatment and care, with the least possible restriction of their freedom and with the least possible interference with their rights in an environment which has respect for their dignity.

The implication of this object is that treatment and care provided needs to be in line with evidence based practice, up-to-date and proven to be effective. The clinician needs to consider whether the environment in which the treatment is offered places unnecessary restrictions on freedom and whether there is a less restrictive intervention. For example, when a patient is behaviourally disturbed in an authorised hospital, consideration must be given to ways of managing the behaviour without placing the patient in seclusion or using bodily restraint even though those pathways exist. Essentially these are clinical decisions but performed through the prism of the Objects of the Act.

10(1)(b) to recognise the role of carers, families and others in the treatment, care and support of people who have a mental illness.

10(1)(c) to recognise and facilitate the involvement of people who have a mental illness, their nominated persons and their carers and families in the consideration of the options that are available for their treatment and care.

This emphasises the principle of inclusion and making these significant people partners with clinicians in a patient's journey.

10(1)(d) to help minimise the effect of mental illness on family life.

This may mean intervening and providing care when a family is under stress. While clinicians offer patient centered care, for families and carers the effect of caring for someone who is experiencing a mental illness, cannot be underestimated and needs to be included in the decision making processes.

10(1)(e) to ensure the protection of people who have or may have a mental illness.

People experiencing mental illness can be amongst the most vulnerable people in the community and at times may behave, because of their mental illness, in ways which may be harmful to themselves or others. The Act has an essential role to play when patients lack capacity and are unable to act in their own best interests and clinicians are required to take on the responsibility of giving treatment and care without consent.

10(1)(f) to ensure protection of the community.

At times a patient may, because of their mental illness, act towards others, especially those close to them, in a way which places the people in the community at risk. In those circumstances the state has the responsibility, acting through clinicians, to ensure the safety of the community, by using the Act.

Lastly the Objects note that a person or body performing a function under this Act must have regard to these Objects.

A person centered and recovery approach to detention and compulsion ³

Choice, control, social inclusion and personal responsibility have been identified as the goals of a modern mental health service (Roberts et al, 2008)⁴ and are important in developing recovery oriented practices. Many clinicians view recovery principles as separate from legislative requirements which can order the detention and compulsory treatment of patients. However, there is a new approach which includes paying attention to recovery oriented principles when considering detention and compulsion.

Recovery for patients is about self-determination, taking back control over treatment and having the opportunity to do the things that provide value and meaning, while also instilling hope in the future. The traditional approach has more of an emphasis on risk assessment; with clinicians using legislation to manage the risk posed by some people experiencing mental illness who clinicians believe pose a risk to themselves and others. In doing so clinicians use clinical assessment skills and actuarial methods to gauge risk to ensure informed decisions can be made about whether to use the powers within the Act.

Boardman and Roberts⁵ suggest that if recovery is about self-determination and doing the things you value, then a recovery focused approach should move away from 'managing risk' to 'promoting safety and opportunity' and will be founded on shared understanding, shared decision making and shared responsibility for safety.

Decisions that involve detaining people and imposing compulsory treatment are usually made in difficult and sometimes critical circumstances. For many clinicians it is a struggle to reconcile the different and often dissonant perspectives of patients, carers and clinicians and to work out how best to support a patient's recovery.

If recovery is strongly connected to personal responsibility and choice, and that includes having the ability to make decisions and have control over all aspects of daily life, then it is not surprising that some consider that a person cannot recover when they are subject to compulsion. An alternative view is that there should be no 'recovery free zones' in any mental health service. However, if it is also true that there are good reasons for involuntary treatment as part of psychiatric care then there is a definite need to work out the values and philosophy of recovery-oriented practice at every level, including how that applies to involuntary patients.

³ **A national framework for recovery-oriented mental health services: Guide for practitioners and providers;** Commonwealth of Australia 2013

⁴ Roberts et al (2008) Detained- What's my choice in *Advances in Psychiatric Treatment* (2008), vol. 14, 172–180 doi:10.1192/apt.bp.107.003533

⁵ Boardman, J. and Roberts, G. (2014) Risk, Safety and Recovery, IMROC Publication, www.imroc.org/media/publications

The experience of patients is that involuntary status diminishes choice. Clinicians decide where the patient will stay, what medication or other treatment they will receive, with whom they can communicate, and what freedom of movement they may have. Part of a recovery focus for involuntary patients would be to enhance choice by engaging the patient in a dialogue about treatment and care. As the Scottish Recovery Network points out, 'Working in a recovery oriented way to achieve personal outcomes not only helps people with lived experience, but it is better for practitioners. It is important to consider how we can really help those who work with people in distress to adopt new approaches and ways of working that inspire hope and are genuinely recovery focused'.⁶

While the Act promotes a legal and clinical response to health, safety concerns and risk of self-harm, a number of advocates who promote recovery principles note that while attempting to respond to an immediate 'need' to act, forcing someone to do something against their will because they have a mental illness, can be a traumatic and injurious experience with long term consequences for their health and wellbeing. It is not only disempowering and re-traumatising, but can permanently damage the relationship between the clinician and the patient and may result in reducing and even obliterating feelings of hope and optimism. While it may be an important immediate response, over time it can do little to help people achieve their personal recovery goals.⁷

Many recovery concepts such as independent advocacy, supported decision making, choice of a nominated support person, listening to patient's wishes and Advance Health Directives are reflected in the Act, and one important aspect of the clinical approach is to respect and include these concepts in practice.

There is no course of action initiated by a clinician which is 'risk free'. While removing someone from the community and compulsorily treating them in hospital can reduce the immediate risk of harm to self or others it may at the same time exacerbate stigma, lower self-esteem, be very damaging to familial and therapeutic relationships and could result in loss of a job or accommodation. This may be particularly relevant to Aboriginal people who are separated from their community when treated in hospital. For patients being transferred from rural and remote areas there are additional risks associated with transporting a person by aircraft or road over great distances and a loss of community supports.

The traditional landscape of mental health legislation and involuntary detention and treatment has been populated with concepts such as risk assessment, restraint, seclusion, depot medication, search and seizure where the staff must be in control. The new landscape of a recovery approach to involuntary status emphasises the importance of having a respectful relationship between staff and patients, giving involuntary patients choice, allowing for the dignity of risk and involving patients, carers and relatives as equal partners in the journey to wellness.

⁶ Proposed Mental Health (Scotland) Bill 2014 SRN response to the Scottish Government consultation, March 2014.

⁷ O'Hagan. M., (2012) at <http://www.scottishrecovery.net/Latest-news/legal-coercion-the-elephant-in-the-recovery-room.html>

At times coercion is used as a response to 'unpredictable behaviour'. In contesting that concept Boardman and Roberts ask clinicians to explore why someone may be behaving in a particular way, while recognising that it may be due to delusions or hallucinations. Through the different perceptions of the patient and the staff a shared understanding of what is happening can be explored which allows alternative options to coercion to be considered.

An important aspect of a recovery approach to detention and compulsion is a shared responsibility for safety, where the emphasis is on 'safety' rather than 'risk'.

Spending time on a safety plan and truly exploring what triggers certain behaviours, what the early warning signs are and honestly engaging the patient in problem solving can lead to a co-produced safety plan rather than one drawn up by the staff without involvement of the patient.

When drawing up a patient's safety plan it is important to discuss what is important to the patient, such as what their goals and priorities are and what concerns they have. If there have been previous challenging incidents get the patient's perspective of what happened as that will provide more insight into the event and may present options of how incidents may be handled or avoided in the future.

It is important to establish the context for the incident, what happened before it occurred and how serious it was. For example, a staff member being assaulted while trying to give an intra-muscular injection to a resistive patient is significantly different from a patient, while responding to voices, suddenly assaulting a staff member. Spending time looking at the triggers for distress and anger, issues such as unwelcome anniversaries or thoughts can all be used to articulate a safety plan that is individual and owned by the patient and which provides staff with tools to avoid similar incidents occurring in the future. Involving carers and relatives can also provide insights and a more holistic approach, which will add value to a safety plan and minimise the chances of incidents happening.

While the purpose of compulsory detention and treatment appears to be the protection of everyone, including the patient, in fact the real purpose is to enable patients to regain their mental health and personal control so that they can return to and stay in the community, out of hospital and lead a meaningful life.

"The therapeutic purpose of detaining someone and treating them against their will is to achieve the gradual handing back of choice and control in ways that are safe and to enable them to resume responsibility for themselves." (Roberts et al 2008)

How the Clinicians' Practice Guide is structured

The Act is complex covering some 27 parts and 2 schedules. Although structured in parts with specific headings, it cannot be read in a narrative fashion with one issue naturally leading to another. As is common in legislative documents, the reader needs to move back and forth in the text to fully understand the legislative processes.

The CPG therefore does not follow the parts of the Act, 1 to 27, but rather arranges the content with subject headings and explores as many of the issues related to that subject as possible. While attempting to be coherent, there are times when specific issues can only be discussed in another context. The CPG notes what is in the legislation and also provides examples of how a particular legislative process may be interpreted so that the reader can more fully understand how a legislative process should operate.

The CPG includes a number of addendums, including the Chief Psychiatrist's Guidelines as required by Section 545 of the Act, where specific issues are explored in more detail or from a particular perspective.

Chapter 1: The rights of patients, carers, family members and personal support persons (Parts 2, 4, 16, 17 and 18)

1.1 Background

- 1.1.1 Patient rights are the cornerstone of the legislation and there are a number of clinical duties which ensure that these rights are upheld. While the Act imposes responsibilities on clinicians, it also removes some liberty and freedom of choice for patients, at times placing patients in situations where they can only exercise their rights through the legislation. It is imperative that attention is given to patient rights. Matters regarding patient rights are scattered throughout the Act and this chapter is a compilation of the rights of patients, carers, family members and personal support persons as well as details regarding the obligations of clinicians to ensure these rights are observed.

1.2 Charter of Mental Health Care Principles (Part 4 and Schedule 1)

- 1.2.1 The Charter of Mental Health Care Principles (Charter) is a schedule to the Act related to patient centered care, the recovery approach and the involvement of carers. It is essentially a set of expectations for patients who receive care and treatment at mental health services. It is intended to influence the interconnected factors that facilitate recovery from mental illness.
- 1.2.2 A person or body performing a function under the Act must have regard to the principles set out in the Charter. A mental health service must make every effort to comply with the Charter when providing treatment, care and support to people experiencing mental illness (Part 4, s. 11).
- 1.2.3 It is recommended that a poster of the Charter be on view at every mental health facility and a pamphlet also be made available to patients, carers and others. This may require media that utilise other community languages and/or ways of effectively communicating with Aboriginal people.
- 1.2.4 A mental health service is not committing an offence under the legislation if they fail to comply with the Charter. However, matters related to the Charter may form the basis of a complaint to the Health and Disability Services Complaints Office (HaDSCO) (s. 320(2)(f)).
- 1.2.5 Having regard for the Charter implies active engagement with the principles. Services should be able to demonstrate compliance with the Charter.
- 1.2.6 This may be complex because the principles are broad, and how they are applied, understood and experienced may differ from person to person and situation to situation. However, every complaint that a principle is not being upheld should be investigated and the complainant provided with a response.
- 1.2.7 The 15 principles of the Charter are outlined here.

Principle 1: Attitude towards people experiencing mental illness

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.

This principle is a basic right and emphasises that the attitudes and behaviours of staff employed by a mental health service must meet the standards expected by the community. Every patient, carer and relative expects to receive a service that is free from discrimination, sensitive to the needs of people experiencing mental illness and of a standard equal to any other health provider. This is a fundamental issue of cultural change. Clinicians need to be responsible for their own attitudes and behaviours as well as the behaviour of colleagues.

Principle 2: Human rights

A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

These standards include the *United Nations' Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)*⁸ and the *United Nations' Convention on the Rights of Persons with Disabilities (2006)*,⁹ to which Australia is a signatory, as well as the *National Standards for Mental Health Care (2010, Australian Government Department of Health and Aging)*.¹⁰ Care and treatment standards are also be addressed by the Chief Psychiatrist and made available as an addendum to this guide (see Addendum 1) and on the website of the Chief Psychiatrist.

Principle 3: Person centered approach

3.1 A mental health service must uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including recognising life experiences, needs, preferences, aspirations, values and skills, while delivering goal-oriented treatment, care and support.

3.2 A mental health service must promote positive and encouraging recovery focused attitudes towards mental illness, including that people can and do recover, lead full and productive lives and make meaningful contributions to the community.

All clinicians should be familiar with the principles of recovery which promote optimism. If clinicians want patients to recover it has to be more than just about medication compliance. Recovery has been defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles' and 'a way of living a satisfying, hopeful, and contributing life even within the limitations

⁸ <http://www.health.wa.gov.au/mhareview/reports/synthesis/15%20MHA%20Synthesis%20%20-%20Appendices%201.pdf>

⁹ <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

¹⁰ [http://www.teamhealth.asn.au/content_images/attachments/National%20Mental%20Health%20Standards%20\(2010\).pdf](http://www.teamhealth.asn.au/content_images/attachments/National%20Mental%20Health%20Standards%20(2010).pdf)

caused by illness'.¹¹ Clinical practice is about supporting a patient's personal recovery and moving beyond seeing a person as an involuntary patient to a person recovering from mental illness. Clinicians need to be familiar with and apply the National Framework for Recovery-Orientated Mental Health Services.¹²

Principle 4: Delivery of treatment, care and support

A mental health service must be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is consistent with their needs.

This principle recognises that services need to be provided when they are needed and without obstacles to accessing the services, so that they provide the maximum benefit to patients with the minimum intervention. There should be a 'no wrong door' policy which means that even if a specific service cannot be provided, the patient is given enough information, direction, support and assistance to access another appropriate service. This principle also emphasises that clinicians should be aware of best practice (for example, integrating recovery principles into the provision of care and treatment).

Principle 5: Choice and self-determination

A mental health service must involve people in decision-making and encourage self-responsibility, cooperation and choice, including by recognising people's capacity to make their own decisions.

The Convention on the Rights of Persons with Disabilities (2006) emphasises the change from alternative decision making, in relation to people who may lack capacity, to supportive decision making, where a patient is assisted and encouraged to be responsible and actively involved in making choices, rather than accepting the choices of others no matter how well intentioned. Staff can assist in promoting patient choice, encouraging self-determination and supporting patients in decision making.

Principle 6: Diversity

A mental health service must recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

Clinicians are expected to demonstrate a non-discriminatory approach in the way they provide treatment and care, as well as sensitivity to the diversity of people who experience mental illness (including their carers and family members). Prejudices and assumptions need to be put to one side when providing care and treatment. It is not expected that clinicians will have expertise in every area, however when

¹¹ Anthony W.A. Recovery from mental illness: the guiding vision of the mental health system in the 1990s. Psychosoc Rehabil J, 1993;16:11-23.

¹² A national framework for recovery-oriented mental health services: Guide for practitioners and providers: Online ISBN: 978-1-74186-011-5

uncertain they should seek advice and refer patients to services where there is more knowledge or familiarity with particular cultural issues.

Principle 7: People of Aboriginal or Torres Strait Islander descent

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

Aboriginal people are particularly vulnerable to experiencing mental illness as a consequence of inter-generational trauma associated with the detrimental impacts of colonisation, dispossession, the forced removal of children from families, racism and discrimination. This is further compounded by socioeconomic disadvantage and lack of resources in remote and regional areas.

To gain a greater understanding of Aboriginal mental health, clinicians can speak to their local Mental Health Aboriginal Liaison Officers or access the Aboriginal mental health page on the Mental Health Commission's website or the Australian Indigenous mental health page on the website of the Royal Australian and New Zealand College of Psychiatrists.¹³ There are also many reports and documents which provide guidance, such as *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*.¹⁴ Specific guidelines developed by the Aboriginal Advisory Group for the Mental Health Act 2014 are included as Addendum 5 of this guide.

Principle 8: Co-occurring needs

Factors relating to intellectual disability will need to be included in the realm of co-occurring needs.

A mental health service must address physical, medical and dental health needs of people experiencing mental illness and other co-occurring health issues, including alcohol and other drug problems.

It is well recognised that people who experience long-standing mental illness tend to also experience significant physical health and lifestyle problems. These could include physical problems that have not been addressed by primary health providers, or health issues that are a consequence of mental illness or side-effects of treatment. Certain treatments may cause metabolic and weight problems as well as reducing motivation. Other essential treatments like dental care are often not affordable for many patients on disability or other type of benefits. People experiencing mental illness may also use alcohol and other drugs to a greater degree than the general population.

¹³ <http://indigenous.ranzcp.org/index.php>

¹⁴ http://aboriginal.telethonkids.org.au/media/54847/working_together_full_book.pdf

Care and treatment in a mental health setting needs to address these co-morbid problems. When devising care plans clinicians must take into account physical, dental and lifestyle issues so that holistic care can be developed. The Chief Psychiatrist outlines its expectations through the 'Psychical health care of mental health consumers standard', which is included in Addendum 1, and with which mental health services are expected to comply.

Principle 9: Factors influencing mental health and wellbeing

A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, accommodation, recreation, education, financial circumstances and employment.

Mental illness may be linked with social and wellbeing problems such as homelessness, unemployment and damaged relationships. Clinicians need to take a holistic approach so that these social and wellbeing problems are also addressed alongside the mental illness. Failure to do so may result in relapse and possible readmission.

Principle 10: Privacy and confidentiality

A mental health service must respect and maintain privacy and confidentiality.

Because stigma and prejudice continue to affect people experiencing mental health issues, upholding privacy and confidentiality becomes particularly important in treatment and care. Despite the advances made in raising awareness of mental health issues, when people such as work colleagues or friends of a patient become aware of their mental illness, it can still lead to discrimination. Clinicians who have access to very confidential information about the life of another person have a strict duty to maintain confidentiality.

Section 319(2)(e) states that a complaint may be made to HaDSCO on the basis that a service provider acted unreasonably in disclosing records or confidential information. While there is a statutory requirement regarding confidentiality, this must be considered within the framework of carer engagement. A clinician should continue to proactively engage carers even when a patient declines release of information.

Principle 11: Responsibilities and dependents

A mental health service must acknowledge the responsibilities and commitments of people experiencing mental illness, particularly the needs of their children and other dependents.

The impact of mental illness extends beyond the patient. Families, friends and colleagues of the patient, as well as work and community organisations are all affected by issues related to a patient's mental health.

Consideration needs to be given to involving families and dependants in the recovery process. Many of the responsibilities a person has when they are well - working, paying bills or looking after pets - may not be well managed while they are experiencing mental illness. How these issues are dealt with is part of the clinician's

responsibility towards a patient. These essentially non-medical, wellbeing issues are as much a part of a recovery plan as medication or other treatments.

Principle 12: Provision of information about mental illness and treatment

A mental health service must provide, and clearly explain, information about the nature of the mental illness and about treatment (including any risks, side effects and alternatives) to people experiencing mental illness in a way that will help them to understand and to express views or make decisions.

The provision of relevant information to a patient and their family is fundamental to upholding patient's rights. The Act details when information should be provided, when it should be offered and when carers and family must be notified. Engaging important people in the patient's life assists recovery. The provision of information is an integral part of a psychiatrist's clinical practice. It should be given a high priority within mental health services, while taking into account language and cultural differences. In order to give accurate information to patients and others, clinicians need to be up-to-date and knowledgeable about mental health treatments.

Principle 13: Provision of information about rights

A mental health service must provide, and clearly explain, information about legal rights, including those relating to representation, advocacy, complaints procedures, services and access to personal information, in a way that will help people experiencing mental illness to understand, obtain assistance and uphold their rights.

When a person is deprived of their liberty or their right to refuse treatment, as can occur under this Act, it is essential that they have rights of review, representation and advocacy. The duty of providing information falls upon individual clinicians, advocates and more generally on mental health services. Clinicians should make the time to explain to a patient and their carers what their rights are. This needs to be supplemented by pamphlets and guides.

Principle 14: Involvement of other people

A mental health service must, at all times, respect and facilitate the right of people experiencing mental illness to involve carers, families and other personal and professional support persons in planning, undertaking and evaluating their treatment, care and support.

Experiencing mental illness can be frightening and traumatic and the involvement of family members and carers can reduce the stress the patient may be feeling. Family members are in a good position to contribute to the recovery of the patient and the Act obliges clinicians to involve them. There are provisions in the Act which allow for family members to be excluded when it is not in the best interests of the patient. However, the default position is that it is important to involve significant people in the patient's life.

Principle 15: Accountability and improvement

A mental health service must be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the

treatment, care and support of people experiencing mental illness, including their carers, families and other personal and professional support persons.

Mental health services should have a model of treatment and care which considers the overall wellbeing and quality of the patient's life. Clinicians should consider what a patient and their family need from mental health services and develop goals with the patient and significant others which can enable recovery and reduce relapse.

Every mental health service is encouraged to consider the principles in the Charter and provide practical guidelines to staff to ensure they have a real and significant effect on the way services are delivered and on the lives of patients.

1.3 Best interests and wishes of a person (Part 2, Divisions 3 and 4) (and Patient's psychiatrist must ensure regard to patient's wishes (Sections 179 and 180))

- 1.3.1 When any clinician performing a function under the Act is making a decision about treatment and care (or anything else the person feels is relevant), they must have regard to the patient's wishes and, to the extent that it is practicable, try to ascertain what those wishes are. It is not possible to know what those wishes are unless the patient is specifically asked. There may be situations where it is not practicable to ascertain a patient's wishes (for example in a crisis situation with behavioural disturbance, where it may be detrimental to delay intervention or treatment), however the default position is always to ascertain what a patient's wishes are. If the determination is made that it is not practicable to obtain those wishes then the documentation in the patient's medical record should reflect that decision and reasons for that decision.
- 1.3.2 Although patient's wishes must be considered there are limits to the extent they can be met. Normally, for example, when a patient does not want to be visited by a particular family member patient choice will prevail even if the ward staff believe the visit would be beneficial. However there may be other occasions, such as a family interview when decisions are being made about treatment and care, when the patient's wishes cannot be supported because it is in the patient's best interests to involve the family.
- 1.3.3 This is particularly important if the person has made an Advance Health Directive (AHD) or there are specific terms of any enduring power of guardianship. Every effort should be made to establish whether the patient has an AHD, and because in emergency situations it may not be easy to establish if there is one, any existence of an AHD should be noted clearly in the patient's medical record at admission. A psychiatrist, medical practitioner or a clinician is not obliged to follow a patient's wishes or an AHD where the action is illegal, unethical or contrary to the clinical code of practice (see Addendum 3 for more information on AHDs).
- 1.3.4 The clinician must consider the views of others, such as:

- a) the patient's guardian
- b) the parents of a child
- c) the nominated person
- d) the carer
- e) any close family member.

1.3.5 Being mindful of a patient's best interests helps make decisions that might be more objective than decisions made by a substituted decision maker (as listed in 1.3.4). The clinician should think about the best course of action for the patient, which should not be based on the personal views of the clinician, or anyone else.

1.3.6 Essentially 'best interests' is at the heart of patient centered care. The clinician should consider the current and future interests of the patient and decide which course of action is, on balance, the best course of action for the patient. In determining the patient's best interests, the clinician should avoid making assumptions on the basis of the person's age, culture or appearance or on an aspect of the patient's behaviour, which might lead to unjustified assumptions about what might be in the patient's best interests. For example, just because a patient is in a wheelchair does not mean that they must have a 24 hour carer. Evaluating abilities is just as important as noting disabilities.

1.3.7 The views, opinions and assistance of others is important, but so also are the views of others such as more experienced staff members and those who know the patient well or have developed a good rapport with the patient.

1.3.8 Before being asked whether they consent or do not consent to treatment, a patient must be given enough information, time and opportunity to discuss the issue with others and seek advice (see Chapter 2: Decision making capacity and informed consent).

1.3.9 A patient's wishes can be ascertained at the time the person seeks treatment or is admitted to hospital or care. This does not have to wait until just before treatment is given. As part of the admission process and at other significant points in a patient's journey, a patient should be asked about their wishes and documented in their medical record.

1.3.10 As noted previously these wishes can comprise an AHD which is a directive made under the Guardianship and Administration Act (GAA Act) Part 9B, or an instrument recognised as such under the GAA Act Section 110ZA, or a directive given by a patient under the common law containing treatment decisions in respect of the patient's future treatment.

1.3.11 If a psychiatrist gives treatment contrary to a patient's AHD the psychiatrist must record in the patient's medical record the decision and reasons for that decision. A copy of those reasons must then be given to the patient and, where applicable, a carer, family member, guardian or nominated person as well as a copy being provided to the Chief Mental Health Advocate and the

Chief Psychiatrist. This could be on a separate form or a photocopy of the page of the notes which details these reasons. This must be placed in the medical record.

- 1.3.12 The purpose of this requirement is to ensure that AHDs are properly considered before treatment is delivered and only overruled when it is not in the best interests of a patient. The psychiatrist does not need to provide reasons to the patient or others if they have been given a copy of previous reasons for an earlier decision made regarding the same issues in the AHD (s. 179(4)). However, before overruling an AHD the psychiatrist must give the patient sufficient information about the treatment so that informed consent can be sought (s. 180).

1.4 Voluntary patients

- 1.4.1 A voluntary patient is defined as neither an involuntary patient nor a mentally impaired accused (MIA) who is detained at an authorised hospital. Under the 1996 Act there was a term 'referred person' who was neither a voluntary nor an involuntary patient, but a person who had been referred for an examination by a psychiatrist and could be detained for up to 24 hours in an authorised hospital.
- 1.4.2 People may still be referred under this Act however the term 'referred person' is not within the legislation, and therefore they fall within the term 'voluntary patient', even though they may at times be detained. Unless otherwise specified, the rights of voluntary patients, such as the right to refuse treatment, extends to voluntary patients who are referred for examination. Additionally, referred persons who are also subject to a Detention Order have the right to have contact with or a visit from a Mental Health Advocate. In certain circumstances voluntary patients who are referred for an examination by a psychiatrist may be detained and provided with treatment under the provisions of emergency psychiatric treatment. While this Act does not specifically deal with all the rights of voluntary patients, such as the right to refuse treatment or discharge themselves against medical advice, it does note that voluntary patients do have the right to seek admission.
- 1.4.3 A voluntary patient (or the parent of a child) has the right to seek admission (Part 16, Division 2, Subdivision 1), however only a medical practitioner can admit a voluntary patient to an authorised hospital and the admission must be confirmed by a psychiatrist. If a medical practitioner refuses the admission or a psychiatrist refuses to confirm an admission the patient (or parent) must be informed of the reasons for the refusal. There is a right for the patient (or parent) to make a complaint either to the person in charge of the hospital, the Director of HaDSCO or the Chief Psychiatrist.
- 1.4.4 Giving clinical reasons for not admitting a patient may be reasonable, however indicating that the reason is due only to a lack of resources is insufficient. There needs to be an assertive process escalating what is required to enable an admission, if an admission is identified as the preferred

option. Decisions based only on lack of resources within the mental health system rather than the patient's clinical presentation, need to be discussed with the head of service or the director of patient flow coordination.

- 1.4.5 If the decision to refuse admission is given verbally the patient may request the decision in writing which must be complied with. In those circumstances the decision must be given in a language, form of communication and terms that the patient is likely to understand using any means of communication that is practicable and using an interpreter and any culturally appropriate support where necessary.

1.5 Explanation of rights for voluntary and involuntary patients (Part 16, Division 1, Subdivision 1)

- 1.5.1 There are some overarching principles regarding the provision of patients' rights and information. The explanation of patient rights must be:

- a) done as soon as is practicable
- b) appropriately communicated in a language and medium which can be understood by the patient
- c) repeated at the next most appropriate juncture at a time when the patient is most likely to receive it.

- 1.5.2 In relation to a variety of issues a psychiatrist, medical practitioner, authorised mental health practitioner or person in charge of the hospital is responsible for ensuring that a voluntary or involuntary patient is given an explanation of their rights in a language, form of communication and terms that the patient is likely to understand, using any means of communication that is practicable and using an interpreter if necessary and practicable. It may at times be necessary to repeat the explanation of rights.

- 1.5.3 Means of communication may include oral explanations such as staff sitting down with a patient and explaining their rights, written material in the form of pamphlets, information in an audio format, information on websites and information translated into a number of community languages. Information should be handed to the patient as well as being available in a patient's area in a ward or clinic.

- 1.5.4 The right to an explanation of rights extends to a patient's carer, their close family members or other personal support persons. While this role primarily falls upon mental health staff, information can also be provided to patients by mental health advocates when performing their duty to contact identified persons (s. 352). It is important for clinicians to document when an explanation of rights has been given as this can be one measure of compliance undertaken by the Chief Psychiatrist.

1.6 Right to access records (Part 16, Division 1, Subdivision 2)

- 1.6.1 A current or a previous mental health patient is entitled to inspect and be given a copy of any relevant document, such as the patient's medical record,

that is in the possession or control of the mental health service. However this right is subject to the restrictions detailed below.

- 1.6.2 This right is distinct from the right of persons to apply for information under the *Freedom of Information Act 1992* and should be dealt with separately from a Freedom of Information application.
- 1.6.3 The person in charge of the service must ensure that the request is complied with as soon as practicable after the request has been received. In other words there should not be unjustified delay in ensuring this occurs.
- 1.6.4 Allowing patients to access their medical records, and in some cases amending the medical records to rectify any confirmed mistakes identified by the patient or a concerned person is consistent with the principles of recovery and patient centered care.¹⁵ Research indicates a high degree of satisfaction by doctors and patients where patients are able to review the notes written by their primary health care provider.¹⁶
- 1.6.5 It is noted that allowing patients to read what clinicians write about them will confer a number of benefits such as making the relationship more transparent and increasing trust.¹⁷ This makes it important for the notes to be legible and understandable to any reader.
- 1.6.6 It will also be of benefit to clinicians to be mindful of the way progress notes are documented. Eliminating pejorative expressions and expressing issues in a behavioural context is important.
- 1.6.7 However, even if the medical record contains no pejorative comments, it could be devastating for an unprepared patient to read that he or she has been diagnosed with a serious mental illness, such as schizophrenia or personality disorder which are still stigmatised. There may also be significant third party information in the patient's medical record. Therefore it may be appropriate at times to withhold parts of the medical record.¹⁸
- 1.6.8 It is recognised that in order to see whether access should be restricted the document may need to be examined. Depending on the length of the document that may cause delays in providing the documentation. However, the default position is that the request is complied with as soon as practicable unless one of the factors described below applies (see 1.6.10).
- 1.6.9 If the request is refused, the reasons for the refusal must be written in the patient's medical record and a copy given to the patient. There must be valid reasons for the refusal and that may require a review of the documentation

¹⁵ Detmer, D., Bloomrosen, M., Raymond, B. & Tang, P. (2008) Integrated personal health records: Transformative tools for consumer-centric care. *BMC Medical Informatics and Decision Making*, 8, 45. <http://www.biomedcentral.com/1472-6947-8-45>

¹⁶ Delbano, et al (2012) Inviting patients to read their doctors notes. *Annals of Internal Medicine*, 157, 461-470

¹⁷ Kahn et al, (2014) Editorial, *Journal of the American Medical Association*, p1291.

¹⁸ Thomas, S.P., (2014) Sharing records with patients with mental illness, *Issues in Mental Health Nursing*, 35: 495-496.

which may result in a delay in complying with this right. In those circumstances the patient should be informed of the reasons for any delay and how long that delay may be.

- 1.6.10 The request can be refused because the psychiatrist reasonably believes any one or more of the following apply:
- a) disclosing the information poses a significant risk to the health or safety to the patient or others; or
 - b) there is a risk of significant harm to the patient or others; or
 - c) it would involve disclosing personal information about somebody else; or
 - d) information is of a confidential nature that was obtained in confidence; or
 - e) the patient is a MIA detained in an authorised hospital and the relevant document came into existence under, or for the purposes of, the Prisons Act 1981.
- 1.6.11 Refusing a request can be contentious as the psychiatrist is making judgements about risk and harm. Good practice should ensure a thorough examination of the reasons to refuse and should never be an automatic reaction because of the acuity of the patient or because it was done previously.
- 1.6.12 It will be rare that a whole document is restricted as within any medical record there will be information which is known to the patient that would not meet the criteria for restriction. It is more likely that particular correspondence or passages of a record may need to be restricted and that can be done while allowing the rest of the document to be accessed.
- 1.6.13 Information that was previously of a confidential nature may no longer be confidential and it would be discriminatory to use out-of-date information in making decisions in the here and now.
- 1.6.14 The decision can be challenged by the patient and the patient does have the right to make a complaint or request access under the *Freedom of Information Act 1992* (Section 28 of the Freedom of Information Act deals with medical and psychiatric information). Ultimately a patient may appeal to the Information Commissioner who may direct a service to provide access. Section 319(2)(d) of the Act also provides for a complaint to be made to HaDSCO if a mental health service acts unreasonably by denying or restricting access to records kept by the service provider.
- 1.6.15 If the request has been refused the patient may nominate a doctor and/or a legal practitioner to inspect and be given a copy of the document. It will most often be a legal practitioner representing the patient at a Mental Health Tribunal (Tribunal) hearing and the information may need to be provided without delay as Tribunal hearings can be scheduled at short notice, especially for requested reviews.

- 1.6.16 The person nominated is allowed access and even has a right to information that has been refused to be provided to the patient due to the risk of harm. Information that would reveal details about an individual other than the patient or information of a confidential nature that was obtained in confidence cannot be disclosed to the patient or a medical or legal practitioner nominated under Section 250 of the Act. Whenever possible, mental health services should promptly assist the nominee to identify redactable information without placing undue barriers to timely access.
- 1.6.17 The person who has access must not disclose the restricted information in the document to the patient in any form, written or oral. The person who has access should be aware or be made aware of this restriction. If it has come to the notice of a clinician that the person nominated has not complied with this restriction the matter should be reported to the head of service for further investigation. A person who has had access who fails to comply may be fined \$5000.

1.7 Rights and duties regarding confidentiality (Part 26, Division 2)

- 1.7.1 Subject to exceptions allowed in the Act, a clinician must not directly or indirectly record, disclose or use any information about a patient obtained while performing his or her duties generally and also in relation to the Act.
- 1.7.2 A clinician who fails to uphold a patient's confidentiality without lawful reason commits an offence for which there is a penalty of a fine of \$5000.
- 1.7.3 To record, disclose or use statistical or other information that is not personal information, information needs to be de-identified.
- 1.7.4 A person is not committing an offence if the recording, disclosure or use of information is authorised or used in good faith in any of the following circumstances, such as when:
- a) in the course of duty under this Act or otherwise. For example, when informing another clinician of a patient's history who needs to be aware of that history in order to provide a clinical service. When providing information in the course of duty a clinician will not incur any civil or criminal liability and also will not incur a breach of professional ethics or standards or be accused of unprofessional conduct
 - b) a patient's guardian needs to be identified and the Tribunal may request that information from the State Administrative Tribunal (SAT)
 - c) the CEO of the Mental Health Commission requests information from a state authority, an interstate authority, a corresponding overseas authority or a mental health service
 - d) the CEO of a prescribed state authority requests information from the CEO of another prescribed state authority

- e) under another law such as the reporting of child abuse or the mandatory reporting of child sexual abuse or under mandatory reporting of unlawful sexual contact or unreasonable use of force under this Act
- f) providing information to a court or for any judicial proceedings, or providing information on an order from a court or other judicial authority. Though if the information is in a response to a complaint by a respondent the information is not admissible in proceedings before a court or Tribunal. However, the information can be disclosed to the Parliamentary Commissioner for the purposes of an investigation under the Parliamentary Commissioner Act 1971
- g) investigating a suspected offence or disciplinary matter
- h) the person to whom the information relates provides consent. The type of consent is not identified and could be written or verbal
- i) there is another circumstance prescribed by the Regulations
- j) information is provided to the Chief Psychiatrist on direction (s. 521).
- k) For further information see Department of Health Information Circular 0164/13 Patient Confidentiality (www.health.wa.gov.au/circularsnew/pdfs/13003.pdf).

1.8 Right to make a complaint (Part 19)

- 1.8.1 The Act codifies HaDSCO as the formal complaints agency.
- 1.8.2 Making a complaint is a fundamental right for patients. This right extends to other persons involved in the patient's care and treatment such as carers, family members and nominated persons.
- 1.8.3 A complainant may make a complaint to the service provider or to the Director of HaDSCO. Mental health services should assist patients to resolve complaints in a timely manner and at a local level wherever possible.
- 1.8.4 It is preferred that a complaint is made to a service provider, such as a mental health service first. That service should provide information such as how to lodge a complaint and the process involved.
- 1.8.5 Information about making complaints should be made available on admission and at all reasonable times afterwards. Pamphlets or information on a website that provide details about how to lodge a complaint should be made available to patients and other important people in the patient's life.
- 1.8.6 Chapter 7 of this guide deals more fully with Part 19 of the Act.

1.9 Examination to assess a person's physical condition (Part 15, Division 1)¹⁹

- 1.9.1 The physical examination of a patient admitted to hospital is a right for the patient but also a duty for staff at the hospital.

¹⁹ For further information see the Clinical Guidelines for the Physical Care of Mental Health Consumers <http://www.psychiatry.uwa.edu.au/research/community-culture/?a=1502386>

- 1.9.2 There are a number of ways that mental and physical illness might be linked. This includes that symptoms appearing to indicate mental illness can be caused by a physical illness as in the case of acute confusional states or delirium.
- 1.9.3 Before making a person an involuntary patient the possibility that presenting symptoms could be due to a physical illness must be considered.
- 1.9.4 It is also well recognised that certain treatments, particularly psychotropic medications, cause physical side effects such as dental cavities, obesity and metabolic problems.
- 1.9.5 The nature of the physical examination will be primarily based on the presentation of the patient, but also on physical health issues common to individuals with mental illness and, where relevant, related to previous and proposed treatments.
- 1.9.6 Medical practitioners have the skills to diagnose physical health problems; however at times there may be a tendency to misinterpret physical health problems as extensions of mental illness because of the way the symptoms are being presented by the patient.
- 1.9.7 No matter what the mental state of the patient, and how this impacts on the way the physical health problems are described, it is important for a proper physical examination to be conducted.
- 1.9.8 If the medical practitioner conducting the examination is uncertain of his or her observations, it is essential to contact and involve the primary health care provider. It may also be necessary to refer the patient to a specialist for specific tests to determine whether there is a physical illness or a physical cause of what appears as mental illness symptoms.
- 1.9.9 When a person is admitted as a voluntary or involuntary patient or a MIA the hospital must ensure that as soon as practicable, and in any event within 12 hours of when the person came into hospital, that a medical practitioner assess the patient's physical condition.
- 1.9.10 If the person is a voluntary patient, the patient's consent is needed to conduct the examination and they cannot be compelled to have a physical examination. However if it appears that their refusal is a symptom of a mental illness requiring treatment, it may be appropriate to review whether the person should remain as a voluntary inpatient.
- 1.9.11 If it is not possible to conduct an examination of an involuntary patient or a MIA within the 12 hours timeframe because, for example, the patient actively refuses to be examined or the patient is unable to cooperate with the examination, then the medical practitioner must make attempts to conduct the examination at reasonable intervals thereafter.

- 1.9.12 There is no specific expectation that the physical examination be completed within 12 hours, as often this is an ongoing process awaiting test results and involving further physical examinations.
- 1.9.13 If the patient is an involuntary patient or MIA consent is not required though good practice dictates that informed consent should be sought. This section also provides for the taking of samples without express consent, specifically the person's blood, saliva, tissue and excreta. However, if an involuntary patient is adamant that they will not cooperate with the taking of samples than any such procedure should be postponed to a time when cooperation can be assured and it is safe for the staff member and the patient for samples to be taken.
- 1.9.14 The intent of this section is to highlight the issue that mental health patients frequently also having physical health problems and it is as important to attend to those problems as it is to any mental health issue. It is important that the results of any physical examination be documented in the patient's medical record.
- 1.9.15 The Chief Psychiatrist provides standards in regard to physical treatment which are required to be followed. See Addendum 1 Chief Psychiatrist's Standards. ²⁰

1.10 Rights of involuntary inpatients in hospital with regard to personal possessions (Part 16, Division 2)

- 1.10.1 Personal possessions (s. 259) are items such as clothing, jewellery, footwear and other articles for personal use as well as aids for daily living, such as glasses or walking sticks, or any medical prosthesis which allows the patient some dignity such as dentures.
- 1.10.2 It is important to record accurately all items that a patient brings into the hospital and those that remain with the patient, those that are stored and those that are kept temporarily in the nursing station such as mobile phones. Possessions such as money and credit cards need particular attention to prevent claims later that these possessions are missing. At times a witness such as another staff member should be present and a record kept.
- 1.10.3 Personal possessions can be used by patients and authorised hospitals should provide means to securely store personal possessions and allow access when required.
- 1.10.4 The staff may determine that it is inappropriate for an item to be stored at the hospital and the patient's carer or family member should be informed. Any such items should remain with the carer or family member or removed from the hospital. This can include items such as the patient's car or any electronic devices which the hospital cannot take responsibility for.

²⁰ Chief Psychiatrist's Standard for Physical Health Care: Addendum 1

- 1.10.5 If in the opinion of the staff, any item should not remain in the hospital because it may pose a risk of harm to the patient or another person (such as a knife or other sharp object) then the item should remain with or be given to any carer or family member or be stored securely until the patient is discharged. Even at the point of discharge it may be deemed unsafe to return some items to the patient.
- 1.10.6 If any personal possession is left at the authorised hospital for more than 6 months after discharge the hospital has the right to dispose of the article (which could include selling it) if it has not been claimed by a carer, close family member or support person. However before such a decision can be taken the hospital must give at least 1 months' notice to the carer, close family member or support person of the intention to dispose of the article.

1.11 Right to interview by a psychiatrist (s. 260)

- 1.11.1 While admitted to an authorised hospital a patient may at any time request an interview with a psychiatrist.
- 1.11.2 It is expected that the request be complied with within a reasonable timeframe and notes made in the patient's medical record of the date and time of the interview and what was discussed.
- 1.11.3 However, the psychiatrist may decide to refuse the request because he or she is satisfied that the patient is acting unreasonably in making the request.
- 1.11.4 If a request is refused, a record of the reasons for the refusal must be made in the patient's medical record and a copy given to the patient. This could be a photocopy of the entry in the medical record.
- 1.11.5 As a comment it is acknowledged that there is no available resource to enable psychiatrists to interview patients on a daily basis in most cases. Ongoing psychiatrist interviews will be based on clinical need with the expectation of involvement of other clinicians more regularly.

1.12 Freedom and restriction of communication (s. 261 and 262)

- 1.12.1 Patients have a right to private, lawful and uncensored communication, such as being able to see and speak to others in the hospital, writing and receiving letters, making and receiving phone calls, communicating through electronic means such as email or Facebook, and being visited or contacted by others including a legal representative. Mental health advocates can also visit and make contact with the patient at any time.
- 1.12.2 The major role played by social media in the lives of patients should be recognised and for therapeutic reasons patients should have the same access to social media as any other person in society. Likewise although it should be assumed that all mobile phones have the ability to record and take photos, this should not automatically diminish patient access to their phones. Restrictions should only be used if there is evidence that there is improper use. The status quo should be that patients have access to all means of

communication unless it is determined that the rules of confidentiality within a ward environment are being breached or there is misuse of certain functions of the phone.

- 1.12.3 A psychiatrist can prohibit or limit this right to access means of communication if he or she is satisfied that it would not be in the patient's best interests for them to exercise this right. For example a patient may be making frequent phone calls or using the internet to place bets when they are experiencing a manic phase of an illness and it would be in the patient's best interests to restrict phone calls related to betting. However the patient may have a lifestyle which includes frequent betting and while it may be best to restrict communication for financial reasons there may be less sound lifestyle reasons for the restriction. Each case must be looked at individually and there should be very few incidents of blanket restrictions.
- 1.12.4 Restrictions of communication can apply to voluntary patients, persons referred for examination, involuntary patients and MIAs. To make an order to restrict access to a specific device or devices, the psychiatrist completes a form (Form 12C) indicating the reason and gives a copy to the patient and any carer, close family member or support person of the patient.
- 1.12.5 The Mental Health Advocacy Service also needs to be informed of the restriction within 24 hours.
- 1.12.6 The restriction lasts up to 24 hours however the psychiatrist can review the restriction and decide to confirm, amend or revoke the order before the time lapses (record of confirmation or revocation of restriction of freedom of communication- Attachment to Form 12C).
- 1.12.7 It is the responsibility of the psychiatrist to conduct this review, however it is not mandatory to examine the patient. The psychiatrist can make his or her decision on information received from the clinical staff about whether the restriction should continue.
- 1.12.8 Counselling the patient which could lead to a modification of the patient's behaviour is preferable to continuing a restriction without discussion. In line with the principle of least restriction the restriction on communication should be lifted at the earliest possible opportunity.
- 1.12.9 Any confirmation lasts for up to 24 hours and must then be reviewed with the psychiatrist having the same options as before.
- 1.12.10 Restricting a patient's right to communicate with others is an aspect of involuntary status that patients may find demeaning and can impact on the therapeutic relationship that the patient has with staff.
- 1.12.11 There needs to be sound reasons for restricting communication and it should only be done when it is clear that exercising this right is not in the patient's best interest. At times there may be inappropriate communication between a patient and a relative or partner and responding to relatives' concerns may at times be seen as acting in the patient's best interests.

- 1.12.12 At times a patient's symptoms might result in them behaving and communicating with others in a way that they would not do if they were well, and restricting this right would be in their best interests.
- 1.12.13 It is important that the review before the 24 hour expiry period must give consideration to lifting the restriction. Confirming the order should not be an automatic process.
- 1.12.14 The psychiatrist must not restrict a visit by the patient's legal representative or a mental health advocate unless the psychiatrist is satisfied that there is a serious risk to the safety of the representative or advocate and there are no other steps which can be taken to reduce that risk. If there are steps such as having a member of staff present or conducting the visit in a safer environment then the visit should be allowed. Restricting a legal representative or an advocate should be a rare occurrence.
- 1.12.15 There should be no restriction for any other types of communication such as a phone call between a patient and his or her legal representative or a mental health advocate.
- 1.12.16 A patient or carer, close family member or other support person of the patient or a mental health advocate or another person who in the opinion of the Tribunal has sufficient interest in the matter may apply to the Tribunal for a review of the restriction. Chapter 9 provides details regarding the options available to the Tribunal which are that after hearing the matter they may confirm, amend or revoke the order.
- 1.12.17 The Act does not state how often such an application for review can occur and the Tribunal will determine whether to conduct a review.

1.13 Further opinion in regard to treatment (s. 182)

- 1.13.1 A request for a further opinion may be made either verbally or in writing.
- 1.13.2 The right to a further opinion, often referred to as a 'second opinion', is an important right from the perspective of patients, carers and families. It is often viewed as a chance for a fresh consideration of the issues on which the patient and psychiatrist may disagree. Patients, carers and families may place great store in having another opinion that may potentially affirm their point of view or suggest a change to the treatment.
- 1.13.3 For clinicians it is important to understand the desire for a further opinion from the perspective of the patient, carer or family member. Imposing involuntary treatment may be seen by the patient as a breach of their human right to refuse treatment. They may believe that their reasons for refusal of treatment are misunderstood. For example, the patient may have had previously tried a type of medication which in their view was not effective and was detrimental to their mental and physical health and yet the psychiatrist wishes to prescribe the same medication again. The Act provides to patients, carers and family members a right to have a further opinion and it is the duty of

clinicians to inform patients of this right and support them in exercising this right.

- 1.13.4 Any involuntary patient or a MIA patient in an authorised hospital may make a request for a further psychiatric opinion regarding treatment. This right extends to a number of other people including a carer or a close family member, a nominated person, or the person authorised by law to give consent on the patient's behalf, such as a parent or guardian for a child.
- 1.13.5 If the patient or any of those persons are dissatisfied with the treatment being given, they can request either verbally or in writing that the patient's psychiatrist or the Chief Psychiatrist obtain the opinion of a psychiatrist who is not the patient's psychiatrist about whether it is appropriate to give the patient this treatment.
- 1.13.6 If it is a carer, close family member or a nominated person who makes the request and the patient objects to the further opinion being obtained, then the patient's psychiatrist or the Chief Psychiatrist will not process the request. That should be documented and the person who requested the opinion notified of the patient's decision.
- 1.13.7 It is the treating psychiatrist or the Chief Psychiatrist who receives the request, and it is their responsibility to arrange for the examination to be conducted as soon as is practicable. They must have regard to the guidelines published about the independence of psychiatrists from whom further opinions are obtained.
- 1.13.8 Organising further opinions can be time consuming. Requests for further opinions can be reduced by collaborating with and involving patients, carers and family members at all stages of decision making. However, further opinions can be of assistance to the treating psychiatrist as it may confirm that the treatment plan is, in the opinion of the further opinion psychiatrist, the correct one. This support of a treatment plan by an independent psychiatrist may make adherence to treatment easier to achieve.
- 1.13.9 Discussion needs to occur with the patient and, if it was not the patient then the person who made the request, as to which psychiatrist will provide the further opinion and what arrangements need to be made for that to occur. Issues of independence, the patient's wishes and what psychiatrists are available are all germane to these discussions. However, it is the responsibility of the treating psychiatrist in conjunction with the further opinion psychiatrist to make the final decision as to which psychiatrist should conduct the further opinion, while having regard for the Chief Psychiatrist's guidelines (547(1)(c)).
- 1.13.10 Mental health services have a responsibility to ensure timely access to a psychiatrist outside of their service for a further opinion if requested. To assist a patient to make an informed decision as to how they wish to receive a further opinion, they must be advised of:

a) Pathway options:

- i. Public sector
 - a. Same site
 - b. Other mental health service

ii. Private psychiatrist

It is reasonable for a clinician to arrange a further opinion with a private psychiatrist of the patient's choice, but not reasonable to expect a clinician to sequentially contact several private psychiatrists if sequential private psychiatrists decline to undertake the further opinion. A patient may then choose to seek a private psychiatrist themselves or may opt to request a further opinion from within the public sector.

iii. Other psychiatrist if relevant.

b) Practical timeframes for each of the above options.

1.13.11 When a patient or other person requests a further opinion it would assist the psychiatrist providing the further opinion to be clear as to why the further opinion is being sought and what exactly is the outcome desired. For example, the patient or other person making the request may indicate that a desired outcome is to cease a particular type of medication, be prescribed a different medication or have the dosage changed.

1.13.12 The psychiatrist providing the further opinion must examine the patient in the least restrictive way and in the least restrictive environment practicable. The patient and the psychiatrist may be in the physical presence of the other (i.e., in the same room) or they can communicate through a door or via audio-visual (AV) means such as videoconferencing. Audio-visual means can be used in relation to further opinion examinations in both metropolitan and non-metropolitan areas. While no timeframe is mandatory the Act states that the further opinion be obtained as soon as practicable after receiving the request.

1.13.13 The psychiatrist who agrees to conduct the further opinion needs:

- a) access to the patient's medical record
- b) the opportunity to examine the patient either face-to-face or via AV means
- c) the opportunity to speak to other significant people in the patient's life
- d) the opportunity to speak to the person who requested the further opinion if it was not the patient
- e) the opportunity to speak to the treating psychiatrist or other members of the treating team
- f) if the patient is an Aboriginal person, the opportunity to speak to significant persons from the patient's community

- g) if the patient is from a CALD community the opportunity to speak to a person from the patient's community and, where necessary, access an interpreter
- h) a copy of the written request or information about any oral request
- i) time to complete the report.

1.13.14 At a minimum the patient needs to be provided with:

- a) the name of the psychiatrist providing the further opinion
- b) the name of the service the psychiatrist works for
- c) approximately when the patient will be examined by the further opinion psychiatrist
- d) whether conducting the examination will require the patient travelling to another service and what arrangements can be made to assist that process
- e) approximately when the report will be provided to the treating psychiatrist and patient
- f) if it is a report provided by a private psychiatrist, any costs involved.

1.13.15 In providing a further opinion the psychiatrist should observe the following principles:

- a) Seek to understand and give due weight to the patient's views on the treatment plan, including any AHDs.
- b) Explore any objection to the proposed treatment and reasons for those objections.
- c) Consider any preference the patient may have for an alternative form of treatment.
- d) Give due weight to the opinions, knowledge, experience and skills of those consulted such as carers, family members and people important in the patient's life.
- e) Have a sound understanding of the treatment plan devised and implemented by the treating or supervising psychiatrist.
- f) Consider any information from previous psychiatrists or practitioners which may be relevant.
- g) Balance the potential therapeutic efficacy of the proposed treatment against the adverse or side effects and any other potential advantages to the patient.
- h) Take into account any previous experience the patient may have had of comparable treatment for a similar episode of disorder.
- i) Consider the appropriateness of alternative forms of treatment not just that proposed.

- 1.13.16 In forming an opinion the psychiatrist can obtain information from the patient in response to questions, from observing the patient's behaviour, consulting with carers and family members and from the patient's medical record.
- 1.13.17 The opinion is in regard to treatment, not whether the patient should or should not be an involuntary patient. If the issue is about involuntary status or compliance with the Act, the patient or other person should seek remedy through the Tribunal or other complaints processes. However there is nothing preventing a psychiatrist from making comment in his or her report as to whether involuntary status is appropriate. At times a patient may request a further opinion in order to have written evidence which can be laid before the Tribunal.
- 1.13.18 Once the further opinion psychiatrist has gathered all the necessary information he or she will require time to complete the report and send it to the treating psychiatrist. The report must be in writing, which can be handwritten, and may include recommendations about the treatment given to the patient.
- 1.13.19 It is the responsibility of the treating psychiatrist, not the further opinion psychiatrist, to provide a copy of the report to the patient and, if the person who requested the further opinion was not the patient, that person, as well as a copy being put in the patient's medical record.
- 1.13.20 The further opinion psychiatrist may provide an alternative or contrary report regarding treatment and those issues need to be addressed by the treating psychiatrist. While there is no absolute requirement that the treating psychiatrist accept the recommendations of the further opinion psychiatrist, he or she has a duty to fully consider and have regard to the alternative views.
- 1.13.21 Sharing the report with the patient or the person who requested the further opinion is an opportunity to also inform the patient as to the recommendations made by the further opinion psychiatrist and any possible changes to the treatment plan. If the decision is not to follow the recommendations then the patient should also be informed about what their rights are in those circumstances as set out below. The matter should be documented in the patient's medical record.
- 1.13.22 If the patient or the person who requested the further opinion remains dissatisfied he or she can ask the Chief Psychiatrist to direct the patient's psychiatrist to reconsider the treatment recommendations or the treatment plan.
- 1.13.23 The Chief Psychiatrist may, but is not obliged to, request that the patient's psychiatrist reconsider the decision to give that treatment and provide the Chief Psychiatrist with a report on the reconsideration and any outcome of the reconsideration. The patient's psychiatrist must also give a

copy of the report to the patient and if the request was made by another person, that other person. Ultimately the Chief Psychiatrist can direct a treating psychiatrist to cease or vary treatment in regard to treatment for an involuntary patient (see Chapter 11).

- 1.13.24 The patient's psychiatrist or the Chief Psychiatrist may refuse to provide a further opinion if there has already been a further opinion given and the psychiatrist or the Chief Psychiatrist is satisfied that, having considered the guidelines, the additional opinion is not warranted.
- 1.13.25 If a request for a further opinion is refused the reasons need to be put in the patient's medical record and a copy given to the patient and if it was another person who made the request, then a copy given to that person also.
- 1.13.26 If it was the patient's psychiatrist who refused to provide an additional opinion then a copy of the decision needs to be given to the Chief Psychiatrist and if it was the Chief Psychiatrist who made the decision a copy given to the patient's psychiatrist.

1.14 Treatment, support and discharge plans (Part 13, Division 3)

- 1.14.1 An involuntary detained patient, a patient on a CTO and a MIA have a right to be involved in the preparation and review of a treatment, support and discharge plan whether or not they have the capacity to consent or whether or not the plan can be implemented. The patient's opinion and preferences should always be sought and given due consideration.
- 1.14.2 If the patient does not have capacity to consent and the plan cannot be implemented without their consent, then a person who is authorised by law, such as a parent or guardian, may consent on the patient's behalf. For example, if the plan includes living in a particular place and the patient does not have the capacity to sign the agreement to live at that place then a parent or guardian can sign on behalf of the patient.
- 1.14.3 Once the treatment, support and discharge plan has been completed a copy must be given to the patient. A copy also needs to be given, where applicable, to the patient's parents, carer, nominated person and close family member. A copy can also be given to a person or an organisation who has been involved in the preparation or review of the plan if the psychiatrist thinks it would be appropriate to do so. For example, if an organisation providing accommodation has been involved in the preparation of the plan then they may also receive a copy of the plan.
- 1.14.4 Treatment, support and discharge plans must be prepared as soon as practicable after the person becomes an involuntary patient and be reviewed regularly and revised as necessary.
- 1.14.5 When the Tribunal conducts a review they must receive a copy of the treatment, support and discharge plan and can make nonbinding recommendations to the psychiatrist. If a treatment, support and discharge

plan is not completed the Tribunal can make a compliance notice requiring the completion of such a plan.

1.14.6 Further information about treatment, support and discharge planning is in Chapter 4, Addendum 1(3) and Addendum 2(e).

1.15 Nominated person (Part 16, Division 3) - Form 12A

1.15.1 The role of a nominated person is to assist the person who made the nomination by making sure that the patient's rights and interests are upheld.

1.15.2 A nominated person can be a friend or relative of the patient or even a patient's guardian. It is whoever the patient or another person feels can help the patient. The person nominated must be an adult over the age of 18 even if the patient is a child (under the age of 18).

1.15.3 The person should not be paid for taking on the role and should not charge the patient for undertaking any of the duties of a nominated person.

1.15.4 The nominated person is entitled to be given information and be involved in matters related to the patient's care and treatment. For example they are entitled to information about the mental illness the patient is experiencing, the grounds on which they were made involuntary, the treatment and care proposed and other options that may be reasonably available the use of seclusion or restraint and the services available to meet the patient's needs.

1.15.5 They may also be involved in looking at treatment and care options available, how support will be given and the preparation of a treatment, support and discharge plan. For example, if there is a discharge planning meeting involving the patient it may be appropriate to invite the nominated person.

1.15.6 The nominated person may also exercise on behalf of the patient any right the patient has, such as applying to the Tribunal for a review of status. However they cannot on the patient's behalf apply for their admission or discharge or make a decision in regard to treatment. They do not perform the role of a guardian who can make decisions on their behalf, though it is possible for a guardian to also be the nominated person and exercise their authority in that role.

1.15.7 However, if the patient's psychiatrist believes it is not in the patient's best interests for the nominated person to be given information or be involved, then involvement and access to information can be restricted. It is a restriction which can be revoked at any time by the psychiatrist. If such a restriction is made a record of the reasons for the restriction must be placed in the patient's medical record and a copy given to the patient, and a copy sent to the Chief Mental Health Advocate. Because a patient has a right to have a nominated person, restricting the right of the nominated person to information or involvement should only be used when it is absolutely clear that having the nominated person involved is detrimental to the care and treatment of the patient. It is a restriction which needs to be justified. This right of the psychiatrist should be used judiciously.

- 1.15.8 There is no need to inform a nominated person that certain information is being withheld from them. However, the nominated person has a right to request that certain information be provided, such as a change in the medication or the organisation involved in the patient's rehabilitation. If a decision is made to withhold that information then the nominated person must be informed that the information is being withheld. In such circumstances the patient's psychiatrist must advise either orally or in writing that certain information is being withheld, and the reasons for that decision. Any advice provided orally can be requested by the nominated person to be in writing.
- 1.15.9 Any person, including a child, may nominate a person over the age of 18 to be a nominated person. The person nominated must understand what it means to be a nominated person and be willing to take on the role. The Form12A asks for personal details and must be signed by the person making the nomination (most often the patient), the nominated person and a witness who cannot be the person making the nomination or the nominated person.
- 1.15.10 A patient cannot have more than one nominated person at any one time, however, the patient, or the person who applied for the nomination, can revoke a nomination and nominate another person. A nominated person may also resign at any time by writing to the person who made the nomination, stating the date of resignation, if not immediately. If resigning or if the nomination has been revoked the nominated person should take all reasonable steps to notify mental health staff at the hospital or in the community that they will no longer be the nominated person. If the patient revokes a nomination a mental health staff member should take all reasonable steps to notify the nominated person.
- 1.15.11 Any person who the Tribunal feels has sufficient interest in the matter may apply to the Tribunal for the nomination of a nominated person to be declared valid or invalid. If the application is because of a defect in the form used to nominate a person, then the Tribunal can declare the nomination valid and vary the terms of the nomination in line with the intentions of the person who made the nomination. At a review of this application the Tribunal may revoke the nomination if satisfied that the nominated person is not an appropriate person to perform the role. This may be because it is likely the nominated person will adversely affect to a significant degree the interests of the patient. It may also be that the person is not capable of performing the role because of mental or physical incapacity, or that the person is unwilling or not reasonably able to perform the role.

1.16 Right to access a mental health advocate (Part 20)

- 1.16.1 In the part of the Act which gives details about the Mental Health Advocacy Service (Advocacy Service) the term 'identified person' is used. An identified person is any of the following:
- a) an involuntary patient

- b) a patient referred under the Act to be examined by a psychiatrist at an authorised hospital or other place
 - c) a voluntary patient detained in an authorised hospital to be assessed by a medical practitioner or an AMHP
 - d) a patient whose detention continues following an examination by a psychiatrist, but has neither been made an involuntary patient nor release
 - e) a patient who is under a hospital order made under the *Criminal Law Mentally Impaired Accused Act 1996* (CLMIAA)
 - f) a MIA who is detained in an authorised hospital or released under a release order on conditions imposed under the CLMIAA
 - g) a resident of a private psychiatric hostel (*Hospital and Health Services Act 1927*)
 - h) a voluntary patient who the Minister for Mental Health has deemed an 'identified person'
 - i) a patient who may have a mental illness who is being provided with treatment and care by a body or organisation prescribed by the Regulations.
- 1.16.2 Mental health advocates have a duty to visit or otherwise contact identified persons and identified persons have a right to request the services of a mental health advocate.
- 1.16.3 More details about the Advocacy Service and how clinicians should relate and work with advocates can be found in Chapter 8.
- 1.17 Right to a review from the Mental Health Tribunal (Part 21, Division 3)**
- 1.17.1 The legislative responsibilities of a psychiatrist are extensive in this Act. They can make a person an involuntary patient, order detention or compel treatment.
- 1.17.2 To ensure these responsibilities are only exercised in the best interests of people experiencing mental illness, the right to an independent review is essential from a human rights perspective.
- 1.17.3 Involuntary patients (or any person who the Tribunal believes has a sufficient interest in the matter) have the right to seek or have a mandatory review of:
- a) their involuntary status
 - b) the provision of certain treatments such as electroconvulsive therapy and psychosurgery
 - c) the validity of an involuntary treatment order
 - d) certain non-clinical matters where the Tribunal can make compliance notices
 - e) restrictions in regard to freedom of communication
 - f) jurisdiction in relation to a nominated person

g) decisions affecting rights.

1.17.4 Details regarding the Tribunal and the SAT can be found in Chapter 9 and Chapter 10.

1.18 Challenging the validity of an involuntary treatment order (Part 21, Division 4)

1.18.1 An involuntary patient, a carer, a family member, a personal support person, a mental health advocate or any other person, who in the opinion of the Tribunal has a sufficient interest in the matter, including the psychiatrist who made the order, can apply to the Tribunal for a review of whether an involuntary treatment order is valid.

1.18.2 The Tribunal will review whether there was any failure to comply with the requirements of the Act in the making of the treatment order, or in the conduct of an assessment by a medical practitioner or Authorised Mental Health Practitioner (AMHP) or in the conduct of an examination by a psychiatrist which led to the making of a referral order or involuntary treatment order.

1.18.3 If a failure is identified, the Tribunal has to further consider whether because of that failure, alone or in combination with one or more other such failures, the rights or interests of the involuntary patient have been substantially prejudiced.

1.18.4 For example, if the applicant believes that the psychiatrist, when examining the patient, refused to consult with a carer, then the Tribunal can review whether the rights of the patient have been substantially prejudiced. Likewise the Tribunal may wish to conduct a review when an AMHP assesses a person by AV means with no prescribed person being present. The Tribunal may conclude that despite the failure to comply, the rights of the patient have not been substantially prejudiced.

1.18.5 Following a review where the Tribunal may listen to all interested parties the Tribunal can declare an order either valid or invalid.

1.18.6 In declaring an order valid the Tribunal can also make an order to vary the terms of the order in a way the Tribunal considers most likely to give effect to the intention of the psychiatrist who made the treatment order. For example if a wrong expiry date was the only defect on the form the Tribunal may vary the expiry date, aligning it with the requirements of the Act without making the order invalid.

1.18.7 If the Tribunal declares an inpatient treatment order invalid then the order ceases to be in force. However, if the Tribunal suspects that the person is actually in need of an inpatient order it may make an immediate order for an assessment of the patient by a medical practitioner or AMHP and the person can be detained at the hospital for a period specified in the order for the assessment to occur.

1.18.8 If the Tribunal declares the continuation of either an inpatient treatment order or a CTO to be invalid, then it is invalid from the time the involuntary treatment order expires (when it would have expired had the continuation order not been made). For example a continuation order can be made before the initial order or the previous continuation order expires.

1.18.9 If the Tribunal declares a CTO invalid then it ceases to be in force immediately.

1.18.10 If the Tribunal declares that a recently varied CTO is invalid then the variation is no longer in force but the original CTO continues. For example, the terms of a CTO can be varied to report to a different clinic but if the variation was done without considering the patient's wishes the Tribunal could state that the variation is invalid but not the CTO itself.

1.19 Right to request a compliance notice (Part 21, Division 8)

1.19.1 An involuntary patient, a carer, a family member, a personal support person, a mental health advocate and any other person, who in the opinion of the Tribunal has a sufficient interest in the matter, can request that the Tribunal review certain things the service is expected to do (a prescribed requirement) and issue a compliance notice.

1.19.2 The Tribunal can independently decide to conduct a review on its own initiative.

1.19.3 A prescribed requirement means:

- a) giving a document or other information to the patient or another person
- b) including a document or information in the patient's medical record
- c) complying with a request made by the patient or another person.

For example, a carer should be notified if an involuntary detained patient is granted leave. If the service does not notify the carer on the basis that it is not in the patient's best interests for the carer to be informed, the carer can request the Tribunal to issue a compliance notice.

1.19.4 The compliance notice cannot be about a clinical matter such as changing a treatment or insisting a patient be granted leave. However a compliance notice can be made to ensure that a treatment, support and discharge plan for a patient is prepared, reviewed or revised.

1.19.5 Before issuing a compliance notice the Tribunal can consider whether it would be more appropriate for the matter to be dealt with by the CEO of the service, the CEO of the Department of Health, the Chief Psychiatrist or a Registration Board.

1.19.6 When reviewing the issue the Tribunal can involve the patient, the person who requested the review if it was not the patient, the mental health service or any other person the Tribunal wishes to involve.

1.19.7 If the Tribunal issues a compliance notice they can direct a service provider to comply with a prescribed requirement, for example providing a document or revising a treatment, support and discharge plan, within a particular time frame.

1.19.8 They may also require the service to report back to the Tribunal about whether the action has been taken or not taken. If the action has not been taken the service should give reasons for not doing so.

1.19.9 The Tribunal may further review the issues on their own initiative and, if they wish, make another compliance notice. A person (which includes a person in charge of a service) who does not give effect to a decision by the Tribunal, according to its terms, commits an offence punishable by a fine.

1.20 Review of decisions affecting rights (Part 21, Division 11)

1.20.1 The person whose rights are affected - a carer, close family member or other personal support person, a mental health advocate or any other person - who in the opinion of the Tribunal has a sufficient interest in the matter can apply to the Tribunal for a review of a decision made which impacts on their rights.

1.20.2 The application must be about a matter that is different from the other rights that a person has such as a review of involuntary status, consideration of a restriction of freedom of communication, or whether a person should be a nominated person.

1.20.3 The Tribunal review can include the person who made the application or any other person the Tribunal feels has a sufficient interest in the matter.

1.20.4 After completing the review the Tribunal can make any orders or give any directions they feel are appropriate.

1.20.5 For more information see Chapter 9.

1.21 Right to not be ill-treated and the duty to report certain incidents (s. 253 and s. 254)

1.21.1 Staff of mental health services including private psychiatric hostels must not ill-treat or wilfully neglect any voluntary or involuntary mental health patient including a person referred for an examination by a psychiatrist, or a MIA detained in an authorised hospital.

1.21.2 Ill-treatment or wilful neglect is not defined in the Act. However, the Charter of Mental Health Care Principles does provide some guidance on expected standards of mental health care.

1.21.3 Any claim that a patient or identified person is being ill-treated or wilfully neglected needs to be reviewed by the mental health service, HaDSCO, the Chief Psychiatrist or another complaints body.

1.21.4 Any person who suspects that a patient is being ill-treated or wilfully neglected should make their suspicions known to a person or body that will

progress the complaint such as an advocate, a case worker, a psychiatrist, the head of a service, the manager of a hostel, the Chief Psychiatrist or any other person who they trust. It would not be a breach of confidentiality for such a suspected offence to be reported.

- 1.21.5 It is the duty of the person that receives the complaint to investigate the accusation and report the matter to the police or Director of Public Prosecutions if there is sufficient concern that this section of the Act has been breached.
- 1.21.6 Any staff member who has been found to be in breach of this section may be fined \$24,000 and imprisoned for 2 years.
- 1.21.7 Staff have a mandatory duty to report any reasonable suspicion that there may have been any unlawful sexual contact between a staff member and an inpatient of a hospital or between an inpatient and another person who is not a staff member such as another patient or visitor, or unreasonable use of force on a patient by staff.
- 1.21.8 It may include that a staff member is having close, intimate contact with a patient or a patient discloses sexual contact with another patient, or in relation to 'unreasonable use of force', a staff member applying extra force when detaining a patient. See information provided by the Sexual Assault Referral Center.²¹
- 1.21.9 From the context of professional ethics it is never appropriate for a clinician to have even consensual sexual contact with a patient or a close family member of the patient.
- 1.21.10 'Reasonable suspicion' is a lower threshold than certainty, where waiting for more 'proof' may be detrimental to patient care.
- 1.21.11 It should be clear that staff cannot choose whether to report or not report any reasonable suspicion of these incidents. It is a mandatory duty to report these suspicions to the Chief Psychiatrist or person in charge of the hospital and failure to report can result in a fine of \$6000.
- 1.21.12 Reporting a colleague for suspected unlawful sexual contact or unreasonable use of force may be difficult. However the duty of care to patients is now enshrined in legislation which puts patient care first. Failure to report may lead to a fine, and it may also leave the perpetrator free to commit other offences.
- 1.21.13 There may at times be reporting which is personally vindictive and that will not be known unless investigated. An investigation of the suspected incident should occur even where it is known that there are relationship problems between certain staff members or where there have been previous complaints which have not been proven.

²¹ <http://kemh.health.wa.gov.au/services/sarc/education.htm>

- 1.21.14 While reporting to the Chief Psychiatrist can be anonymous it does make follow up difficult and limit the depth of the investigation. However a staff member reporting an incident can make a request to remain anonymous while divulging their identity to the Chief Psychiatrist.
- 1.21.15 The important issue here is that any investigation either by the mental health service or the Chief Psychiatrist must be robust while also being sensitive to the concerns of the complainant and the staff member.
- 1.21.16 While reporting an incident can be essential from the patient's viewpoint it can also be very damaging to a staff member's reputation and career. The Chief Psychiatrist and the mental health services will develop a protocol for the investigation of notifications under these sections.

1.22 Recognition of the rights of carers and families (Part 17)22

- 1.22.1 The role of carers, close family members or personal support persons is specifically recognised in this Act and emphasises the importance in the overall care of a patient to include and consult with important people in the patient's life.
- 1.22.2 Often the carer, close family member or personal support person is familiar with the issues that concern the patient and may be in an ideal position to represent those views to the mental health service.
- 1.22.3 A clinician must consider the value and weight of experienced carer observation, particularly in the context of a cross sectional psychiatric assessment, in a guarded patient displaying little psychopathology.
- 1.22.4 Although previously the involvement of carers and family members occurred regularly there was nothing in the legislation which obliged mental health staff to consult with and involve these important people in the patient's life. This Act rectifies that position with statutory provisions which oblige services to involve carers and family members.
- 1.22.5 A carer is usually a family member or a person who is a carer under the Carers Recognition Act 2004. It can be a contentious term and a patient may not identify a family member as a carer or the family member might not see themselves in that role. That does not prevent them from exercising carer's rights. For the clinician, rather than asking the patient who their carer is, it would be better to ask who is important in the person's life, who supports them and who would they like information to be given to.
- 1.22.6 A close family member of a patient is any person whose relationship with the patient is established or can be traced through consanguinity (from the same ancestor as siblings would be), marriage, a de facto relationship, written law (for example through adoption) or a natural relationship (some extended family members). These people include a spouse or de facto partner, a child,

²² <http://www.carerswa.asn.au/resources/CRA-2004.pdf>.

a step child, a parent, a step parent, a foster parent, a sibling, a grandparent, an aunt or uncle, a niece or nephew or a cousin.

- 1.22.7 The term 'personal support person' describes any carer, family member or nominated person who fulfils the role of giving personal support to the patient. Multiple terms are used because people might identify themselves in different ways and that should not exclude them from having the same rights as a carer. Irrespective of what term is used the role of the carer should be acknowledged and respected.
- 1.22.8 If the patient is an Aboriginal person then who is considered to be a close family member can extend to any person regarded under the customary law or tradition of that person's community.
- 1.22.9 When a patient is being admitted to a mental health service the patient needs to be asked whether he or she has a carer, close family member or personal support person. If they do the patient needs to be asked whether they would like that person to be given information and be involved in their treatment and care, and the best ways of making contact.
- 1.22.10 If the patient, initially or later, decides they do not want their carer, close family member or personal support person involved any longer, then despite the decision they need to be asked periodically whether they have changed their mind. This recognises that at times a patient may feel antagonistic towards a carer, close family member or personal support person perhaps because they were involved in his or her admission to hospital, however a few days later they may feel differently and be willing for the carer, close family member or personal support person to be involved. Asking the question at regular intervals allows this issue to be explored. Whether or not a patient is asked about this they can decide at any time to consent or withdraw consent to a carer, close family member or personal support person being given information or being involved.
- 1.22.11 If a patient has more than one carer or more than one close family member then it is sufficient compliance with the Act if at least one carer or family member is involved. In these circumstances it may be appropriate to find out from the patient which carer or family member the patient would like to involve. However it is also important to obtain the views of the carers and close family members as to which support person should be involved.
- 1.22.12 Subject to certain exceptions, carers, close family members or personal support persons have a right to be given information and included in discussions about the patient's care and treatment including discussions about:
- a) the type of mental illness the patient is being given treatment for
 - b) whether the patient is an involuntary patient and the grounds on which they were made involuntary

- c) the care and treatment proposed and what other options are available, for example, the kind of antidepressant medication being prescribed and what other antidepressants may also be appropriate
- d) the types of services available, including support services that may meet the patient's needs
- e) the rights of the patient and the carer in the Act and how those rights can be accessed and exercised
- f) involvement in the preparation and review of any treatment, support and discharge plan
- g) the use of seclusion or restraint.

1.22.13 While it is the responsibility of the psychiatrist to ensure that carers, close family members or personal support persons are informed and involved, any member of the treating team can undertake that task.

1.22.14 At times it may be difficult to identify and contact a carer, close family member or personal support person. Every effort should be made to contact the carer, close family member or personal support person, which may mean repeated attempts until either contact is made or a reasonable assumption can be made that no carer, close family member or personal support person can be contacted. In rural and remote areas it is recognised that contact may be even more difficult and alternative methods should be considered such as using others to assist. In either case a record of the outcome should be made in the patient's medical record.

1.22.15 Carers, close family members or personal support persons can indicate to the mental health staff the extent to which they want to be given information or involved. For example, if a carer states that they do not want to be invited to every discussion about the patient's care then that right should be respected.

1.22.16 Any information given to a carer, close family member or personal support person needs to be in a language, form of communication and terms that the carer, close family member or personal support person is likely to understand. For example use of interpreters would be encouraged and information in other community languages should be made available.

1.22.17 The Act makes clear what the boundaries are for the involvement by carers, close family members or personal support persons. For example a carer, close family member or personal support person is not allowed to apply on the patient's behalf for admission or discharge from a mental health service or make a treatment decision unless they have the legal authority to do so, for example if they are a guardian or a parent.

1.22.18 A voluntary patient with capacity to consent can give, or withhold, consent for a carer, close family member or personal support person to receive information and be involved.

- 1.22.19 A carer, close family member or personal support person of a voluntary patient who lacks capacity may also be given information and involved. However, if the patient's psychiatrist reasonably believes that it is not in the patient's best interests for the carer, close family member or personal support person to be given information or involved then the information or involvement can be withheld. In this circumstance the psychiatrist must document the decision, including reasons for the decision, and give the patient a copy.
- 1.22.20 If a carer, close family member or personal support person has made a request for certain information or to be involved in a specific aspect of care and treatment and the psychiatrist decides against it, then the carer, close family member or personal support person is entitled to be informed of that decision. If the decision is given orally the carer, close family member or personal support person can request the decision and reasons in writing. For example, a personal support person wants to know to which address a patient is being discharged and the psychiatrist believes that it would not be in the best interests of the patient for the carer to know this. If the carer makes a specific request for that information, the psychiatrist will need to inform them that the patient is being discharged but does not need to provide the specific address. Any oral or written information given to a carer, close family member or personal support person must be in a language, form of communication and terms that they are likely to understand, using interpreters or translated material where appropriate.
- 1.22.21 The carer, close family member or personal support person of an involuntary patient may also be provided with information and be involved in the patient's treatment and care, so long as the patient has the capacity to consent to this. The involuntary patient may give consent, or the psychiatrist may determine that the refusal to give consent is unreasonable. For example, it may be very important for the carer to be aware of what medications a patient is taking and, even though the patient refuses to consent to their carer being informed of this, the psychiatrist might believe that this is unreasonable given the relationship between the carer and patient.
- 1.22.22 The psychiatrist may withdraw the right for a carer, close family member or personal support person to be informed and involved if they believe it is not in the patient's best interests for the information to be shared, especially in relation to voluntary or involuntary patients with no capacity to consent. A record of that decision and the reason for it needs to be placed in the patient's medical record (s. 292).
- 1.22.23 The carer, close family member or personal support person of an involuntary patient or MIA who does not have the capacity to give consent, can be involved or given information, unless the psychiatrist reasonably believes it is not in the patient's best interests. For example, an involuntary patient may be adamant that their mother not be informed of a specific aspect of treatment and thus refuse to give consent to this. The psychiatrist may

determine that the refusal to consent is unreasonable and inform the mother nonetheless. Whether the refusal is reasonable or not, the essential task for the psychiatrist is determining what is or is not in a patient's best interests and to act on that belief. A record of the decision and reasons for it needs to be placed in the patient's medical record.

1.23 Children who have a mental illness (Part 18)

- 1.23.1 Rights and responsibilities in regard to children are covered by various parts of the Act, and specifically by Part 18.
- 1.23.2 A child is any person under the age of 18. It is recognised that some children, particularly those between the ages of 14 and 18, may have a degree of maturity which is similar to an adult and should be able to make their own decisions about their care and treatment. These matters are discussed in Chapter 2: Decision making capacity and informed consent.
- 1.23.3 A clinician, when performing any function under this Act, such as making an assessment or prescribing treatment, must have regard to the best interests of the child as the primary consideration. Children most often live in families and at times a clinician might feel that it is in the best interests of a child's family that the child be made an involuntary patient, however the Act makes it clear that this consideration alone is not sufficient. The matters discussed in 1.22 have equal relevance when providing care and treatment to a child.
- 1.23.4 Clinicians must also have regard to a child's wishes to the extent that it is practicable to ascertain those wishes. Having regard to the child's wishes does not mean the clinician must comply with those wishes as they may be unreasonable and not in the child's best interests. However having regard does mean that consideration is given to those wishes, and that can best be achieved by dialogue between the clinician and the patient.
- 1.23.5 Although the wishes of a mature minor and the best interests of a child are the primary considerations, the views of a parent or guardian are also important. Parents need to be involved in discussions, be provided with information and asked for their opinions and views. Parents who are divorced or separated may provide contrary views and the Act does not stipulate which parent has precedence. The task for the clinician is to ascertain who should be heard - the primary carer or another person - unless a Family Court has made a determination. There is no requirement that the parent's or guardian's views should be complied with, only that the primary consideration should be the best interests of the child.
- 1.23.6 A parent or guardian can apply for the admission or discharge of a child unless it is shown that the child has the capacity to make the application themselves. If the child has that capacity then they can apply or decide not to apply for admission or discharge.
- 1.23.7 A parent or guardian may make decisions about treatment for their child, in other words giving or not giving consent, unless it is shown that the child has

the capacity to make their own treatment decisions. However, if a child has the capacity to give informed consent to treatment they cannot be made an involuntary patient.

- 1.23.8 When admitting a child to a mental health service as an inpatient every effort should be made for the child to be admitted to a unit or ward that caters to the specific needs of children and adolescents.
- 1.23.9 However it is recognised that at times a child and adolescent unit or ward or a place that ordinarily treats persons under the age of 18 might not be available. In those circumstances there is a duty on the person in charge of a mental health inpatient service to ensure that a child is not admitted, unless the child can be given the sort of treatment, care and support that is appropriate for the child's age, maturity, gender, culture and spiritual beliefs. This could mean, where appropriate, that a child be cared for in a part of the unit or ward where adults are not cared for.
- 1.23.10 Treating and caring for a child in a part of a unit or ward separate from adults may be difficult to achieve. If that cannot be done other steps should be put in place that involve a considered response to having a child on an adult ward. This could include having a chaperone for the child, allowing a parent to remain with a child, providing for sleeping arrangements for a parent or carer, and providing schooling activities.
- 1.23.11 Special consideration needs to be given to the needs of Aboriginal children or children from CALD backgrounds. Involving people from the child's community may be necessary in deciding what is in the child's best interests.
- 1.23.12 If a child is admitted to an adult facility then the person in charge of the mental health service must give a report to the parents or guardian. The report should state why it is necessary to detain the child in the adult ward, detail the safety issues that are part of the care plan, indicate when the child might be moved to a children's ward and any other matters relevant to ensuring the safety of the child. A copy of that report also needs to be sent to the Chief Psychiatrist.
- 1.23.13 If a psychiatrist or medical practitioner prescribes an 'off-label' medication to a child who is an involuntary patient, then the practitioner must record the decision to provide an 'off-label' medication and the reasons for doing so. A copy of that record should be put in the patient's medical record and must also be sent to the Chief Psychiatrist.
- 1.23.14 'Off-label' treatment is the use of a registered therapeutic good (usually a medication) other than in accordance with the approved product information. For example, a number of antidepressants have been approved by the Therapeutic Goods Administration for use in adults but not in children.

1.24 Notification of certain events (Part 9)

- 1.24.1 One difficulty experienced by carers and family members is not knowing when a patient is made an involuntary patient, is discharged or is given leave from the hospital.
- 1.24.2 Usually, as part of good practice, carers and family members are contacted when these events occur, but there has been no statutory obligation for these people to be notified. This Act now lays an obligation on mental health services to notify a carer, close family member or other personal support person when these events occur. Nominated persons are included when referring to personal support persons.
- 1.24.3 Notifiable events are:
- a) detention to enable a patient to be taken to an authorised hospital or other place (s. 28(8))
 - b) release of a patient from a detention order (s. 28(12));
 - c) making a transport order for a referred person (s. 29(4));
 - d) revoking a referral order when a referred person is also subject to a Detention Order (s. 31(7));
 - e) any decision by a psychiatrist after examining a patient referred to an authorised hospital such as making them an involuntary detained patient, putting them on a CTO, extending the referral up to 72 hours from the time the patient was received, or making no order (s. 55(6))
 - f) any decision by a psychiatrist after examining a referred person in another place such as making them an involuntary detained patient in a general hospital, putting them on a CTO, referring them to an authorised hospital or making no order (s. 61(5))
 - g) transfer of an involuntary detained patient from a general hospital to an authorised hospital (s. 66(5))
 - h) confirmation of inpatient treatment order (s. 68(7))
 - i) release of an involuntary detained patient at any time (s. 89(6))
 - j) changing the involuntary status from detained to a CTO (s. 90(5))
 - k) transferring an involuntary patient between authorised hospitals (s. 91(5))
 - l) when an inpatient treatment order expires (s. 93(4))
 - m) when a referred person who has been detained and, an involuntary detained patient is absent without leave (s. 97(3))
 - n) when an involuntary patient is given leave (s. 105(13))
 - o) when leave is varied or extended (s. 106(4))
 - p) when leave is cancelled (s. 110(5))
 - q) after an examination when a CTO is revoked and the patient is made no longer involuntary or made a detained involuntary patient (s. 120(7))

- r) at any time when a CTO is revoked and the patient is made no longer involuntary or made a detained involuntary patient (s. 123(8))
 - s) confirmation of inpatient detaining order following revocation of CTO made by AV examination (s. 124(7))
 - t) when a CTO patient is released after being detained in place specified, in order to attend (s. 130(5))
 - u) for a CTO patient following a breach - making the person no longer involuntary or making an order for them to be a detained involuntary patient (s. 131(8))
 - v) provision of urgent non-psychiatric treatment (s. 242(5))
 - w) transfer from hospital to an interstate mental health service (s. 555(4))
 - x) transfer from an interstate mental health service to hospital (s. 557(6)).
- 1.24.4 It is recognised that notifying a personal support person of a certain event can be problematic. It is sufficient that reasonable efforts are made until at least one personal support person is notified, or that, despite a number of attempts, no personal support person is notified.
- 1.24.5 While no specific number of attempts is required in the Act, the importance of informing personal support persons should take precedence and every effort should be made to comply with this requirement in the Act.
- 1.24.6 However, if reasonable steps have been taken to make contact and that has not been achieved, then that is sufficient compliance with the Act. Whether or not the personal support person was contacted the matter must be fully documented in the patient's medical record including the efforts made if no contact was achieved.
- 1.24.7 In regard to all these notifications there is a 'best interests' test. The person who is expected to decide whether to provide the notification is usually the psychiatrist, though in relation to detention orders and transport orders it can also be a medical practitioner, AMHP or mental health practitioner. If that clinician decides that it is not in the best interests of the patient for the personal support person to be notified then the notification need not occur.
- 1.24.8 The decision and the reason for the decision must be noted in the patient's medical record and a copy given to the Chief Mental Health Advocate. At any time a decision not to notify can be revoked and the personal support person notified.
- 1.24.9 If the personal support person has previously stated that they wish to be notified of a certain event and the psychiatrist has decided that they should not be notified, then they need to be aware that they will not be notified. This can be very awkward if done at the point when notification needs to occur. It would be preferable if the decision to notify or not notify is made at the time of request. The dilemma is that it might not be obvious that a personal support

person should not be notified until the event is occurring and then telling the person that an event has occurred but they are not being provided with the details may lead to dissatisfaction. When informed of the decision, the personal support person may request to have the decision in writing.

- 1.24.10 The default position is that the right of notification should prevail unless there are very good reasons for a personal support person not to be notified.

Chapter 2: Decision making capacity and informed consent (Part 5 and Part 13, Division 1)

2.1 Background

- 2.1.1 Deciding whether a patient has capacity to make informed decisions about their care and treatment is a complex issue, broader than what will be considered in this chapter of the Guide. However, there are many references to capacity in the Act and one of the significant tasks for mental health clinicians is to decide, in regard to Section 25, whether a person has demonstrated or failed to demonstrate they have the capacity to make informed treatment decisions (s. 25(1)(c)). Additionally, whether a person authorised by law as an alternative decision maker, should have their views sought. Part 5 of the Act is divided into considering capacity generally and then more specifically in regard to informed consent to treatment.
- 2.1.2 Further information with regard to the capacity criteria for making a person an involuntary patient see the Chief Psychiatrist's Guideline 1(a) - Making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order, which is included as Addendum 2.

2.2 Decision making capacity generally, including consent to treatment

- 2.2.1 The Act emphasises the status quo position regarding capacity within common law, which is that:
- 2.2.2 a) A person 18 years or older is presumed to have capacity to make decisions about themselves unless it is shown that the person does not have capacity (s. 13).
- 2.2.3 b) A person under the age of 18 (a child) is presumed not to have capacity to make decisions about themselves unless it is shown that the child does have capacity (s. 14).
- 2.2.4 In either case if a patient is found not to demonstrate capacity to make informed decisions, then a person who is authorised by law such as a guardian or a parent, can make decisions regarding the mental health treatment on the patient's behalf.
- 2.2.5 The only exception with regard to psychiatric treatment is a decision regarding psychosurgery, where only the patient's consent is deemed valid and therefore does not apply to a person who lacks capacity to make informed decisions about treatment and by extension to any involuntary patient (s. 208).
- 2.2.6 For information on the relationship between the Guardianship and Administration Act 1990 and the Act see Addendum 4.

2.3 Determining capacity to make decisions with regard to treatment

- 2.3.1 The WA Department of Health Consent Policy (2011) defines capacity as ‘the extent to which a person is able to make reasonable judgements about their treatment and personal welfare’.²³
- 2.3.2 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 cannot be used to avoid determining capacity.
- 2.3.3 The Act provides direction for the clinician when deciding whether a person has capacity generally, or with regard to treatment, and the following directions are in regard to treatment (s. 15 and s. 18).

a) *Can the patient understand the information about the treatment, or explanations about alternative treatments, and warnings of any inherent risks? Essentially, understand how the proposed treatment will impact on the patient in order for them to make a balanced judgement.(see 2.4.6)*

Understanding can be impaired by intoxication, a head injury, delirium, intellectual disability, dementia or experiencing mental illness which interferes with the capacity to comprehend.

Some of these impairments, such as intoxication, are temporary, some are more permanent, such as dementia, and some are transitory such as experiencing mental illness, where capacity may be regained as the patient’s mental health improves.

There may be obvious stumbling blocks like an inability to understand English. Other less obvious stumbling blocks might be cultural differences that might lead to misunderstandings, or illiteracy, where a patient might not want to disclose their inability to read when given written information.

Clinicians must be sensitive to the information they are getting back from the patient verbally, visually or through other behavioural clues which may indicate that the patient does or does not understand.

The following 4 sections, b) to e), all relate to the decision to make a patient an involuntary detained patient under the Act.

b) *Can the patient understand the matters involved in the decision?*

This is more than just understanding information or advice and is broader than a mere retention and regurgitation of what the clinician tells the patient.

²³ Capacity is the clinical equivalence of competence, however the terms capacity and competence are used interchangeably in the literature. For clarity this addendum will only refer to ‘capacity’.

Some patients will have the capacity to understand complex matters easily and others, maybe because of the mental illness itself, will be unable to comprehend the information being provided.

If a person does not believe they have an illness then they are failing to understand the matters involved in the decision.

How the information is delivered by the clinician will also have a significant effect on the patient's ability to understand and is therefore an important consideration. Use of medical jargon or complex specialist knowledge may result in patients failing to understand the matters involved in the decision. At times, a patient might agree just to disguise their failure to understand. This should not mean that clinicians should omit details or provide information in very simplistic terms, which the patient or carer may find offensive. Essentially it means that clinicians must match their information with what the patient or carer can understand and check regularly that even simple issues are being understood.

For immigrant and refugee groups, it is important that clinicians do not assume that routine concepts and protocols associated with the Western psychiatric paradigm and the mental health system on which it is based are understood.

Deciding whether a patient has capacity in relation to this criteria, requires a more detailed explanation from the clinician and an opportunity for the patient and personal support persons to ask questions.

c) Can the patient understand the effect of the decision?

One aspect of clinical responsibility is to explain the possible past, present and future effects of the illness which is now requiring treatment. There may also be the significant impact of no treatment on the patients' health and safety to explain.

This information includes how the patient will personally be impacted on when making a particular decision, to 'grasp the fundamental meaning' of the information.

For every decision made about care and treatment the clinician needs to explore whether the patient understands their outcomes or consequences. This may relate to adverse or side effects of treatment, not accepting any treatment, or decisions more broadly about how accommodation or work will be affected.

Understanding has a wide application in the clinical setting. The patient needs to understand the facts of the treatment and how it will impact on his or her particular situation. The ability to understand treatment decisions encompasses two domains: firstly whether the patient acknowledges that they are experiencing a mental illness which requires treatment, and secondly, whether they understand the consequences of experiencing that mental illness and the treatment options.

The patient's decision may depend on how the clinician communicates the information, particularly in relation to patients from CALD backgrounds or

Aboriginal patients. From that perspective, the effects of a treatment decision on the patient's relationship with their community and family may be more significant in some particular cultures when compared with Anglo-Celtic culture.

Whether the patient will be able to articulate these anticipated consequences or have the confidence to disclose their fears will depend significantly on the clinician's ability to be culturally sensitive to the patient's situation. Use of good interpersonal skills for patient engagement may result in a greater understanding of the information.

d) Can the patient weigh up the factors in relation to understanding the information, understanding the matters involved in the decision making process and understand the effects of the decision?

This criterion relates to the ability to reason, which may require some rational thought processes or at least the ability to give a rational reason for the decision.

This criterion does not refer to the reasonableness of the decision. A patient may weigh up the matters very reasonably but come to a decision that in the view of the clinician is unreasonable. For example, the patient may have a thorough understanding about the efficacy of a particular medication but nevertheless decide against it.

The ability to weigh up the factors is what is important here, not whether the decision makes clinical sense. The abilities that may be relevant to this clause include the ability to:

- i. stay focused on a particular task
- ii. consider the options
- iii. consider and imagine the consequences of the decision
- iv. assess the likelihood of those consequences
- v. weigh up the desirability of consequences in light of personal values
- vi. deliberate by taking all these factors into account.

e) Can the patient communicate the decision in some way?

The litmus test for whether the patient has understood the information is for the patient to be able to tell the clinician in their own words what they have understood and the impact of the decisions they are making on their lives.

At times a person's capacity may be uncertain because of a language barrier or a hearing impairment and the clinician needs to work through those difficulties perhaps with the use of a translator or Auslan interpreter.

- 2.3.4 Any decision by a patient must be made freely and voluntarily. At times patients feel pressured to make decisions because a clinician or carer believes it is in their best interests. Decisions made under any sort of duress are not considered to be decisions made freely or voluntarily. Persuasion can

often turn into coercion, which the clinician needs to guard against. A patient's decision may be strongly influenced by collective values and cultural norms rather than their own individual needs, and the difference may not be necessarily understood by the clinician.

- 2.3.5 Demonstrating capacity is different from eliciting capacity. If the patient does not cooperate with the clinician in taking the test then they are not demonstrating that they have capacity and may therefore meet the criteria for involuntary status. If a child does not demonstrate capacity to consent to treatment, a parent or guardian may provide consent.
- 2.3.6 When determining whether a patient does or does not demonstrate capacity it would be important for the clinician to consider the following issues:
- a) The patient's past and present wishes and feelings (and, in particular, any relevant written statement or AHD made by him or her when he or she had capacity).
 - b) The beliefs and values that would be likely to influence his or her decision if he or she had capacity.
 - c) Any other factors that he or she would be likely to consider if he or she were able to do so.
 - d) The views of significant others such as carers, guardians and family members or anyone named by the patient as someone to be consulted.
 - e) When assessing capacity in Aboriginal people, cultural factors such as eye contact, pauses in conversation and monosyllabic answers, may lead the clinician to determining the patient lacks capacity, when further investigation in a culturally safe environment could indicate a different conclusion.
- 2.3.7 Within these broad parameters clinicians need to 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 any documentation will just need to justify the decision taken. A formal test will not always be required, but the factors contained in s.18 and s.19 of the Act must be addressed.

2.4 Informed consent to treatment

- 2.4.1 Principle 12 of the Charter of Mental Health Care Principles outlines the importance of providing information about treatment to all patients. All voluntary patients including referred persons must give informed consent before treatment is given (s. 175). Where consent is provided in a written format a copy of that consent must be filed on the patient's medical record (s. 176). However, emergency psychiatric treatment (Form 9A) can be given to a voluntary patient, including a referred person, without consent (s. 203) (see 3.9).

- 2.4.2 The rules that apply to consent and capacity issues generally also apply when specific decisions need to be made about treatment. Consent to treatment has been defined as *‘the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent’*.
- 2.4.3 There are two main types of consent; implied and expressed. Implied consent is when the behaviour of the patient, for example holding out their arm for an injection, indicates agreement with the treatment decision and is appropriate for low risk and minimally invasive types of treatment. Expressed consent is either verbal or written consent and should be obtained where there is a higher degree of risk or invasiveness, for example when Clozapine is provided.
- 2.4.4 However, there is a difference between implied consent and the clinician assuming consent has been given. For example, just because a patient does not offer resistance that should not be interpreted in itself as giving consent. It should not be assumed that consent has been given without exploring whether consent really has been given and is a consequence of information and advice being provided as well as specific personal matters as to how treatment will impact on the patient.
- 2.4.5 One way that a patient can give informed consent is through an Advance Health Directive (AHD) (s. 17). If there are doubts as to whether a person has capacity at the time a decision needs to be made and there is an AHD then use of the AHD as an avenue of consent should be considered. However, it should be noted that a patient has a right to withdraw an AHD at any time and an AHD may in certain circumstances be overruled by a psychiatrist (see s. 179(2)(c) and Addendum 3).
- 2.4.6 Before a patient is asked to make a treatment decision they must be given a clear explanation of the treatment including the following.

a) *Sufficient information to enable the person to make a balanced judgement about the treatment (s. 19(1)(a)).*

A clinician should provide the patient with sufficient information, either verbally or in writing, or even direct them to information on the Internet so that they can make a balanced judgement. Information on the internet can be very informative but also confusing and contradictory as organisations or individuals opposed to the treatment may post inaccurate information for public access. However, even the clinician discussing inaccurate information with the patient will indicate a degree of openness which can help to fully engage the patient.

The clinician needs to judge what information is relevant for the patient to make a balanced judgement. While providing information in a community language appropriate to a person from a CALD background is essential, it may be

preferable to use interpreters. Clinicians should be aware that a person from a CALD background may not be literate in their own language.

Excessive and sometimes contradictory information can lead to confusion while too little information can lead to an uninformed decision. There should always be a baseline of essential information which, for example in regard to medication, should include: adverse effects (side effects), including any:

- i. potential impacts on the ability to drive and work
- ii. dangers of overdose
- iii. expectations as to when the medication starts to be effective
- iv. how the medication is expected to work including limitations of effectiveness
- v. what to do when the medication is not taken at the right time or frequency
- vi. whether there could be drug interactions with other prescribed drugs, non-prescribed drugs or herbal medications
- vii. interactions with alcohol and illicit drugs.

b) Identifying and explaining about any alternative treatment about which there is insufficient knowledge to justify it being recommended or to enable its effects to be predicted reliably (s. 19(1)(b)).

As in general health, treatments in mental health must be evidenced based and proven to be clinically effective. However, there is a plethora of information about other therapies and treatments which are not evidenced based and have not undergone trials for clinical effectiveness.

Patients and their carers or relatives may show an interest in these alternative approaches, for example Aboriginal people or people from CALD backgrounds may seek treatments related to cultural beliefs and traditional practices.

Clinicians should not dismiss these alternatives but it may be necessary to clearly explain why they may not be appropriate treatments for the patient who is experiencing mental illness. It is recognised that clinicians may not be experts in alternative treatments. It should be noted that some alternative treatments can interfere with psychiatric treatment making it less effective or resulting in unwanted outcomes.

c) Warning the patient of any risks inherent in the treatment (s. 19(1)(c)).

All treatments have some degree of risk, and the clinician needs to provide the patient with balanced and relevant information which the patient can use to determine whether to provide consent.

One of the important considerations is balancing adverse or side effects from the treatment versus no treatment which can lead to an exacerbation of the mental illness.

Risks from the treatment should be provided verbally and also in writing. It is important to engage with carers and relatives in this process as they may be the first to identify when and if an adverse reaction to the treatment occurs.

- 2.4.7 In deciding what information is to be given to the patient the clinician makes a decision on what a reasonable person in the patient's position would think is significant. At times a particular patient may need more information than what a clinician may consider reasonable, because the patient may have experienced particular effects from the treatment which have made them suspicious of that treatment, or perhaps resentful and not accepting of the need for that particular treatment. Clinicians need to be flexible in their approach and not just provide a basic kit of information to every patient. For example, some people from a CALD background may interpret the clinician's role as that of a person in authority and respond from that perspective. Some patients may need more verbal and written information or speaking with a peer who has had similar treatment.
- 2.4.8 Any information given needs to be provided in the terms, language and form of communication that the patient is likely to understand. Clear, precise and comprehensible guides are required. Specific consideration needs to be given to people from CALD backgrounds. Translated information or use of interpreters is recommended. These considerations extend to people with hearing impairment who may require an Auslan interpreter to those who are visually impaired who may need information verbally or in braille.
- 2.4.9 With the treatment of Aboriginal patients, to the extent that it is practicable and appropriate, consent and capacity issues should be made in collaboration with Aboriginal Mental Health Workers or significant people from the patient's community such as important family members, traditional healers or elders identified by the patient or significant members of their community. For example, a patient may identify as a person of Aboriginal descent but not want people from his or her community to be involved in their treatment or care and therefore it would not be appropriate to collaborate with an elder from that community. Although not specifically mentioned in the Act, similar issues are relevant to people from CALD backgrounds.
- 2.4.10 Before a patient or guardian makes a decision about whether to consent to a particular treatment they must be given enough time to consider all the information the clinician has provided as well as a reasonable opportunity to discuss the issues with their doctor or other health professionals and seek advice from other sources about the treatment. The Act does not specify an amount of time so this should be determined by the clinician in collaboration with the patient and other significant people in the patient's life. Extra time should be given if requested. Before making a decision some patients may wish to consult with a trusted previous clinician or their GP, or with peers who have had the same treatment, and should have the opportunity to do so. Patients with capacity to make treatment decisions have the right to refuse

treatment even if it appears to others, such as clinicians or their relatives, that it would be in their best interests to receive the treatment.

- 2.4.11 Informed consent is required for all voluntary patients (s. 175) and the clinician must ensure that details of that informed consent are recorded in the patient's medical record (s. 176(1)). This includes in regard to people from a CALD background relevant information about the interpreter. The record should state the date the informed consent was given and whether it was the patient or a guardian or parent who gave consent (s. 176(3)). Any change of treatment or change of dose will require further informed consent which can be provided orally. For written consent a recommendation would be the use of the Department of Health Consent to Treatment template.
- 2.4.12 Informed consent is not required when treatment is given to involuntary patients or when emergency psychiatric treatment or urgent non-psychiatric treatment for involuntary detained patients is required. However, in line with the Charter of Mental Health Care Principles, informed consent should always be sought when providing treatment to involuntary patients.

Chapter 3: Referral (Part 6, Division 2 and other related sections)

3.1 Background

- 3.1.1 Referring a person for an examination by a psychiatrist can be the first step in ensuring that a person experiencing mental illness receives treatment, but it also may result in the person becoming an involuntary patient. It is therefore a process which needs to be carefully considered and only used when it is clear that less restrictive options are not available or suitable.
- 3.1.2 Some consumer groups have concerns about the power of referral, believing that at times it may be used by practitioners with limited experience and little knowledge of mental illness. Under the Act referral is restricted to medical practitioners and AMHPs.
- 3.1.3 There is no obligation for a practitioner to use his or her power of referral and if uncertain whether to invoke the referral process, advice should be sought from more experienced practitioners or the Helpdesk provided by the Office of the Chief Psychiatrist.

3.2 Police powers

- 3.2.1 A police officer may apprehend a person they suspect is experiencing mental illness in order to protect the health and safety of that person, the safety of another person or prevent the person causing or continuing to cause serious damage to property (s. 156). Being apprehended is different from being arrested, in that the person does not have to appear in court or answer to any charge.
- 3.2.2 In order to apprehend a person the police officer may enter any premises where the person is reasonably suspected to be, search the person and seize certain articles (s. 159(2)) (see list of articles in 4.11.18). At times the use of reasonable force may be necessary and police have the power to use reasonable force and ask another person such as a staff member to assist them in the process (see 3.8.8 to 3.8.12).
- 3.2.3 The purpose of apprehending the person is to take them as soon as practicable to be assessed by a medical practitioner or AMHP. It is the task of the practitioner to assess the person and decide whether they need to be referred for an examination by a psychiatrist. For example, although the police have no specific training in understanding mental illness, they may apprehend a person behaving in a way which makes them suspect, as any lay person might, that the person is experiencing a mental illness. Instead of arresting the person or getting them to move on, they can apprehend the person and take them to a place such as a general hospital Emergency Department (ED) to see a medical practitioner or AMHP. This is a recognition that police have a duty of care to people they come across in the community as part of their front line service. They have experience in dealing with

welfare issues and managing people who may present with behavioral symptoms of mental illness. The role of the police officer is significant for ensuring the safety of people experiencing mental illness in the community. At times police may wish to contact triage at a mental health service to discuss the apprehension of the person. Whenever possible if a matter is known in advance to be a mental health issue mental health services must seek to assist the police. Where there is a known mental health issue it is not acceptable for mental health services to refer matters to police for a welfare check. Although clinicians must adhere to confidentiality provisions under section 576, police may be provided with relevant information where a matter is of public interest. WA Health staff can seek legal advice from the Department of Health's Legal and Legislative Services for clarification on the matter of public interest.²⁴

- 3.2.4 The authority to detain the person continues until either the person is received at the place where the assessment is to occur, or the person is delivered into the care of a medical practitioner or AMHP (s. 156(3)(b)). This implies that once a person is received by the ED or other place such as a clinic, the police are entitled to leave. This does not mean that the police can leave as soon as the person arrives at the place of assessment. It is the duty of the police to inform staff of their arrival and the person needs to be 'received' which implies being placed in an area where they will receive some care and attention. A waiting room is not an appropriate area to leave a person experiencing an acute phase of mental illness. The fact that police have apprehended a person implies a high priority and staff need to respond as soon as practicable when an apprehended person is brought for assessment. A high degree of cooperation between the police and health staff is needed to ensure patient and community safety.
- 3.2.5 Alternatively, if police are satisfied at any time that the grounds for suspecting that the person needs to be apprehended no longer exist, they may revoke the apprehension (s. 156(3)(b)). For example, police may apprehend a person who is behaving as though they are experiencing mental illness but on the way to the ED it is clear that the behavior is due to alcohol and drug intoxication. The police may then decide on alternative methods of managing the person rather than taking them for an assessment by a medical practitioner or AMHP. There is nothing preventing the police from arresting or charging a person they have apprehended at any time (s. 156 and s. 157).
- 3.2.6 Separate from the apprehending process the police may also arrest a person and then suspect that the person is experiencing mental illness and is in need

²⁴ OD 0556/14, Department of Health, 050814- Summary: If mental health staff have concerns regarding the mental state or physical welfare of a known patient with psychiatric illness in the community, assessment is to be undertaken by mental health clinicians. In situations where police or ambulance are required to attend, mental health clinicians are to provide all appropriate assistance to WA Police, Ambulance, the patient and the associated family or carers.

of immediate treatment. They may then divert the person into the mental health system for an assessment by a medical practitioner or AMHP.

- 3.2.7 The place of assessment is not defined in the Act and can be anywhere such as an ED, clinic or a person's home. The place where the person can be referred to for the psychiatric examination can be either an authorised hospital or another place deemed appropriate by the Chief Psychiatrist, such as a general hospital or community clinic. In most cases police will take the person apprehended to an ED or a mental health clinic, or in a non-metropolitan area to a place such as a clinic or nursing post. It can be anywhere that a medical practitioner or AMHP is available to conduct an assessment. Wherever the assessment occurs for people from CALD backgrounds consideration should be given to timely access to an onsite or telephone interpreter.
- 3.2.8 In relation to a person arrested, the police may request that the assessment is conducted somewhere other than the person's home or a health setting, such as a police station.
- 3.2.9 Alternatively, perhaps because of the seriousness of the offence, the police may decide that the person should appear in court and the Magistrate or Judicial Officer may make a determination under the *Criminal Law (Mentally Accused) Persons Act 1996* to make a hospital order so that an assessment can be conducted in an authorised hospital. In those circumstances and separate from this Act the police may request intervention by mental health staff to ensure the treatment and care of a person in custody.
- 3.2.10 There is a qualitative difference between an assessment to be conducted on a person apprehended and a person arrested. Being arrested implies much greater criminal justice input and the expectation is that in those circumstances the police should remain with the person arrested until and perhaps after the assessment is conducted. This is because if the assessment indicates no further action under the Act such as a referral to a psychiatrist, the police then have full jurisdiction, having arrested the person.
- 3.2.11 After apprehending a person or taking them for an assessment following an arrest, the police must be informed if the medical practitioner or AMHP decides not to refer the person for an examination by a psychiatrist, as the person is then allowed to leave (s. 158). After the police are informed the information needs to be put into the patient's medical record as soon as is practicable. The name of the person who informed the police and the name, rank and location of the police officer informed should be documented.
- 3.2.12 An arrested person may be assessed by a medical practitioner or AMHP and referred to be examined by a psychiatrist. If the psychiatrist decides to make no order, or is considering making a CTO, the patient cannot be immediately released, because they were originally arrested. If they are not going to be detained under the Act the police must be informed so they can take whatever action is appropriate from their perspective, such as organising bail.

- 3.2.13 If the person is made an involuntary detained patient and then released from detention or placed on a CTO, the police must be informed before the patient is released. It is important for clinicians when organising a discharge to note the way that the person was admitted, so appropriate legal action can be taken when the person is made no longer involuntary, or released on a CTO.

3.3 Referrers

- 3.3.1 There are two types of referrers:

- a) Medical practitioners – any doctor including a psychiatrist who is registered under the *Health Practitioner Regulation National Law (WA)* (HPRNL-WA) as being in the medical profession (s. 4).
- b) Authorised Mental Health Practitioners (AMHPs) – these are mental health practitioners who are authorised by the Chief Psychiatrist if he or she is satisfied that the mental health practitioner has the qualifications, training and experience appropriate for performing the functions of an AMHP in the Act (s. 539). A mental health practitioner can be a psychologist, a nurse, an occupational therapist (all registered under the HPRNL-WA), or a social worker. All four types of mental health practitioner must have at least three years' experience in the management of people who experience mental illness (s. 538). The Chief Psychiatrist keeps a Register of AMHPs.

- 3.3.2 Referrers may refer any person to an authorised hospital or another place for examination by a psychiatrist (s. 26).

- 3.3.3 A medical practitioner or an AMHP cannot refer a person who is a relative, a person on a Guardianship Order to the referrer, or a person with whom the referrer is in partnership (for example in a business, or is an employer or employee of the person, for example their superior or subordinate in a work situation). This restriction extends to a referrer who wants the psychiatric examination conducted at a private hospital by a psychiatrist who holds the license for the private hospital (s. 579).

- 3.3.4 As noted a referrer has considerable power under the Act and needs to have a good understanding not only of mental illness but also of the provisions in the Act. He or she should also undertake education, including up-to-date information sessions on the legislation and what is deemed good practice in this field of mental health care.

- 3.3.5 With regard to AMHPs the Chief Psychiatrist can specify limits and conditions on the powers of an AMHP, for example, requiring them to work under supervision for a period. The Chief Psychiatrist can also revoke the powers of an AMHP on a number of grounds (s. 539). Further information is provided in the Regulations and Addendum 8: Role of Authorised Mental Health Practitioners.

3.4 Criteria for referral

This part of the guide needs to be read in conjunction with the Chief Psychiatrist's guideline 1 (s. 547(1)(a)) Addendum 2.

- 3.4.1 When considering whether to refer a person for an examination by a psychiatrist, a practitioner (medical practitioner or AMHP) must take into consideration the criteria on which a psychiatrist makes a person an involuntary patient (s. 26).
- 3.4.2 The criteria must include all of the following:
- a) that the person is experiencing a mental illness for which the person is in need of treatment
 - b) that, because of the mental illness, there is a significant risk to the health or safety of the person or another person, or a significant risk of serious harm to the person or another person
 - c) that the person does not demonstrate that they have the capacity to make treatment decisions
 - d) that there is no lesser restrictive way to provide the treatment which the person needs.

For further information on criteria see Chapter 4: Examination and involuntary inpatient status, and Chapter 5: Community Treatment Orders.

- 3.4.3 If the practitioner reasonably suspects that the person is in need of an involuntary order, or if on a CTO in need of an inpatient treatment order then they may exercise their power of referral. The term 'reasonably suspects' is a lower threshold than certainty and is in the legislation to ensure that even if there are doubts as to whether the patient should be referred the practitioner may still, in the best interests of the patient, refer them for a psychiatric examination.
- 3.4.4 A practitioner may be conducting an assessment in a crisis situation in a community setting or an ED and the ability to differentiate between symptoms of mental illness and behavioural disturbance (from, for instance, alcohol or drug intoxication, acute distress or personality issues) may be extremely difficult. For example, a person may be referred but it is later discovered that their behaviour was due to the effects of intoxication with a psychoactive substance such as amphetamines. The subsequent diagnosis does not detract from the valid suspicion that the person needed to be referred and the term 'reasonable suspicion' allows for a degree of uncertainty in the best interests of the person.
- 3.4.5 This does not imply that a practitioner should reach a decision to refer without as good an assessment as possible, which includes consulting with relatives and other people important in the person's life. Removing a person's liberty by detaining them is a serious matter and the practitioner needs to exercise their knowledge, skills and experience at a high level to prevent unnecessary or hasty decisions.

- 3.4.6 As noted in 1.17 of this guide, the validity of an involuntary treatment order may be challenged because of the conduct of an assessment which led to a referral. Any assessment can undergo further review, so practitioners need to ensure that their assessment is as thorough as possible.
- 3.4.7 However, when a practitioner has referred a person they suspect is experiencing mental illness, which is shown to be incorrect, the practitioner is not liable if they have completed the referral in good faith and complied with the processes under the Act (s. 583).

3.5 Rules concerning referrals (Part 6, Division 2, Subdivisions 3 and 4)

- 3.5.1 A practitioner must not refer a person unless they have been assessed (s. 39) and the assessment must be within 48 hours of the referral being made (s. 40(1)).
- 3.5.2 An assessment must be conducted in the least restrictive way and in the least restrictive environment (s. 48(1)). If a person has been restrained or given medication, any assessment should, if possible, be postponed until the person is able to communicate with the practitioner more freely. It is important to get a picture of the person's mental state as free as possible from elements of coercion, or the person feeling compelled to make certain statements. For example, if there is a family member in the room that does not allow the patient to communicate freely then that family member should be asked to leave the assessment, although the family member can and should be encouraged to provide additional information to the practitioner at a more suitable time.
- 3.5.3 The person and the practitioner should be in each other's physical presence, for example in the same room. If that is not practicable, for example if the person has locked themselves in a room, then an assessment can still be conducted if the practitioner and the person are able to hear each other and communicate through the locked door (s. 48(2)). However, this does not include the use of a telephone.
- 3.5.4 If a person is not allowing entry to a place or have barricaded themselves so no face-to-face assessment can be conducted, then crisis management may include using the police to assist entry. Before police are requested to attend, there needs to be an initial assessment to ascertain whether police are required, when they may be required, other options for resolving the situation (such as involving relatives) and any risks associated with delaying entry.
- 3.5.5 There is nothing in the Act detailing the use of police in assisting with entry in these circumstances. Police work has a welfare component and there is nothing preventing them assisting health staff in managing these situations. Police may use their apprehending powers as described in 3.2, if their suspicion that the person may be experiencing mental illness is raised by information provided by the health staff. Police do not have to conduct a face-

to-face assessment to reach a conclusion that a person needs to be apprehended.

- 3.5.6 In non-metropolitan areas an assessment may be conducted using audio-visual (AV) means (videoconferencing) if it is not practicable for the practitioner and patient to be in each other's presence (s. 48(3)). A health professional must be with the patient when an assessment is conducted using AV means. A health professional is a medical practitioner, a nurse, an occupational therapist, a psychologist, a social worker and, if the patient being assessed is an Aboriginal person, an Aboriginal mental health worker (see Addendum 7 which provides further information about the use of AV means). The purpose of the having a health professional with the patient is to support the patient and manage the equipment. There is nothing preventing the patient also being supported by a relative or other support person as well as a health professional.
- 3.5.7 The Act allows an assessment and referral of a patient who is on a CTO. For example a patient on a CTO, may turn up for their regular appointment but the medical practitioner or AMHP may be so concerned about the patient they believe the patient should be referred for an examination by a psychiatrist. In those circumstances instead of the supervising psychiatrist revoking the CTO and ordering that the person be returned to the hospital, the medical practitioner or AMHP can refer the patient directly.
- 3.5.8 In those circumstances the CTO is automatically suspended from the time the referral is made until either of the following occurs:
- a) the patient is made an involuntary detained patient in an authorised hospital
 - b) the person is examined again at an authorised hospital following the extension of the referral for up to 72 hours from the time the patient was received
 - c) an order is made that if the person is examined at another place for the patient to be taken to an authorised hospital and received
 - d) an order is made stating that the person can no longer be detained.
- If (d) is made following an examination then the person remains on the original CTO.
- 3.5.9 In making an assessment, information can be gathered directly from the person, their medical record or from a carer or family member. However, a referral cannot be made just on information obtained from another person or from the medical record. There needs to be some information obtained from an assessment made by the practitioner. Collateral information is important as it can impact significantly on a referral and can even be decisive when considering whether a person should be referred, but it cannot be the only information which informs a referral (s. 49).
- 3.5.10 If the person being assessed is Aboriginal then, to the extent that it is practicable and appropriate, any assessment should be conducted in

collaboration with an ATSI mental health worker and significant members of the person's community, such as important family members, traditional healers or elders identified by the person (s. 50). The purpose of this collaboration is to ensure that cultural issues are recognised and any possible misinterpretation minimised (see Addendum 5). Although not specifically mentioned in the Act, similar issues are relevant from people from CALD backgrounds.

3.5.11 A referral must be on an approved form (s. 41) (Forms 1A) and must specify the following:

- a) the date and time the referral form was completed
- b) the date and time it will expire (which is 72 hours from the time it was completed unless (i) below applies, which relates to non-metropolitan areas)
- c) the place where the form was completed, for example a person's home, an ED, a GP clinic
- d) the name of the authorised hospital or other place where the examination by the psychiatrist will take place
- e) the date and time when the assessment was completed, which cannot be longer than 48 hours from when the referral order is completed
- f) details on which the suspicion that the patient needs to be an involuntary patient are based, differentiating between information directly obtained from the person, such as answers to questions, and observations from collateral information from other people or from the medical record
- g) the name and qualifications of the referring practitioner
- h) the signature of the practitioner which certifies that having considered the criteria in section 24, the practitioner reasonably suspects that the person is in need of an involuntary treatment order
- i) if the referral is in or from a non-metropolitan area, whether the referral was done by AV means or was extended and if it was extended what process was used.

3.5.12 The referred person must be given information which is in the Form 1A, but not necessarily a copy of the form. In most circumstances it would be appropriate to provide a copy of the form. If the information in the Attachment to Form 1A is from a collateral source such as a carer or family member and if that person has requested that the information not be given to the referred person, then a copy of the Attachment must not be given to the patient.

3.5.13 There is no timeframe for when a copy could be given to the referred person. If the referred person requests it as soon as practicable then that is when it should be provided. Access to photocopiers may delay giving the form to the referred person. However, not providing a form because the clinician believes it may impact on the referred person's mental state should in most cases not

be a reason to delay providing the form. The form should not be provided to the patient at a time when the risk cannot be managed. A temporary delay should only be considered in a situation where the patient has an uncontained risk of absconding, or harm to self or others. A copy of the forms must also be placed in the patient's medical record (s. 43). In regard to people from a CALD background or who have a limited understanding of English, a verbal explanation of information on the form should be provided.

- 3.5.14 While carrying out an assessment and referral, if a practitioner is obstructed or hindered (without reasonable excuse) by a person such as a friend or relative of the patient, that person is committing an offence and could be liable for a fine of \$6000 (s. 580). For example, a relative or friend may firmly believe that the person is not experiencing mental illness and may attempt to stop the practitioner carrying out their functions under the Act. The practitioner should explain the reasons for the referral and inform them of their rights as a support person. The person may also need to be reminded that they may be committing an offence if they obstruct or hinder the referral process (s. 580). With regard to people from CALD backgrounds it may be appropriate to identify significant persons in the community to assist.
- 3.5.15 A referred person who has presented at a mental health service (which includes an Emergency Department or a general ward to the extent it is providing mental health treatment to a particular patient) or who has been detained may be searched if it is suspected that they have in their possession something, such as a weapon or drugs, which may compromise the health and safety of themselves or any other persons involved in the referral process such as family members, clinicians, ambulance staff or police (s. 162) (see 4.11).
- 3.5.16 While the Act provides search powers, a voluntary search with the patient's consent is preferable. If it is suspected that the person has on them certain things such as a weapon or drugs (prescribed or non-prescribed) and it would be unsafe to conduct an assessment then one option, when all other ways of voluntary searching have been exhausted, is to request assistance from the police, or authorised person. If a referral order has been completed and a search is needed before transporting the person and the patient refuses to be searched then, after all other ways of voluntary searching have been exhausted, the referrer may make a request for a search by a police officer or authorised person to conduct a search. The issues here are patient and staff safety and while every effort should be made to enable a voluntary search, if there is a high suspicion that the patient has on them something which may pose a risk to health and safety, then use of the police or authorised person may be an option (see 4.11).
- 3.5.17 If the person is on a referral order (Form1A) and leaves the place, then an Apprehension and Return order (Form 7D) cannot be made. The personal support person should be notified that the referred person is absent without leave and efforts should be made to return the person.

- 3.5.18 However, if the referred person is also subject to a Detention Order (Form 3A) and the option of using family members is not viable or successful, then the person in charge of the hospital or other place or a medical practitioner may make an 'Apprehension and Return Order'(s. 99) (Form 7D). The Apprehension and Return Order authorises a police officer or a person prescribed in the Regulations such a a staff member of the service to apprehend the person and return the person to the hospital or other place specified in the order before the order expires (s. 101) (see 4.10).
- 3.5.19 An Apprehension and Return Order can be revoked at any time (Form 7D) if it is determined that police or authorised persons are not needed, or if the referral order is revoked (Form 1A).
- 3.5.20 Although the apprehension and return order has a life of 14 days (s. 100) the Referral Order only lasts 72 hours in the metropolitan area or 144 hours in non-metropolitan areas (s. 28). If the person is not returned before the referral order expires then the Apprehension and Return Order is no longer valid.
- 3.5.21 If a referred person subject to a detention order is absent without leave then a personal support person must be notified.
- 3.5.22 When referring a person and removing them from their home or place of residence, there are a number of welfare issues which become the responsibility of the referrer. This might include arranging for the care of children and pets, and securing the property. For children it may be necessary to liaise with child protection if care from a relative is not possible. For pets it may be essential to contact the appropriate welfare organisation. The patient's home may need to be secured, or their personal property stored. For unattended property it may be appropriate to turn off the power except where necessary to keep fridges and freezers working. All of these decisions need to be made in conjunction with the referred person's, or relatives, wishes and in consultation with welfare agencies and local service policy. Some of these concerns may become the responsibility of a carer or relative but, where that is not an option, it is the responsibility of the referrer to ensure these issues are managed.

3.6 Revoking a referral order (Form 1A)

- 3.6.1 At any time following a referral order being made, a medical practitioner or AMHP may revoke the referral order if they are satisfied that the person being referred is no longer in need of an involuntary treatment order (s. 31(1)).
- 3.6.2 The revocation can be done by the practitioner who made the order or by another practitioner, but only by that other practitioner if he or she has consulted with the referring practitioner as to why the order should be revoked (s. 31(2)).
- 3.6.3 At times following a referral the referred person's mental state may change, perhaps because they have received some medication or recovered from an

intoxicated state and it becomes clear, given the principle of least restriction, that there is no need to use the referral processes under the legislation. The person may not need any further mental health treatment or may be compliant with referral and treatment. This can be part of the discussion between the referring practitioner and the practitioner who wishes to revoke the order.

- 3.6.4 However, the referring practitioner may have additional information about the referred person which indicates that the referral should continue. Despite this the other practitioner may still revoke an order. This is based on the principle that the practitioner who is with the referred person may be in a better place to make such a decision.
- 3.6.5 This decision can be contested especially if the referring practitioner is senior to the revoking practitioner or knows the patient better. The revoking practitioner needs to justify the decision and note that any objections by the referring practitioner are answered. Changes to the situation, such as the patient now complying with treatment or willing to become a voluntary patient, are some of the matters that need to be considered when contemplating a revocation of referral. However, in the spirit of always striving to use the least restrictive way of providing treatment and care, revoking a referral order is a valid pathway to comply with the Objects of the legislation.
- 3.6.6 If the referring practitioner cannot be contacted despite reasonable efforts being made, then the other practitioner can decide whether to revoke the order without consulting the referring practitioner. Clearly these decisions can be complex and if a practitioner is undecided then they should consult with a senior colleague before making a decision.
- 3.6.7 The revocation of a referral order must be on an approved form (s. 31(3)) (Form 1A) specifying the date and time it was made and the reasons for making it, as well as a record of the consultation with the referring practitioner, if that occurred. Also, if no consultation occurred, a record of the efforts made to contact the referring practitioner is required. A copy of Form 1A must be placed in the person's medical record and a copy given to the person (s. 31(4)).
- 3.6.8 If a transport order (Form 4A) was done following the referral order, then the revocation of the referral order extends to the revocation of the transport order. The practitioner should inform the police officer or transport officer of the revocation (s. 31(5)).

3.7 Extending a referral made outside a metropolitan area

- 3.7.1 If a referral is made from a non-metropolitan area, either to another non-metropolitan area or to the metropolitan area, then, where it is needed, a referral can be extended for up to 72 hours from the time it would expire to a maximum period of 144 hours by completing Form 1B (s. 28(3)(b)).

- 3.7.2 The person responsible for taking the person to the authorised hospital or other place (and that can include the police, hospital or community staff or even in some circumstances a relative or carer) can verbally request an extension of the referral order if it looks like the referral order (Form 1A) will expire before the referred person gets to the destination. This can be requested from either the practitioner who made the order or if that person is not reasonably available another practitioner from the service or another service (s. 45(2)(a)).
- 3.7.3 In these circumstances the process should be to contact the referrer. If the referrer is unavailable another practitioner from the same service should be contacted and after that a practitioner from another service. In regard to the latter 2 options the practitioner needs to be fully informed about why the destination cannot be reached in the allocated time and be satisfied that an extension is needed.
- 3.7.4 If the referrer is not reasonably available and the person involved in the transportation is a medical practitioner or AMHP then he or she can extend the referral order themselves (s. 45(2)(b)).
- 3.7.5 The practitioner who extends a referral order must complete a Form 1B, stating when the extension was made, when the extension will expire and the reasons for the extension (s. 45(5)).
- 3.7.6 A copy of Form 1B must be given to the patient and a copy placed in their medical record.
- 3.7.7 A referral can only be extended once (s. 45(6)). If for any reason the extension expires then the referred person can no longer be detained. If required, a new referral, which would include a fresh assessment, would need to be completed.
- 3.7.8 Any Transport Order (Form 4A) is automatically extended to the time when the Referral Order will expire, when a Referral Order is extended.

3.8 Detention to enable the person to be taken to an authorised hospital or other place (s. 28)

- 3.8.1 The Act provides principles relating to detention, which are that:
- a) The person must be detained for as brief a period as practicable.
 - b) The degree of force used to detain the person or to keep the person detained must be the minimum that is required.
 - c) While the person is detained there must be the least possible restriction on the person's freedom of choice and movement consistent with the detention, and the person is entitled to reasonable privacy and to be treated with dignity and respect (Part 12, Division 1).

- 3.8.2 A medical practitioner or AMHP, but not necessarily the medical practitioner or AMHP who made the referral, may make an order (Form 3A) authorising the referred person's detention for up to 24 hours from the time the referral is made, to enable the person to be taken to the authorised hospital or other place for examination (s. 28(2)).
- 3.8.3 This does not mean it should be routine to make a detention order at the same time as a referral order. The elements of referral and detention are separate. Some referred persons will not require a detaining order because they are not trying to leave the place and do not object to being taken to the place of examination. Other referred persons might make it clear of their intention to leave, not cooperate with the transportation, or are so unwell that their behavior is too unpredictable.
- 3.8.4 There may be circumstances where a referral order is made but no detaining order. However a detaining order may be required later on because the person wishes to leave and it would not be safe for them or others if they did. For example a referred person may be assessed at an ED and may require Emergency Psychiatric Treatment (Form 9A) which sedates them. In those circumstances no detaining order is required along with the referral order. However, when the patient is no longer sedated some hours later, he or she may wish to leave and it could be unsafe for him or her to do so. A detaining order can then be completed, for a period of up to 24 hours.
- 3.8.5 The detention order needs to state when it was made, when it will expire (which cannot be longer than 24 hours after it was made), the reasons for making it and the name and qualifications of the practitioner who made it (s. 28(6)). A copy of the order needs to be placed in the patient's medical record and a copy given to the person (s. 28(7)).
- 3.8.6 The practitioner who makes the order needs to be satisfied that the person needs to be detained to enable them to be taken to an authorised hospital or other place. The need for detention can be indicated by any behavior or condition in a patient that could put them at risk. This could include an unwillingness to be transported, or it might be based on their physical condition, for example a person who has self-harmed where it would be unsafe for their physical health to leave.
- 3.8.7 A detention order can only be made following a referral order. For instance, a person with a physical condition such as anorexia but who is not a referred person, who wants to leave an ED, may do so and there is no power under the Act to detain him or her. However, if the person is being referred to be examined by a psychiatrist and they have some physical injury that would place them at risk if they left an ED or they have a state of mind such as suicidal ideation which would also place them at risk if allowed to leave, then they may be detained under the Act. In most cases detention will be used because of the referred person's mental illness and the risk to their own or another person's health or safety.

3.8.8 Reasonable force is authorised for a number of specific functions such as:

- a) detaining a referred person at an authorised hospital or other place for an examination by a psychiatrist (s. 83(2)(c))
- b) detaining an involuntary patient under an inpatient treatment order (s. 86(c))
- c) detaining a person under an apprehension and return order (s. 99)
- d) detention following an order to attend in relation to a CTO (s. 130(3))
- e) detaining a person in order to transport them under transport order (s. 149(1))
- f) the police apprehending a person (s. 156)
- g) a person conducting a search (Part 11, Division 2)
- h) force used to place a person in seclusion (s. 225).

3.8.9 Reasonable force can be used by police or transport officers following the making of a transport order to detain and transport the referred person

3.8.10 Reasonable force is defined by the Butterworth's Legal Dictionary as 'that degree of force, which is not excessive but fair, proper and reasonably necessary in the circumstances'. To determine whether or not the force used was reasonable requires asking the question, 'would it be reasonable for any person, placed in the same situation, to use this degree of force?' In this way an objective standard could be set by which actions can be measured so that only sufficient force to overcome the threat is used.²⁵

3.8.11 In 2011 the Commissioner of Police provided to Parliament, orders and procedures which contain the following guidelines for officers in relation to the use of any force. These guidelines could apply equally to staff performing functions under the Act, where use of reasonable force is required. They are as follows:

- a) Members shall not use more force on persons than is reasonably necessary to perform their lawful duties.
- b) In any circumstances where the use of force is permitted, members should decide whether the use of any force is reasonably necessary.
- c) In any circumstances where the use of force is reasonably necessary, members should use the minimal amount of force required to establish control. Once control has been achieved, lower force options are to be employed at the earliest opportunity.
- d) Members must ensure that they do not use excessive force and, in particular, do not use any force where none is needed, more force than is needed or any force or a greater level of force after the necessity for it has ended.
(Hansard 17 May 2011)

²⁵

- 3.8.12 Section 254, places a duty on staff to report unreasonable use of force on a person by a member of staff (see 1.21). Patients and others can lodge a complaint if they feel unreasonable force was used (Chapter 7).
- 3.8.13 The detention order authorises staff to detain the person and under a duty of care the use of reasonable force by staff or others such as security staff. However even when a Detention Order is active, if a staff member is put at risk of physical harm when attempting to detain and decides instead to allow the person to leave, then that may be considered justified as the personal health and safety of staff is of paramount concern. However this does not justify no action being taken. The referred person may continue to be at risk and be absent without leave. In those circumstances the police or a person authorised by the Regulations such as a staff member may apprehend the person and return them under an Apprehension and Return Order (Form 7D). There may be questions asked into why the detention order was not enforced, however staff should not be expected to place themselves at personal risk when carrying out a function under this Act. It is important for staff to receive training and education in managing behavioural symptoms of mental illness and be aware of, and operate under, the policies and procedures endorsed by the service.
- 3.8.14 At times, in order to detain a person, the person may be restrained or placed in a locked room. This is not 'bodily restraint' or 'seclusion' as defined in the Act unless it occurs within an authorised hospital. However, while exercising a duty of care, it is depriving a person of their liberty and can be distressing and should only be used when it is safe to do so and there are no other options to control a situation which may result in harm to the person or others. Using duty of care needs to be justified. The 'doctrine of necessity' will be a defense if there is any civil action.
- 3.8.15 The making of a detention order is classed as a notification of a certain event under Part 9 (s. 28(8)). This means that the practitioner must make reasonable efforts to notify a carer, close family member or other personal support person that the referred person has been detained (see 1.24).
- 3.8.16 Before the initial detention order expires a medical practitioner or AMHP, and not necessarily the medical practitioner or AMHP who did the first detention order, may extend the period of detention for up to a further 24 hours by completing Form 3B. The medical practitioner or AMHP must assess the person immediately before doing the extension and be satisfied that because of their condition the person needs to be detained further.
- 3.8.17 Further periods of detention can be authorised using the same process up to a maximum time of 72 hours from the commencement of the first Detention Order. In non-metropolitan areas where the referral is extended the detention can also be extended in 24 hour periods to a maximum of 144 hours (s. 28(3)).

- 3.8.18 The practitioner who makes a Detention Order must make sure that the detained person is given the opportunity, if they wish, to contact any carer, close family member, personal support person, a health professional who is currently providing the treatment or the Advocacy Service as soon as practicable after the order is made and at all reasonable times while the person is detained (s. 28(9)). Referred persons should be informed orally and given a pamphlet about the Advocacy Service and offered the opportunity to call the service if they wish. For people from CALD backgrounds the oral explanation and pamphlet needs to be in a language the person will be able to understand, using interpreters if required. This right should be made available as soon as practicable and at all reasonable times while the detention continues. For example, the person may be too unwell to use the phone in a reasonable way when first referred but as their condition improves they should be offered the opportunity to exercise this right. The Advocacy Service can provide advocacy over the phone and are required to visit or make contact with the referred person is detained within three days of a request (s. 357(1)).
- 3.8.19 If the referred person has not been taken to the authorised hospital or other place by the time a detention or continuation order expires, and if they are not detained under a transport order, then they cannot be held any longer even though the referral order may still be valid (s. 28(10)).
- 3.8.20 If the referral order expires before the person is taken to the authorised hospital or other place then the person cannot be detained any longer (s. 28(11)). While a referral order in the metropolitan area cannot be extended, it is possible where appropriate and after a further assessment for a new referral order to be made when an order expires. However, repeat referral orders are contrary to the spirit of the Act as the underlying reason for a referral is that there is some urgency for the patient to be examined by a psychiatrist. If a new referral order is made following a previous order expiring, the reasons should be justified and well documented as the matter may arise at review by the Tribunal.
- 3.8.21 If a referred person who was subject to a Detention Order is released a close family member or other personal support person needs to be notified. At times it may be advisable to request that the voluntary patient remain until collected by a carer or relative (s. 28(12)) (see 1.24).

3.9 Emergency psychiatric treatment for referred persons (Part 14 Division 2)

Note: Emergency psychiatric treatment (EPT) provides more specific statutory protection for staff than a generic duty of care. It is particularly important to consider the use of EPT rather than duty of care if EPT is provided within an authorised hospital.

- 3.9.1 At any time during the referral process, the referred person may require treatment such as medication to manage their distress, their symptoms or their behaviour. Referred persons can be offered treatment and if they provide informed consent to the treatment then it is not deemed to be EPT.
- 3.9.2 If a referred person refuses treatment or is unable to consent because of their mental state and they meet the criteria for EPT then they can be provided with treatment without their consent (s. 203).
- 3.9.3 The criteria for EPT is that the treatment is needed to either save the person's life or prevent the person from behaving in a way that is likely to result in serious physical injury to the person or another person (s. 202(1)). EPT cannot be given just because the clinician feels it is appropriate to commence treatment before the person is made an involuntary patient.
- 3.9.4 Referred persons are deemed to be voluntary patients and therefore can refuse treatment, so EPT can only be given if the criteria are met.
- 3.9.5 In the majority of cases where EPT is provided, the treatment is psychotropic medication. EPT does not include regulated treatments such as ECT, or psychosurgery, or mental health interventions such as seclusion or restraint (s. 202(2)). It also does not include treatment for a medical condition, which can be provided in an emergency under duty of care or the Guardianship and Administration Act, Section 110ZI or 110ZIA.
- 3.9.6 The medical practitioner who provides the treatment must as soon as is practicable, record that EPT was provided and complete an EPT form (Form 9A) (s. 204). The form will include:
- a) the name of the referred person provided with the treatment
 - b) the name and qualifications of the practitioner who provided the treatment
 - c) the names of any other people involved in providing the treatment including staff, who may have been involved in restraining the person for the treatment to be given
 - d) the date, time and place of when the treatment was provided
 - e) particulars of the circumstances of why the EPT was required
 - f) particulars of the actual treatment provided, such as the type of medication.
- 3.9.7 A copy of the Form 9A must be given to the referred person, and a copy sent to the Chief Psychiatrist and, if the person is a mentally impaired accused (MIA), the Mentally Impaired Accused Review Board (s. 204(1)).
- 3.9.8 If the EPT occurs within an authorised hospital, for example to a voluntary patient being referred (see 3.12), and the person needs to be restrained for the treatment to be given then that is deemed as 'bodily restraint' and the Restraint Form 10A or B needs to be completed. This is not required for a restraint external to an authorised hospital.

- 3.9.9 EPT can also be given to any voluntary patient who has not been referred, for example a patient in an ED or any hospital who becomes behaviourally disturbed and meets the criteria for EPT. In any of those situations the process described above applies.

3.10 Transport orders (Part 10)

- 3.10.1 A transport order should only be made if assistance is needed from either a police officer or a transport officer to take the referred person to an authorised hospital or other place for examination by a psychiatrist, because of the referred person's condition and where no other safe means of transport is reasonably available (s. 29).
- 3.10.2 A transport order should never be automatically completed just because a referral order or detention order is made. An independent judgement needs to be made by the referrer as to whether a police officer or transport officer is needed.
- 3.10.3 If transport can be safely provided by the hospital or community staff, perhaps with the assistance of a relative or ambulance service then that is the preferred, less restrictive process for transporting a referred person. There is no requirement for a transport order if the person can be safely transported by the ambulance service without assistance from the police or transport officer. Similarly there is no requirement under the Act for transport by the Royal Flying Doctor Service (RFDS) to always include a transport order. If a patient can be transported by RFDS without police or transport officer assistance, then that is preferred.
- 3.10.4 If a transport order is needed the referring practitioner must complete a transport order form (Form 4A) (s. 148) which specifies:
- a) the name of the person to be transported
 - b) the place they will be transported from and the name of the authorised hospital or other place the person is being transported to
 - c) the reasons why a transport order is necessary
 - d) whether the order will be carried out by a police officer or transport officer
 - e) if it is a police officer, why it cannot be done by a transport officer
 - f) the date and time when the order was made and will expire
 - g) whether the order can be extended because the referral is from a place outside the metropolitan area
 - h) the name and qualifications of the practitioner who made the order.
- 3.10.5 To facilitate safe transport it is appropriate for the clinician to inform the police officer or transport officer of any clinical issues such as a medical or psychiatric condition or other relevant background information.

- 3.10.6 Clinicians should be aware that the transport order when used for a referred person will lapse at the same time the referral order lapses or when the extension of the referral order lapses (s. 150(2)).
- 3.10.7 Authorising a police officer to assist with transport should only be done if there is significant risk of serious harm to the person being transported or another person, or a transport officer is not available to carry out the transport within a reasonable time and any delay is likely to pose a significant risk to the person or another person.
- 3.10.8 The use of transport officers outside the metropolitan area is severely restricted so it is expected that police officers will continue to be used for transport from rural areas to the metropolitan area or between rural areas.
- 3.10.9 Police officers and transport officers are authorised to use reasonable force when apprehending and transporting a referred person (s. 172) (see 3.8.10 and 3.8.11).
- 3.10.10 The transport order authorises the police officer or transport officer to apprehend the person and take them as soon as is practicable to the authorised hospital or other place, and before the referral form expires (s. 149). A transport officer can enter residential premises at any time but only with the consent of the person to be apprehended or the occupier or person in charge of the premises or premises other than residential premises at any time without the consent of any person (Regulation 8)
- 3.10.11 If the referral is from a non-metropolitan area and the police officer or transport officer is of the opinion that the transport order will not be valid because the referral order will expire, then he or she may verbally request an extension of the referral order from a medical practitioner or AMHP. The practitioner may extend the referral order for no longer than 72 hours from the time the order would expire by completing Form 1B and any Transport Order is automatically extended to the life of the referral order. A copy of the extension needs to be placed in the person's medical record and a copy offered to the patient.
- 3.10.12 If a referral order is revoked or expires then the transport order is also revoked (s. 153). A transport order can also be revoked, even though the referral continues, when assistance by a police officer or transport officer is no longer needed. A medical practitioner, AMHP or mental health practitioner can revoke a transport order by making a revocation order (Form 3A). The order needs to specify the date and time the revocation order was completed and the reason for the revocation. A copy must be put in the patient's medical record, a copy given to the patient and a copy given to the police officer or transport officer who was to carry out the transport (s. 154).
- 3.10.13 If a transport order is revoked or expires while the person is being transported, the police officer or transport officer must take reasonable steps to make sure that the person is taken at their request to either the place

where the person was transported from or to another place reasonably nominated by the person (s. 155).

3.11 Changing place where examination will be conducted

- 3.11.1 At times a patient may be referred to a particular authorised hospital or other place and for a number of reasons that place may not be able to receive the person or is inappropriate for the person. For example a referral order may be made to a particular authorised hospital, but in the time following the referral it may become clear that referral should be made to another place such as an ED or another authorised hospital. Bed availability and the patient's medical condition are two dynamic factors which could lead to a different destination being required.
- 3.11.2 In those circumstances the medical practitioner or AMHP must consult with clinicians at the new destination, and where appropriate receive advice from the bed-flow service, and change the place where the psychiatric examination will take place by completing Form 1B (s. 46(1)).
- 3.11.3 The patient, personal support person as well as those involved in transporting the person need to be informed of the new destination and a copy of the form given to the patient and placed in the patient's medical record (s. 46(3)).

3.12 Detaining a voluntary patient in an authorised hospital (Part 2, Division 2, Subdivision 2)

- 3.12.1 While a voluntary patient in an authorised hospital has the right to leave at any time there may be occasions when it is unsafe for the patient, or perhaps other people, for the patient to exercise that right. For example the patient may have received news of a distressing nature which may lead them to want to leave the hospital and behave in a way that would place their own or another person's health or safety at risk. In those circumstances prompt action may be needed to prevent the patient from leaving and placing themselves or others at risk.
- 3.12.2 If a voluntary patient, and that includes a patient on a CTO which has been suspended because the person is a voluntary inpatient, wants to leave the authorised hospital against medical advice and the person in charge of the ward reasonably suspects that the patient is in need of an involuntary treatment order, then that person can make an order for the person to be detained at the hospital for up to 6 hours in order for an assessment to be conducted (s. 34(1)).
- 3.12.3 The person in charge of the ward will usually be a senior mental health nurse who would qualify as a mental health practitioner as they would have at least 3 years' experience in the management of people experiencing mental illness. At times, perhaps during a lunch break, the person temporarily in charge of the ward might be a nurse who does not qualify as a mental health practitioner. However, for the period of time the person is in charge of the

ward they can detain the voluntary patient. Good clinical practice should mean that if there is time and the person in charge of the ward is not a mental health practitioner they should try and consult with a mental health practitioner before taking action. If it is an emergency situation then the person in charge should detain the patient in the best interests and safety of the patient or others.

- 3.12.4 The person in charge of the ward completes a form (Form 2) which specifies the date and time the order was made, the reasons for making it and their own name and qualifications (s. 34(2)). A copy of the form must be given to the patient (s. 34(4)).
- 3.12.5 The assessment must be done by either a medical practitioner or AMHP within 6 hours of the order coming into force. If the assessment has not been completed within that timeframe the person must be allowed to leave the hospital (s. 34(7)).
- 3.12.6 At any time before the assessment is conducted the person who made the order may revoke the order if they are satisfied that the patient is no longer in need of an involuntary order. The revocation (Form 2) must state the date and time of the revocation, the reasons for making the revocation, the name and qualifications of the person who made the order and the patient must be given a copy. For example, the person in charge of the ward may have acted hastily by completing a Form 2 and when a more senior mental health practitioner is available they may conduct a further assessment and decide that the person should not be detained and advise the person who made the order that the order should be revoked. Only the person who made the order can revoke the order so a more senior mental health practitioner can only provide what they believe is sound clinical advice (s. 35).
- 3.12.7 If the medical practitioner or AMHP who conducts the assessment suspect the patient meets the criteria for involuntary status, they may refer the patient for an examination by a psychiatrist at an authorised hospital within 24 hours from the time the detaining (6 hour) order was made Form 1A (s. 53(1)).
- 3.12.8 If while waiting for the examination by the psychiatrist the patient's mental state improves so that referral for examination is no longer necessary, the medical practitioner or AMHP who made the order, or another medical practitioner or AMHP can revoke the order by completing a Form 1A, and the patient may leave if they wish (s. 37).
- 3.12.9 If the revocation of a referral order is done by a practitioner who was not the referrer, they should consult the referrer about whether the referral should be revoked. If despite reasonable efforts to contact the referrer the practitioner could not be contacted then another medical practitioner or AMHP can revoke the order without consulting the referrer. Matters discussed at 3.6 are relevant to this decision.

- 3.12.10 The revocation must specify the date and time of the revocation, the reasons for the revocation, if the referrer was consulted, a record of that consultation and if the referrer could not be contacted then the efforts made to do so. A copy of the order must also be given to the patient (s. 37).

Chapter 4: Examinations and involuntary inpatient status (Parts 6, 7, 10, 11 and 12)

This chapter will consider examination by a psychiatrist at an authorised hospital or another place following a referral by a medical practitioner or AMHP, and also where there has been no specific referral. It will further explore the patient's journey as an involuntary detained patient.

4.1 Examination at an authorised hospital (Part 6, Division 3, Subdivision 1)

- 4.1.1 A person who is referred for an examination by a psychiatrist must be received at the authorised hospital and can be detained there for up to 24 hours for the examination to be conducted (s. 52(1)).
- 4.1.2 If the referred person is on a CTO then the CTO is suspended until the psychiatrist makes a decision following the psychiatric examination.
- 4.1.3 If the person referred is already a voluntary patient in an authorised hospital then the 24 hours commences immediately, minus the number of hours detained before the assessment was conducted (s. 53). For example if the person in charge of the ward detained a patient at 14.00 hours and the patient was assessed by a medical practitioner or AMHP at 16.00 hours and referred for an examination by a psychiatrist, the referral form would expire at 14.00 hours the next day.
- 4.1.4 After being received at the authorised hospital the person in charge of the ward must give the referred person the opportunity and the means, such as a telephone, to contact any carer, close family member, other personal support person, a health professional who is currently providing the person with treatment or the Mental Health Advocacy Service (Advocacy Service) as soon as practicable and at all reasonable times thereafter (s. 52(3) or 53(2)). The Advocacy Service pamphlet must be provided as well as the Referred Person's Rights pamphlet and these should be supported by a verbal explanation of rights and the assessment process. If the patient is too unwell to exercise this right when first received, then it should be provided at the first opportunity, when they are able to exercise this right. For people from CALD backgrounds the oral explanation and pamphlet needs to be in a language they can understand with use of interpreters if required.
- 4.1.5 Although the referred person can be detained in the authorised hospital that does not automatically imply that the person should be in a locked area of the ward. The principles relating to detention should be followed (see 3.8.7). Reasonable force can be used to detain a person and the people authorised to provide assistance under Section 172 are identified in Schedule 1 of the Mental Health Regulations 2015.
- 4.1.6 If the person is not examined by a psychiatrist within the timeframe they cannot be detained any longer (s. 52(4) or 53(3)). If the person was received at the authorised hospital or other place through a police referral, then the

police must be informed that they can no longer be detained. This is particularly important if the person had been arrested but the arrest put to one side because the person was in need of an immediate assessment by a medical practitioner or AMHP. In those circumstances the person can be detained until delivered into custody, which usually means the police will apprehend the patient and deal with the arrest issue (s. 96).

- 4.1.7 The psychiatric examination must be conducted in the least restrictive way and the psychiatrist and the referred person must be in one another's physical presence (s. 79).
- 4.1.8 If the referrer was a psychiatrist acting in the role of a medical practitioner then the examination must be conducted by another psychiatrist. In other words the referrer and the examining psychiatrist must be different clinicians (s. 78).
- 4.1.9 When conducting the examination the psychiatrist may use relevant and updated information from the patient's medical record, and information obtained directly from the person, or another person such as a carer, personal support person or previous treatment provider. In regard to Aboriginal people, information should also, where it is appropriate and practicable, be obtained from elders, traditional healers and Aboriginal mental health workers, or other significant people in the patient's community. However the decision about what to do cannot be based solely on information from the medical records or another person (s. 80).
- 4.1.10 After completing the examination the psychiatrist has 4 options (s. 54):
- a) Make an involuntary treatment order (Form 6A) authorising the person's detention at the authorised hospital for up to 21 days for an adult and 14 days for a child. If the person was on a CTO the CTO is automatically cancelled.
 - b) Make a CTO (Form 5A) which can last up to 3 months. If the person was already on a CTO then the new CTO supersedes the suspended CTO which is then automatically cancelled.
 - c) Make an order detaining the referred person for up to 72 hours from when they were received so that a further examination can be conducted (Form 3C). Extending the referral period can be done when it is uncertain if the patient will meet the criteria for involuntary status and a longer time frame is needed for that determination to be made.
 - d) Make an order that the person can no longer be detained (Form 3E). If the person was on a CTO the suspended CTO is no longer suspended and again comes into effect.
- 4.1.11 For option a) the psychiatrist must determine that the criteria for detained involuntary status (which is similar to the criteria for referral (see 3.4)) is met and a Form 6A must be completed. The form must specify the date and time the order was made, the reasons for making it, the qualifications of the psychiatrist making the order and when the order will expire - which for an

adult cannot be longer than 21 days and for a child 14 days from the time it was made. A copy of the order must be given to the patient and the Tribunal. The Advocacy Service also needs to be informed and provided with a copy of the order when a person is made a detained involuntary patient so they can make contact within 7 days for an adult and 24 hours for a child. Making a person a detained involuntary patient is an event that requires that the patient's personal support person be notified unless it is not in the person's best interests (see 1.24). The name and contact details of the personal support person who has been notified, must be provided if known, to the Mental Health Tribunal or Mental Health Advocacy Service or the MIA Board for a MIA patient. If no personal support person has been notified of the making, revocation or expiry of an involuntary treatment order then the MHT and Advocacy Service must be informed and the reasons for not notifying the personal support person.

- 4.1.12 For option b) the psychiatrist must determine that the criteria for making a person subject to a CTO are met, and Form 5A is completed. A copy must be given to the person and the Tribunal and the Advocacy Service so the Advocacy Service can contact the patient within 7 days for an adult and 24 hours for a child. If the person was already on a CTO they need to understand they are on a new CTO with possibly a different expiry date. Making a person subject to a CTO is an event that requires the person's personal support person be notified unless it is not in the person's best interests (see 1.24). For more information on CTOs see Chapter 5.
- 4.1.13 For option c) the psychiatrist must complete Form 3C, provide a copy to the patient, inform the Advocacy Service and notify a personal support person of the decision to extend the referral process (1.23). Before the order expires, which cannot be longer than 72 hours from when the person was received, the psychiatrist must conduct a further examination and choose either option a), b) or d) under 4.1.10. Whatever the decision the person's personal support person needs to be notified of the decision.
- 4.1.14 For option d) the psychiatrist must provide the patient with a copy of Form 3E (person released from detention), inform the Advocacy Service and notify a personal support person. If the person was referred following either apprehension or arrest by police, then the police must be informed that the person is no longer being detained. If the person was on a CTO which was suspended they need to understand that the CTO is no longer suspended and they are back on the original CTO.

4.2 Examination at a place that is not an authorised hospital (Part 6, Division 3, Subdivision 2)

- 4.2.1 A person may be referred to a place that is not an authorised hospital such as a general hospital, an Emergency Department (ED), a clinic or a rural nursing post. The Chief Psychiatrist provides guidelines on making decisions about

whether or not a place that is not an authorised hospital is an appropriate place to conduct an examination (Addendum 1b).

- 4.2.2 When referring a person to a place that is not an authorised hospital the referrer must make arrangements to enable the examination to be conducted at that place. This includes informing clinicians at the destination about the referral, providing information about the patient, and arranging for the patient to be examined by a psychiatrist. Failure to make these arrangements could result in poor clinical practice or referred patients being detained longer than necessary or being no longer detained because the referral order has lapsed.
- 4.2.3 The referred person should be received and detained at the place and the time noted as the psychiatrist must examine the referred person within 24 hours (s. 58). It is important to inform the psychiatrist as soon as possible to reduce unnecessary delay and to comply with the legislation.
- 4.2.4 In non-metropolitan areas an examination may be conducted using audio-visual (AV) means (video conferencing) if it is not practicable for the psychiatrist and patient to be in each other's presence (s. 79(3)). A health professional must be with the patient when an examination is conducted using AV means. A health professional is a medical practitioner, a nurse, an occupational therapist, a psychologist, a social worker and, if the patient being assessed is an Aboriginal person, then an Aboriginal or Torres Strait Islander mental health worker (s. 81) (see Addendum 7). The purpose of having a health professional with the patient is to support the patient and manage the AV equipment. There is nothing preventing the patient being supported by a relative or other support person as well.
- 4.2.5 The person should be given the opportunity to contact any carer, family member or personal support person as well as the Advocacy Service.
- 4.2.6 If the place where the person is to be examined is in a non-metropolitan area and it is not practicable to complete the examination with the 24 hour period, then the referred person can continue to be detained for a further 48 hours from the end of the 24 hours (s. 59(2)). This should be the exception rather than the rule as the delay will significantly impact on the patient and others important in the patient's life. If this option is used it must be justified and noted in the patient's medical record.
- 4.2.7 After completing the examination the psychiatrist can make 1 of 4 decisions (s. 61):
- a) Make an inpatient treatment order providing for the patient to be detained and treated in a general hospital (Form 6B). For further details of this option see 4.5.
 - b) Place the person on a CTO (Form 5A).
 - c) Refer the person on to an authorised hospital where they should be taken to as soon as practicable (Form 3D). If the person needs to be detained then matters detailed under 3.8 apply. If the person requires a transport order then

matters under 3.10 apply and a Form 3B needs to be completed. Once the person is received at an authorised hospital they can be detained for a further 24 hours to be examined by a psychiatrist.

d) Order that the person can no longer be detained (Form 3E).

- 4.2.8 Notification of a personal support person applies for any of the 4 decisions outlined above (s. 61(5)). The name and contact details of the personal support person who has been notified, must be provided if known, to the Mental Health Tribunal or Mental Health Advocacy Service or the MIA Board for a MIA patient. If no personal support person has been notified of the making, revocation or expiry of an involuntary treatment order then the MHT and Advocacy Service must be informed and the reasons for not notifying the personal support person.

4.3 Examination without referral (Part 6, Division 3, Subdivision 5)

- 4.3.1 Without a specific referral a psychiatrist can examine a patient and decide that the patient should be on a CTO (s. 75). This can be done at the usual consultation with a psychiatrist or if a psychiatrist examines a patient in another type of setting such as an ED or clinic.
- 4.3.2 If the patient needs referral for an examination by a psychiatrist in an authorised hospital or other place then the psychiatrist acting in the role of a medical practitioner can complete Form 1A and refer the person.
- 4.3.3 Psychiatrists cannot make a person a detained involuntary patient in an authorised hospital or a general hospital without a referral (Form 1A).
- 4.3.4 The examination can be done face-to-face or in non-metropolitan areas using AV means (video conferencing) if it is not practicable for the psychiatrist and patient to be in each other's presence. When using AV means health professional must be with the patient when an examination is conducted (s. 79(3)(c)). A health professional is a medical practitioner, a nurse, an occupational therapist, a psychologist, a social worker or, if the patient being assessed is an Aboriginal person, then an Aboriginal or Torres Strait Islander mental health worker (s. 4) (see Addendum 7). An examination in any authorised hospital including those in non-metropolitan areas must be done face-to-face.
- 4.3.5 Following the examination the psychiatrist may place the person on a CTO using a Form 5A, and all the matters as detailed in Chapter 5 apply.
- 4.3.6 All CTOs done without a referral order must be confirmed by a psychiatrist, or if another psychiatrist is not available a medical practitioner or AMHP within 72 hours (s. 76).
- 4.3.7 Confirming a CTO should be an independent review of the decision to place the person on a CTO. Although not legislated for it would be best practice for the confirming practitioner to examine the person, discuss the issues with significant others such as carers and relatives and reach a conclusion that

the patient meets the criteria for being on a CTO. Deviation from best practice may be appropriate in extenuating circumstances but would require clear documentation as to why this has occurred. A confirming examination can be done via AV means in non-metropolitan areas.

- 4.3.8 If the confirming practitioner does not believe that the criteria are met, he or she should not confirm the CTO and if an order is not confirmed the CTO immediately lapses.
- 4.3.9 It would not be acceptable for the psychiatrist to then request another practitioner to confirm the order.
- 4.3.10 A copy of Form 5A must be given to the patient, the Tribunal, so they can organise a review, and the Advocacy Service so that can make contact within 7 days for an adult and 24 hours for a child.

4.4 Detention at an authorised hospital (Part 7, Division 2)

- 4.4.1 The principles as set out in 3.8 apply to patients detained as involuntary patients at an authorised or general hospital.
- 4.4.2 Detention does not necessarily mean that a patient is kept in a secure part of the hospital and not allowed to leave. At times, if a patient is an absconding risk or very unwell they may need to be kept in a secure part of the hospital. However, being a detained involuntary patient does not mean the patient cannot be cared for in a less restrictive way such as in an open ward or allowed to leave the hospital for treatment or to visit the local shops. Patient safety is the overarching concern when deciding whether the involuntary detained patient is cared for in a less restrictive way.
- 4.4.3 The involuntary detained patient should be made aware of how long the detaining order will last. Although this is indicated on the ITO it would be good practice to inform the patient verbally. Patients should also be aware when the order will be reviewed and that should be done regularly. The need for detention often diminishes as the patient's mental state improves and the patient may still be an involuntary patient but be cared for in ways similar to voluntary patients.
- 4.4.4 If a person has improved to such a degree, consideration must be given as to the further need for involuntary status. It should be noted that a psychiatrist may make a person no longer involuntary or put them on a CTO (Form 5A) at any time and without the need for a further examination.
- 4.4.5 While it is an object of the Act to use the least restrictive option, it is the patient's health and safety which is paramount. At times, having gone down the pathway of least restriction, the patient's mental condition may deteriorate to the point where their recovery is impeded. More restriction may then be necessary. For example, a patient makes good progress in a secure unit but after moving to an open ward they gain access to illicit drugs or alcohol which exacerbates their mental illness symptoms. Often the patient's journey is not

a steady transition from illness to recovery and health, but an uneven progression.

4.5 Involuntary detained patient in a general hospital

- 4.5.1 A psychiatrist may make a person an involuntary detained patient in a general hospital, after completing Form 6B.
- 4.5.2 This option may be used because the medical condition of the patient poses a significant risk to their physical health and transport to, or treatment at an authorised hospital is not viable. For example, a patient has made a serious suicide attempt by cutting their wrists and the consequent blood loss leaves them physically at risk. In effect the patient needs physical treatment for their physical illness but also psychiatric treatment for their mental illness.
- 4.5.3 In such a situation the psychiatrist must contact the Chief Psychiatrist as approval by the Chief Psychiatrist is required before an order can be made. The Chief Psychiatrist will require detailed information either in a written or verbal form to determine his or her decision. The Chief Psychiatrist may delegate this power to the head of service.
- 4.5.4 If approval is given the person may be detained and treated as an involuntary patient in a general hospital and all the usual rights and restrictions apply as they would in an authorised hospital, except for the use of seclusion and bodily restraint.
- 4.5.5 If the Chief Psychiatrist does not approve the request, he or she will inform the psychiatrist who wished to make the order. The reasons for not approving could be that, in the Chief Psychiatrist's view, the patient could be taken to an authorised hospital or involuntary detained status in a general hospital is not required.
- 4.5.6 The purpose of the Chief Psychiatrist's approval is to ensure that only when the criteria is met that a person should be made an involuntary detained patient in a general hospital and not for other reasons such as convenience or to prevent admission to an authorised hospital. For example, a psychiatrist may be satisfied that involuntary detained status is needed to ensure treatment but may be prevailed upon by relatives not to transport the person away from their local community for that treatment to be provided. The psychiatrist may see this option of making the person an involuntary detained patient in a general hospital as an alternative to providing treatment through detention but this would be an incorrect use of this option. That is not the purpose of this option. The person must have a significant physical illness which prevents transport or treatment in an authorised hospital. Misuse of this option will place a burden on general hospitals that may not have the ability to manage patients with challenging behaviours or place them in seclusion or restraint. It should be noted that seclusion and restraint as provided for under the Act are only available as interventions in an authorised hospital.

- 4.5.7 It is recognised that this detaining option will place an additional responsibility on general hospitals particularly the smaller rural hospitals where providing staff to manage detained involuntary patients might be problematic. At times the management of an involuntary detained patient in a general hospital may require extra resources such as nurse specials or the involvement of security staff, however it would not be significantly different from the expectations that general hospitals already have in caring for people with a physical and mental illness. This detaining option just provides additional legislative power to detain and provide treatment without the need for consent.
- 4.5.8 Treatment in this context, which can be given without consent, applies to a treatment for mental illness or treatment for a physical illness which is a consequence of a mental illness. However, despite this power clinicians should always seek consent first as the least restrictive way of providing treatment. (For more information on treatment see Chapter 6). The provision of treatment for a physical illness which is not a consequence of a mental illness can only be given with the consent of the person or, for a child under 18, a person prescribed by law such as a guardian or a parent.
- 4.5.9 If the Chief Psychiatrist gives approval for an involuntary detained treatment order the psychiatrist may make an order (Form 6B) for an adult for up to 21 days and for a child for up to 14 days (s. 87). All the usual responsibilities that apply to an involuntary detained patient in an authorised hospital apply also in a general hospital with the extra requirement that a report must be provided to the Chief Psychiatrist every 7 days using the attachment to Form 6B. This report documents the mental and physical condition of the patient and any treatment, physical or psychiatric, being provided (s. 65).
- 4.5.10 Once the psychiatrist is satisfied that attempting to take the patient to an authorised hospital no longer poses a risk to the patient's physical health, then he or she may complete a transfer order authorising the transfer to an authorised hospital. In making this decision the psychiatrist may consult with any other medical or health care provider who has been involved in the physical care of the patient (s. 66).
- 4.5.11 The transfer order (Form 4C) needs to be completed and if required a transport order (Form 4A) may also be made requesting the assistance of the police or a transport officer. Where Transport Orders are used for transfers from non-metropolitan areas and the Transport Order may expire before the destination is reached (72 hours) then the persons involved in the transport can request from a medical practitioner, an AMHP or a mental health practitioner an extension of the Transport Order (Form 4B).
- 4.5.12 If a patient is transferred, the patient's personal support person must be notified unless it is not in the patient's best interests (see 1.24).
- 4.5.13 If the patient was made an involuntary detained patient in a general hospital following an AV examination and there has been no face-to-face examination in the meantime, then within 24 hours of being received at the authorised

hospital the inpatient order must be confirmed, following a face-to-face examination by a psychiatrist and by completing a Form 6D. The patient's personal support person must be notified of the confirmation unless it is not in the patient's best interests (see 1.24).

4.6 Continuation orders

- 4.6.1 A psychiatrist, on the day an initial order expires or within the last 7 days of an initial detaining order expiring, must examine the involuntary detained patient and decide whether to continue the order once the order expires, place the person on a CTO (Form 5A) which can commence immediately or when the order expires, or make the person no longer involuntary immediately, or when the order expires (Form 6A) (s. 89). If the order is revoked or expires and the patient released a personal support person must be notified.
- 4.6.2 If the decision is to continue the order, a continuation order (Form 6C) must be completed, a copy given to the patient, and a copy put in the patient's medical record. It would be good practice to explain to the patient why the continuation order is needed, when reviews of the order will be conducted and when the order will lapse.
- 4.6.3 Making a person subject to a continuation order is an event that requires the Tribunal and Advocacy Service be notified.
- 4.6.4 A continuation order cannot be longer than, for an adult, 3 months and for a child, 28 days. Before the expiry of a continuation order or any further continuation order, the psychiatrist must examine the patient again within 7 days of the order being due to expire and decide whether to complete a further continuation order (Form 6C), make the patient subject to a CTO (Form 5A) or make the patient no longer involuntary (Form 6A).
- 4.6.5 At any time and without examining the patient a psychiatrist may make an involuntary detained patient subject to a CTO, or make them no longer involuntary. Any of those decisions is an event that requires that a personal support person be notified unless it is not in the patient's best interests (s. 90) (see 1.24).

4.7 Transfer between authorised hospitals

- 4.7.1 At times it may be necessary to transfer a detained involuntary patient from one authorised hospital to another for a number of reasons. These include that the patient wishes to be closer to their home and community, or more specific management of their treatment is required, or because the patient might have been admitted to a non-catchment area hospital and now needs to be treated in the catchment area hospital.
- 4.7.2 The treating psychiatrist or, if the treating psychiatrist is not reasonably available, another psychiatrist can make a transfer order (Form 4C) authorising the transfer of an involuntary detained patient from one authorised hospital to another (s. 91).

- 4.7.3 Prior to any transfer there must be contact between the two hospitals and suitable arrangements made for the receipt of the patient and transfer of care to a new treating team.
- 4.7.4 A copy of the transfer order (Form 4C) must be given to the patient and a copy placed in the patient's medical records.
- 4.7.5 The decision to transfer a patient from one authorised hospital to another is an event that requires that a personal support person be notified unless it is not in the patient's best interests (see 1.24).
- 4.7.6 It is also important to notify the Tribunal so any scheduled review can be rearranged at the other hospital.
- 4.7.7 A psychiatrist can also make a transport order (Form 4A) if the condition of the patient is such that police or transport officer assistance is required (s. 92). Where Transport Orders are used for transfers from non-metropolitan areas and the Transport Order may expire before the destination is reached (72 hours) then the persons involved in the transport can request from a medical practitioner, an AMHP or a mental health practitioner an extension of the Transport Order (Form 4B).

4.8 Release from hospital or other place

- 4.8.1 The Act makes clear that when a person or a patient cannot be legally detained they must be informed of that and allowed to leave (s. 95).
- 4.8.2 Those occasions include when an order expires, or when an order is made that makes the person no longer an involuntary detained patient, or when a patient who is on a CTO which has been suspended reverts back to being again on a CTO.
- 4.8.3 The person must be advised in writing, for example being given a copy of Form 6A or in regard to a CTO being advised that they are now again on a CTO. It would be good practice to provide a copy of the original Form 5A to the patient.
- 4.8.4 If the person has already left the hospital or other place before getting the form, a record of when they left as well as a copy of the form must be placed in the patient's medical record. It would be good practice to forward a copy of the form to the patient at the discharge address.
- 4.8.5 If the person is on an order under the law of the Commonwealth or state or territory requiring them to be kept in custody, they must not be allowed to leave until they have been delivered into that custody. For example, if the patient is a prisoner on an involuntary order, just because the order lapses or the patient is made no longer involuntary, this should not mean the person is released. The prison service needs to be informed so that a decision may be made about returning the prisoner to lawful custody (s. 96).

4.9 Leave of absence

- 4.9.1 Being allowed leave from the hospital while still an involuntary patient is a common occurrence and can be done if the psychiatrist is satisfied that granting leave will either be likely to benefit the involuntary patient's recovery or mental health in some way, or enable the patient to obtain medical or surgical treatment which is likely to benefit the patient's physical health. For example, an Aboriginal patient might be granted leave for cultural reasons (s. 105).
- 4.9.2 Granting leave must be consistent with the patient's need to be provided with treatment. If the purpose of granting leave is to see how a patient will cope at home or in a hostel, for example, it is important to ensure that treatment will continue in the community. Although the person may be an inpatient of an authorised hospital, community mental health services will be expected to provide treatment and contact while the patient is on leave. Even though the patient is not being detained in an authorised hospital the obligation to receive treatment continues because the person is still an involuntary patient.
- 4.9.3 An involuntary detained patient may also be granted leave because they have a significant physical illness which needs treatment in a general hospital. For this type of leave no approval is required from the Chief Psychiatrist. Even though, when granted leave for this reason, they are no longer in the authorised hospital they are still an involuntary patient and obliged to accept psychiatric treatment and must not leave without permission. If they do leave without permission they will be deemed to be absent without leave and an apprehension and return order may need to be made (s. 98). Staff in the general hospital need to be aware of these responsibilities in relation to involuntary patients (see 4.5).
- 4.9.4 If the patient is a child the psychiatrist must consult and inform their parent or guardian before granting leave (s. 105(2)).
- 4.9.5 The psychiatrist must also consult with the patient's carer or close family member unless the patient does not consent to them being consulted, the patient has the capacity to make those sorts of decisions, and the psychiatrist considers that to be reasonable. The psychiatrist may provide information if he or she feels that the patient's refusal to consent is unreasonable. For example, a patient requires surgical treatment for an ulcer in a general hospital but does not want their carer to be informed. However the post-surgical treatment includes dietary restrictions and medication. The psychiatrist may deem the patient's refusal to consent as unreasonable as it will directly affect their care once discharged, and therefore it is important for the carer to be informed.
- 4.9.6 In relation to a patient who lacks capacity the psychiatrist must consult with the carer or close family member unless he or she feels that is not in the patient's best interests. The decision must be documented on the patient's medical record. If prior to this the carer or close family member has specifically asked that they be consulted and the psychiatrist has decided not

to consult them, the psychiatrist must tell the carer or close family member that they are not being consulted and the reasons for the decision. If the carer or close family member wishes to have that in writing the psychiatrist must comply with the request. The written information needs to be in a language, form of communication and terms that the carer is likely to understand. In some situations an interpreter may be needed. For more information see 1.22- Recognition of the rights of carers and families.

- 4.9.7 The psychiatrist must also consult with the nominated person unless he or she believes that it is not in the patient's best interests for the nominated person to be consulted. If the nominated person has previously specifically requested to be consulted then the psychiatrist must inform the nominated person that they are not being consulted and the reason for that. If the nominated person wishes to have that in writing the psychiatrist must comply in a similar way to a carer or close family member being informed under 4.9.5. For more information see 1.15 - Nominated person.
- 4.9.8 All efforts must be made to contact carers, parents, guardians, close family members and nominated persons. Efforts should continue until it is clear that these people either cannot be identified or are unable to be contacted. If that is the case the unsuccessful attempts should be noted in the patient's medical record. Good practice, from an administrative perspective, would be to obtain contact information for the important people in the patient's life at the time of admission so they can be easily notified.
- 4.9.9 Before granting leave the psychiatrist must consider whether it would be more appropriate to either make the patient no longer an involuntary patient or place them on a CTO.
- 4.9.10 It is up to the psychiatrist to determine the period of leave, which should be noted on the leave form (Form 7A).
- 4.9.11 If the period of leave is longer than 21 consecutive days the psychiatrist must consider whether it would be more appropriate for the patient to be made no longer involuntary, or placed on a CTO. In coming to that decision the psychiatrist may make enquiries, for example with the patient's relatives or the community mental health service (s. 108).
- 4.9.12 The psychiatrist can impose specific conditions on the leave of absence. They can require the patient to reside in a particular place, receive specific treatment or attend a particular place such as the community mental health service and remain there until they receive treatment.
- 4.9.13 The patient will be given a Form 7A which will detail the period of leave, the reasons for granting leave and any conditions imposed. There is an expectation that the patient will comply with any conditions imposed and with any change of conditions (s. 107).
- 4.9.14 Granting leave is an event that requires that the patient's personal support person be notified unless it is not in the patient's best interests (see 1.24).

Information about the conditions of leave should also be provided (s. 105(13)).

- 4.9.15 While a patient is on leave the psychiatrist can extend the leave of absence or change the conditions (Form 7B), such as where the patient is to stay or where they must report to (s. 106). No specific time period is given for an extension of leave but the psychiatrist must, at least every 21 days, consider whether it would be better to make the person no longer involuntary or put them on a CTO. Form 7B will indicate the period of any extension or the changes to the conditions and the patient must be given a copy of that form. Extending leave or changing conditions are events that require that the person's personal support person be notified unless it is not in the person's best interests (see 1.24). It would be good practice to have a 'leave plan' which will indicate how leave is monitored.
- 4.9.16 While a psychiatrist can make a patient no longer involuntary or place them on a CTO at any time, he or she can also receive information from a medical practitioner or mental health practitioner indicating that the person is no longer in need of an inpatient order. On that basis, and without examining the patient, the psychiatrist can change the patient's status to no longer involuntary (Form 6A) or subject to a CTO (Form 5A). There is no obligation on the psychiatrist to follow this advice but a copy of the advice must be placed in the patient's medical record.
- 4.9.17 While the patient is on leave the psychiatrist may form the reasonable belief that the patient should return to the authorised hospital. This usually comes about when the psychiatrist has been provided with information from the mental health service or a carer or family member or even in some situations the police. For example, the patient on leave decides not to keep to the conditions of leave, or be non-compliant with their medication, or decide to leave the place they are residing. In those circumstances the psychiatrist can cancel the leave by completing a Form 7C (s. 110). The form details when and why the leave was cancelled and orders the patient to return to the authorised hospital. The patient can be informed orally for example by telephone or via a visit from the community mental health service however they must at some point also be given a copy of the Leave Cancellation Form (Form 7C). The local mental health service should also be aware when leave is cancelled so they can assist the patient's return to the authorised hospital. If the patient ignores the cancellation they may be considered to be absent without leave. Cancelling leave is an event that requires that the patient's personal support person be notified unless it is not in the patient's best interests (see 1.24).

4.10 Absence without leave (Part 7, Division 5)

- 4.10.1 These rules apply to:

- a) a referred person who has been detained under a Detention Order and who leaves without permission an authorised hospital or another place such as an ED including while being transported
 - b) an involuntary detained patient who leaves an authorised hospital without permission
 - c) an involuntary detained patient who leaves a general hospital without permission
 - d) an involuntary detained patient who refuses to return from leave when leave is either cancelled or expires.
- 4.10.2 A referred person or a patient being absent without leave is an event that requires that the patient's personal support person be notified unless it is not in the patient's best interests (see 1.24).
- 4.10.3 Every effort should be made to return the patient to the authorised hospital before an apprehension and return order is made. For instance, where a patient has wandered away from an authorised hospital while on ground leave, or is unaware of when leave expired, or is unaware the leave was cancelled, making an apprehension and return order should never be an automatic response. Even if the patient leaves without permission on purpose, or refuses to return to the authorised hospital, all efforts should be made, including using family and friends or the local mental health service, to contact the patient and persuade them to return before completing an apprehension and return order. For example a further assessment conducted by a community clinician might indicate that the person does not need to be an involuntary detained patient any longer – with consultation with the psychiatrist at the authorised hospital. This is one area of the Act where the principle of least restriction really applies. Caution is required because carrying out an apprehension and return order, while it may be necessary can also be traumatic for the patient, the family and the staff conducting the apprehension and return.
- 4.10.4 If it is clear that there is no lesser restrictive way or safe means of returning the patient to the place of examination or the authorised (or general) hospital then either the person in charge of the hospital or a medical practitioner can make an Apprehension and Return Order.
- 4.10.5 To make an Apprehension and Return Order, Form 7D needs to be completed which includes the reason for making the order. Further information to assist the process should also be provided. This form authorises a police officer or a person prescribed by the Regulations (transport officer /staff member of a mental health service) to find and return the patient to the hospital or other place indicated on the form, which may not be the hospital from which the patient is absent without leave. For example a patient is on leave in a rural area from a metropolitan hospital and decides to ignore the cancellation of leave. Then it is more appropriate for the patient to

be returned to a local authorised hospital or other place. A further assessment can occur at that place which could determine if the patient needs to be returned to the metropolitan authorised hospital or not.

4.10.6 An Apprehension and Return Order lasts for 14 days and cannot be extended (s. 100). If not acted on within that time or if the patient cannot be found then a new assessment of the need for a further apprehension and return order needs to occur. While a new apprehension and return order can be completed, it would not be in the spirit of the Act to do so without a thorough review of and proper justification for the new order. Patient safety is paramount and if that is not a significant issue, it may not be appropriate for a further order to be made.

4.10.7 If an Apprehension and Return Order is no longer needed the order can be revoked by the person in charge of the hospital or other place by completing the revocation part of Form 7D. The police or whoever was involved in returning the patient must be informed and if the patient is already in transit whoever apprehended the patient should either return them to the place where they were apprehended or to a place reasonably chosen by the patient. However the police or person who apprehended the patient should not take the patient back, even at the patient's request, if to do so would pose a serious risk to the patient or another person. This is a judgement call for the police or person who apprehended the patient. For example, if the patient is intoxicated and they request to be transported back to a place where more alcohol can be consumed, this could be refused by the apprehender.

4.11 Search and seizure (Part 11, Division 2)

4.11.1 The power of search and seizure is available to the police having apprehended a person and to a person authorised by the Regulations (s. 162). All hospitals or mental health services should have policies and procedures regarding search and seizure which sit alongside these legal requirements.

4.11.2 Search and seizure powers should be used with discretion and never as a routine procedure. Referring a person to be examined by a psychiatrist or making them an involuntary detained patient is not the same as arresting a person, or placing a person in custody. In most cases even with people who are significantly mentally unwell there would be no need to conduct a search or seize an article. The sort of things which could prompt a search are the previous history of the patient, being provided with information by a family member or carer, the patient acting in a suspicious way that they may be secreting an article that might compromise the health and safety of themselves or another person. For example if the patient has a history of taking overdoses of medication and they are assessed again because they appear distressed and possibly suicidal, then a search for any medication on them would be appropriate. The police or authorised person may use reasonable force when conducting a search (s. 172(2)). They also have a

power to ask another person to assist in the search and that person may also use reasonable force. For example, if the nurse is authorised then he or she may direct a security officer to assist in the search. However, it is the police or authorised person who is in charge and the person assisting must obey any lawful and reasonable directions from the person authorised (s. 173).

- 4.11.3 Search and seizure powers apply to voluntary and involuntary patients admitted to a hospital, referred persons whether detained at an authorised hospital or other place, or in fact any other person who presents at a mental health service which can include places such as an ED or a general ward (to the extent that the ward is providing mental health treatment to a patient). There are specific times when the powers are particularly relevant such as at time of admission, returning from leave or when providing treatment (s. 162).
- 4.11.4 A request to conduct a search, particularly if it is not routine, is usually viewed by the patient as an issue of trust and patients may feel offended and at times angry if asked to submit to a search. If routine searches are part of the ward practice, for example when returning from leave, patients should be made aware of the policy, perhaps at the time of admission or when going on leave, so that they understand the request is not a slur on their character. Patient's information pamphlets or a notice on a notice board about this policy can reduce any tension that might occur when a search is requested. Clinicians should be aware of trauma-informed principles when conducting a search, particularly in relation to people from CALD backgrounds.
- 4.11.5 Before the search is conducted the person who will conduct the search must, if reasonably practicable, identify him or herself and the position they hold, tell the person the reason for the search and ask the person to consent to the search. The preferred way to manage a search is to request cooperation from the patient, such as asking them to empty their own pockets or remove an article of outer clothing. Staff members can examine what is in a suitcase, backpack or handbag (s. 163).
- 4.11.6 While the search and seizure powers apply to any admitted or detained patient, the approach in relation to voluntary patients who can be searched without their consent needs to be circumspect. If a voluntary patient refuses to be searched, for example when returning from leave, and there are firm suspicions that the voluntary patient is carrying an article as detailed under 4.11.17, and the patient is absolutely refusing to be searched, they should be presented with the option of discharge if they maintain that position. Faced with that option and understanding the need for a search, most voluntary patients will probably comply with the request. If the risks related to discharge are too high consideration should be given as to whether the criteria for involuntary referral are met. A risk assessment may identify that the voluntary patient should be referred for an examination by a psychiatrist. A detained referred person can be searched without their specific consent. These issues can be complex and greatly depend on the relationship between the patient

and staff, however the safety of the patient and others is paramount in deciding how these situations should be managed.

- 4.11.7 If a visitor refuses to be searched and there is a significant risk that they may be bringing in alcohol, drugs, weapons or any other articles that may pose a risk to the health and safety of the patient, other patients or staff then the visitor can be refused entry. If they are already on the ward they can be asked to leave and that can be enforced by security staff. Confiscation of any article should be the last resort and only when patient or staff safety is severely compromised by the behavior of the visitor.
- 4.11.8 If a voluntary patient, involuntary patient or a referred person does not comply with the request to be searched then following a risk assessment, a search can be conducted without consent. Alternatively and if appropriate the patient could be discharged if they continue to refuse a search and the person does not meet the criteria for involuntary status. All steps should be taken to minimise confrontation in these situations. This could mean using particular staff who are familiar with the patient, involving carers, or close family members, or a nominated person before compulsion is used.
- 4.11.9 The person conducting the search should, if practicable, be of the same gender as the person being searched. At times there may be a male and female searcher and their approach should be sensitive to gender issues with males searching females being the exception and only if there are safety issues relevant. It would be good practice to delay a search, if practicable, in order to find an appropriate person to conduct the search.
- 4.11.10 A search can include scanning the person with an electronic or mechanical device.
- 4.11.11 A search can include removing a person's headwear such as a cap, gloves, footwear or outer clothing such as a coat in order to conduct a frisk search. This does not extend to inner clothing such as a shirt, blouse or trousers or underwear. Searchers should also be sensitive to whether it is appropriate to remove clothing of cultural or religious significance such as a scarf, a Kippah, yarmulke, Burqa or Nun's habit.
- 4.11.12 A frisk search is described as searching the person by quickly and methodically running the hands over the outside of the person's clothing (s. 163(4)(c)). Such a search could detect hidden weapons, bottles of medication, alcohol or packages of substances like drugs. However it is very limited in detecting smaller amounts of drugs or small weapons such as a knife. For more detailed searches it might be appropriate to use staff trained and competent in conducting searches.
- 4.11.13 If an article of clothing has been removed such as a jacket, then that article of clothing can be searched as well as anything carried by the person such as a backpack or handbag.

- 4.11.14 The searcher can ask the patient to remove anything themselves, as probing into clothing or luggage may injure the person conducting the search if a bag contains sharp objects. The searcher may also ask the patient to do anything reasonable to facilitate the search such as unzipping parts of clothing or luggage and emptying containers.
- 4.11.15 The searcher may photograph part or all of the search while it is being done (s. 163(5)(c)). This should not be a common practice but if the patient is known to be particularly litigious having a photographic record may assist. It would be appropriate to get the patient's consent to this process. Anything photographed needs to be verified as accurate by another staff member or the patient. Any photographic record should be kept in the patient's medical record and deleted from the camera.
- 4.11.16 Any search must be done as quickly as reasonably possible and not be more intrusive than is reasonably necessary (s. 163(6)). Clinicians should be aware that this is a particularly sensitive interference with the patient's right to privacy and should be conducted in the least intrusive manner possible.
- 4.11.17 If the search includes the searcher removing any clothing or article the patient has on them, they must tell the patient why it is necessary and the patient must be allowed to re-dress as soon as the search is finished. If it is not possible to return the clothing to the patient because for example the lining of a jacket needs to be searched then any clothing or footwear seized must be adequately replaced.
- 4.11.18 If found during a search the following items can be seized:
- a) an intoxicant such as alcohol
 - b) an intoxicating substance such as glue or petrol
 - c) an illicit drug such as marijuana or amphetamines
 - d) an article that may pose a serious risk to the health and safety of the person or other persons such as a weapon of any sort including articles such as razor blades or screwdrivers which can be used as weapons
 - e) any prescribed or non-prescribed drug which could be misused by the patient or other patients
 - f) an article that the person conducting the search believes is likely to assist in determining any question in relation to the patient that is likely to arise for determination under this Act. For example, the seizure of medication from a patient which is likely to inform the practitioner that they may be experiencing a mental illness and may be at risk.

Seized items will not be returned to the patient at this time and may in certain circumstances be dealt with according to the law.

- 4.11.19 Anything seized which is thought to be illegal such as a gun or drugs must be dealt with according to other laws about possession of illegal substances or firearms. In most circumstances it should be handed to the police.
- 4.11.20 Other articles seized need to be stored or managed by the health service responsible. For example, if the search is conducted before a person is transported to an authorised hospital then any articles need to be taken and stored at the authorised hospital.
- 4.11.21 The person who conducts the search must make a record of the search indicating when it was done, why it was done and what if anything was seized (Form 8A). Even if nothing is seized it would be good practice to complete the part of the Search and Seizure form which details the results of the search. A copy of the Form 8A must be placed in the patient's medical record, a copy given to the person in charge of the place where the search was conducted, a copy sent to the person in charge of the authorised hospital or other place (if a copy is in the medical record that would be sufficient), and to the person searched even if the referral is revoked or lapses and the person is not taken to the authorised hospital or other place.
- 4.11.22 If, for example, a search is conducted in a place such as an ED during a referral process and an article is seized, the article needs to be given to the referrer to deal with. If the person is released before transport to the authorised hospital or other place the article must be returned to the person released unless 4.11.24 applies.
- 4.11.23 If the person is released after being examined by a psychiatrist at an authorised hospital, or other place, or released following a period when they were detained at either an authorised or general hospital, then anything seized must be returned to them. Completion of Form 8A - Record of dealing with articles seized, and Form 8B - Record of return of articles seized, are required.
- 4.11.24 The exception in regard to 4.11.21 to 4.11.23 is that when it is the opinion of the person in charge of the hospital or other place that returning the article may pose a serious risk to the health or safety of themselves or another person. For example the patient has secreted a pocket knife which has been seized and even though they do not meet the criteria for referral or involuntary status the patient may still be angry with a close family member and may pose a threat to the family member's safety. In those circumstances the article may be given to a carer, close family member or other personal support person for safekeeping. If there is no-one appropriate who can take the article and it is not safe to return to the patient, the article may be stored at the health service and returned to the patient or family member at some point. If an article has been stored for more than 6 months the article may be destroyed, or otherwise disposed of, but only after all efforts are made to return the article to the patient or family member.

- 4.11.25 The Search and Seizure Form (Form 8A and 8B) must give details of the article seized, when it was returned to the patient, or family member and if not returned the reasons for that decision. If the article is destroyed or disposed of, when and how that happened.

Chapter 5: Community Treatment Orders (Part 8)

5.1 Background

- 5.1.1 Community Treatment Orders (CTOs) are a less restrictive form of involuntary order where a person experiencing mental illness does not need to be detained at an authorised or general hospital to be provided with treatment as an involuntary detained patient. While that might be the legal position and the patient can be provided with treatment without consent, it is also clear that a CTO cannot work unless there is some degree of cooperation between the patient and the treating team. There is also to some degree an aspect of coercion in the process in that if there is no cooperation and the patient meets the criteria for involuntary detained status then they may well be admitted to an authorised hospital and detained for treatment to be given.
- 5.1.2 Patients may be aware of having to make a compromise in accepting treatment in the community in preference to being detained at an authorised hospital and from the patient's perspective it may seem to be the lesser of two evils. There can be at times resentment and some discord due to the restrictive nature of the CTO and inevitably CTOs impact to some extent on the therapeutic relationship a mental health clinician has with a patient.
- 5.1.3 It is always preferable to work collaboratively with patients around planning for care and treatment. In that therapeutic engagement both the patient and the clinician can see the advantages of treatment and explore other psychosocial interventions which can support recovery. In many ways patients on CTOs are no different from voluntary community patients except that they are expected to keep to the terms of the CTO. These are essentially the care plan and if they choose not to cooperate it could result in them being made an involuntary detained patient. It is equally important to involve, listen to and communicate with carers, family members and personal support persons throughout the process of caring for a patient on a CTO.
- 5.1.4 While the Act details the legal actions that could be taken if a patient refuses to comply there is substantially more that can be done before breach proceedings or orders to attend are issued. From the commencement of a CTO there needs to be a clear understanding between the patient and the treating team as to the options available to the team if a patient does not cooperate. The responsible practitioner or another member of the team needs to spend time going through with the patient his or her responsibilities and rights under a CTO as well as the responsibilities and legal pathways for the treating team. Clarity at the commencement of an order may result in a much smoother process.

5.2 Making an order (Division 2)

- 5.2.1 Only a psychiatrist can make a person an involuntary patient on a CTO following an examination or in certain cases, where the CTO is a less

restrictive option, without an examination. A person can be placed on a CTO in the following circumstances:

- a) following a referral and examination at an authorised hospital
- b) following a referral and examination at another place
- c) following a referral and examination by audio-visual (AV) means in a non-metropolitan area
- d) following an examination without a referral with confirmation by another practitioner
- e) following an examination without a referral by AV means in a non-metropolitan area with confirmation by another practitioner
- f) following an examination while an involuntary detained patient at an authorised or general hospital
- g) at any time without an examination while an involuntary detained patient at an authorised or general hospital
- h) at any time with or without an examination while an involuntary detained patient is on leave

5.2.2 Before making a person subject to a CTO the psychiatrist must be satisfied that the person meets the following criteria (s. 25(2)):

- a) the person has a mental illness that needs treatment
- b) because of the mental illness, there is a significant risk to the health or safety of the person or to the safety of another person; or a significant risk of serious harm to the person or to another person; or a significant risk of the person suffering serious physical or mental deterioration
- c) the person does not demonstrate the capacity to make a treatment decision about the provision of the treatment to himself or herself
- d) that treatment in the community can be reasonably provided
- e) 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 a CTO.

5.2.3 In addition to meeting the criteria for a CTO the psychiatrist should only place a person on a CTO if suitable arrangements can be made for their treatment and care in the community, which includes arranging for a supervising psychiatrist and treating practitioner and perhaps also involving a carer or family member. However, if the person is going to live in such a remote area of the state that supervision is extremely difficult or if the person is itinerant and leads a nomadic life style placing them on a CTO may well be ineffective.

5.2.4 The CTO (Form 5A) includes:

- a) the name of the supervising psychiatrist

- b) the name of the medical practitioner or mental health practitioner who will be the treating practitioner, usually the case manager, and the supervising psychiatrist can fulfill both roles
- c) the date and time when the order was made as well as when the order will come into force which cannot be more than 7 days from when the order is made
- d) the treatment period which cannot be longer than 3 months
- e) that the patient notify the supervising psychiatrist or treating practitioner of any change of residential address
- f) that the patient notify the supervising psychiatrist or treating practitioner of any interstate or overseas travel at least 7 days before departure or if the patient needs to travel urgently as soon as it is practicable.

5.2.5 The supervising psychiatrist must ensure that, as soon as practicable and within 14 days from when the CTO was made, the patient is advised or notified in writing about the date, time and location of the first appointment. While this notification needs to occur within the first 14 days the patient is on the CTO, it does not mean the first appointment must occur within the first 14 days. This notification may require the relevant community mental health service to consult with the patient (and, where appropriate, carers or family members) as to a suitable time for this first appointment. While the notification must be in writing other means such as a visit to the patient's home may be used to ensure the patient is aware of these arrangements and will comply with this component of a CTO. If this notification does not occur the patient may well seek a review from the Mental Health Tribunal (Tribunal) on the basis that this failure impacted on his or her rights. This notification can be on the attachment to Form 5A – Terms of the CTO.

5.2.6 When a patient is being made subject to a CTO, a personal support person must be notified.

5.2.7 For the operation of interstate CTOs see Chapter 12.

5.3 Operation of order (Division 3)

5.3.1 The CTO management plan (Terms of the order) should be aligned with the treatment, support and discharge plan to which the patient, carers and significant others have input (see 1.13). That plan should outline the expectations of the service and the wishes of the patient and their carer or family members. Involving and consulting with carers and family members is an important component when developing a CTO plan. Failure to keep to the plan can result in the patient being detained. The service should make it clear that non-compliance may result in a breach or order to attend. The attachment to the Form 5A Terms of the CTO should be given to the patient.

5.3.2 The service should also recognise when drawing up the plan the limitations from the patient's and carer's perspective. For example if the patient has full-

time work expecting attendance at the clinic during working hours may be unrealistic. The plan needs to support the patient through their recovery journey and not be a hindrance to this. While medication may be essential to maintain mental health, equally important is being in and maintaining employment, earning a living, having a social life and being able to form relationships.

- 5.3.3 The plan is not limited to what is in the terms of the order but should be comprehensive from a biopsychosocial perspective. This could include issues related to alcohol and drugs, work, accommodation and social issues as well as treatment from other service providers, such as GPs and psychologists. The plan should be agreed on between the patient and the case manager and where appropriate involve the carer or family member.
- 5.3.4 The patient must be examined monthly as the minimum. The examination should take place within the 14 days before the month expires. For example if a patient was placed on a CTO on 1 May there needs to be an examination by 1 June. That examination can be done any time between the 18 May and 1 June. If the examination was done on 20 May the next monthly examination needs to be by 20 June and can be any time between 7 June and 20 June. If the examination was done on 19 June then the next examination should be by 19 July and can be any time between 6 July and 19 July.
- 5.3.5 The examination should be done by the supervising psychiatrist. If the supervising psychiatrist is unavailable, he or she can request on a Form 5D that a medical practitioner or mental health practitioner conduct the examination and provide the supervising psychiatrist with a report. The supervising psychiatrist may ask that the examination consider specific issues, for example compliance with oral medication or information from a carer, family member or person support person. In most cases it may be appropriate for the treating practitioner (case manager) to conduct the examination.
- 5.3.6 The medical practitioner or mental health practitioner must provide the supervising psychiatrist with the written report and part of the report must address the issue of whether the person should still be on a CTO as the supervising psychiatrist needs to decide whether the CTO should continue or be revoked. A copy of the report must be filed in the patient's medical record.
- 5.3.7 Examinations must to be conducted monthly. At least 1 out of 3 of these examinations must be conducted by the supervising psychiatrist. The other 2 monthly examinations can be conducted by a medical practitioner or mental health practitioner.
- 5.3.8 Examinations should be face-to-face. However in non-metropolitan areas where it is not practicable to have a face-to-face examination the examination can be conducted using telephone or AV means. This can include where the patient is in a non-metropolitan area but the psychiatrist is in the metropolitan area. A health professional must be with the patient when an examination is

conducted using AV means. A health professional is a medical practitioner, a nurse, an occupational therapist, a psychologist a social worker and, if the patient being assessed is an Aboriginal person, an Aboriginal or Torres Strait Islander mental health worker.

5.3.9 Following an examination the supervising psychiatrist has 3 options:

- a) the patient continues on the CTO
- b) the CTO is revoked and the patient made an involuntary detained patient (Form 6A), but only if the examination is done by the supervising psychiatrist
- c) the CTO is revoked and the patient is made no longer an involuntary patient (Form 5B).

5.3.10 If option b) is chosen the examination must be face-to-face in the metropolitan area but can be by AV means in non-metropolitan areas (see Addendum 7). If the original CTO was made using AV means and the patient has not had a face-to-face examination with the supervising psychiatrist at any time since, then following receipt into the authorised hospital the revocation order must be confirmed within 24 hours. This is done by a psychiatrist examining the patient and completing a Form 6D. A personal support person must also be notified (1.24).

5.3.11 Arrangements to transport the patient to an authorised hospital need to be organised and assistance from the police or transport officers can be requested. Where it is safe and appropriate a carer, family member or personal support person could be involved in the transportation.

5.3.12 Alternatively, if a CTO needs to be revoked and the person detained at an authorised hospital and the supervising psychiatrist is not available to conduct an examination, a medical practitioner or AMHP can refer the person for an examination by a psychiatrist at an authorised hospital and the CTO is suspended (see Chapter 5).

5.3.13 If option c) is chosen the patient needs to be provided with a Form 5A indicating they are no longer on a CTO. A copy needs to be sent to the Tribunal and Advocacy Service and the personal support person must also be notified (see 1.24).

5.4 Continuing a Community Treatment Order (Division 3)

5.4.1 Following an examination, which in non-metropolitan areas can be by AV means, the supervising psychiatrist can continue a CTO for a further 3 month period if the criteria for continuing the CTO are met. The continuation order can be completed on or within 7 days before the day on which the existing order is due to expire. The examination by the psychiatrist can be before the 7 days though it would be good practice to conduct the examination as close to the expiry of the CTO as possible.

5.4.2 The continuation order (Form 5B) is for a period of up to 3 months and a copy of the order must be given to the patient.

- 5.4.3 The patient can at any time following a continuation order request in writing a further opinion about whether they should be on a CTO. The timeframe for responding to the request commences at the time the request is received by the mental health service. The request does not have to be immediately following a continuation order but any time during the next 3 months. How that opinion is obtained is similar to the processes of an involuntary detained patient requesting a further opinion (see 1.13).
- 5.4.4 The difference, with this request for a further opinion and one for someone on an inpatient order, is that the decision has a direct impact on whether the order continues and it must be obtained on or within 14 days from the time the request was received. If that does not occur then the CTO may cease to be valid unless the patient does not attend for the examination, then the order remains in force.
- 5.4.5 The implication is that the supervising psychiatrist or the Chief Psychiatrist (depending on who the request was made to) must organise the further opinion as soon as practicable in order for the opinion to be provided within that timeframe. The guidelines of the Chief Psychiatrist are relevant in undertaking this function (see Addendum 2(c)).
- 5.4.6 A CTO can be continued for further periods of up to 3 months with the same rules applying which are that the order can be completed up to 7 days before the order would end and the patient informed of the continuation through the provision of a continuation order (Form 5B). Unlike the 1996 Act the CTO can be continued past a second 3 month period for further periods of 3 months.

5.5 Varying a Community Treatment Order (Division 3)

- 5.5.1 The supervising psychiatrist can at any time vary the terms of the CTO. For example, make changes to the treatment plan or when and where the treatment is to be provided.
- 5.5.2 It is not expected that every change to how the patient is being treated and cared for needs a variation order (Form 5C). A change of appointment time or venue probably does not need a variation order. However change of medication or treating practitioner probably does. The variation form should be reserved for important issues where discussion alone is insufficient. With some patients who may be very reluctant to accept the conditions of a CTO it may be advisable to do a variation order for more minor variations.
- 5.5.3 Form 5C should note what the variation is (which should be discussed with the patient) why it is being done, and a copy given to the patient. More details of the variation should be in the patient's medical record.
- 5.5.4 At times a patient may move to a remote area of the state where supervision of a CTO may be problematic due to distance and difficulties in providing a service. The psychiatrist may feel that the expectations under section 114(b) - 'suitable arrangements can be made for the treatment and care of the person in the community' - cannot be met. In those circumstances it may be

appropriate to revoke the CTO and make the person a voluntary patient, not because the patient does not need treatment but rather because of the difficulties of providing that treatment. Before making the decision the psychiatrist should speak to the clinical director of the remote service.

5.6 Changing the supervising psychiatrist or treating practitioner (Division 6, s.135 (2)(3))

5.6.1 A supervising psychiatrist can transfer the care and treatment of a CTO patient to another psychiatrist after arranging the transfer with the other psychiatrist (Form 5C). This should be done if the supervising psychiatrist is leaving the service or taking leave of absence (even if it is for a short period) as it is important for the patient to know who is responsible for his or her care and treatment at all times. The patient must be informed about the transfer in writing.

5.6.2 The Chief Psychiatrist or a person authorised by the Chief Psychiatrist such as the psychiatrist in charge of a mental health service can also transfer the care and treatment of a CTO patient to another psychiatrist after arranging the transfer with the other psychiatrist. This may need to be done because the supervising psychiatrist has to take leave suddenly, for example because of illness, and has not had the time to transfer the patient to another psychiatrist. The person authorised by the Chief Psychiatrist is authorised in writing for a specific time period.

5.6.3 The supervising psychiatrist can transfer the responsibilities of a treating practitioner to another medical or mental health practitioner after arranging that transfer with the practitioner and the patient informed in writing (Form 5C).

5.7 Revocation of a Community Treatment Order and making an inpatient order (Division 3 and 4)

5.7.1 While on a CTO a patient may become unwell again, perhaps because they are not complying with their treatment or using other drugs which are interfering with the treatment. The Act provides various mechanisms and ways to revoke a CTO and get a patient back into an authorised hospital as a detained patient so they can receive treatment.

5.7.2 At any time after examining the patient the supervising psychiatrist can make the patient an involuntary detained patient as long as the patient meets the criteria (Form 6A).

5.7.3 In non-metropolitan areas where a face-to-face examination may not be possible the examination can be done by AV means if a health professional is with the patient (see 4.2.4).

5.7.4 For patients who are initially put on a CTO via AV means and have had no opportunity for any face-to-face examinations since then, if the CTO is revoked and the patient taken to an authorised hospital the inpatient order must be confirmed by a psychiatrist within 24 hours by completing a Form

6D. This is to ensure that there is always a face-to-face examination when a person is made an involuntary detained patient in an authorised hospital.

- 5.7.5 The patient does not have to be in breach of a CTO or subject to an order to attend for the psychiatrist to revoke the CTO. He or she can make an involuntary detaining order as long as the patient meets the criteria.
- 5.7.6 A personal support person must be notified that the patient has been made an involuntary detained patient (see 1.24).
- 5.7.7 If the supervising psychiatrist is not available to conduct an examination and a CTO needs to be revoked and the patient treated in an authorised hospital, a medical practitioner or AMHP can refer the patient (Form 1A) for an examination by a psychiatrist in an authorised hospital, in which case the CTO is automatically suspended.

5.8 Revocation of a Community Treatment Order and making the patient no longer involuntary (Division 3)

- 5.8.1 The psychiatrist can revoke a CTO and make the patient no longer involuntary at any time. This can happen based on an examination or on the advice of a medical practitioner or mental health practitioner or from what is recorded in the patient's medical record. The reasons could be that the patient no longer meets the criteria for involuntary status or has recovered sufficiently to no longer require compulsion.
- 5.8.2 To revoke a CTO the psychiatrist completes a Form 5A indicating that the patient is no longer an involuntary patient, and gives the patient a copy.
- 5.8.3 A personal support person must be notified that the patient has been made no longer an involuntary patient (see 1.24).
- 5.8.4 If an order expires the psychiatrist must inform the patient that they are no longer an involuntary patient. The best way is by completing Form 5A and providing it to the patient.

5.9 Breach of a Community Treatment Order (Division 4)

- 5.9.1 The introduction to this chapter (5.1 Background) noted that managing and working with a patient on a CTO is very different to treating a detained patient in an authorised hospital. Community Treatment Orders have a supervising psychiatrist and a case manager (treating practitioner) and a considerable effort is made to form and sustain a therapeutic relationship even though the patient is on a compulsory order. These relationships are impacted on by a number of factors, such the personality of the clinician and patient, the past history of the patient, resources available and how effective treatment is. These factors can influence how well the relationship works and inevitably at times there is a fluctuation in the relationship which needs to be managed in the best way for patient care. While the Act provides for breaching an order (which should really be a step taken only when all other avenues of compliance are explored), it is important to acknowledge that a breach will

always negatively affect the therapeutic relationship. It can lead to irritation and distress on the part of the patient and a feeling of frustration on the part of the clinician.

- 5.9.2 A breach is when a patient does not comply with the order - such as refusing medication or not attending at the clinic – even though the treating team have taken all reasonable steps to obtain compliance. What these reasonable steps are can differ from patient to patient and patient's wishes should be part of that consideration. Some patients may respond to a particular staff member or be willing to comply with different medication. Steps could also include looking at any circumstances that are impacting on compliance, such as the patient obtaining work and therefore being unable to attend the clinic during office hours.
- 5.9.3 If the psychiatrist feels that all reasonable steps have been taken and that there is a significant risk of the patient suffering serious physical or mental deterioration if their non-compliance continues, then a breach order may be used. If there is no significant risk despite the non-compliance then a breach order should not be taken. However, because non-compliance can lead to relapse it is important to closely monitor the patient through this period.
- 5.9.4 The breach order (Form 5E) should include details of the non-compliance, the steps that have been taken to obtain compliance, the reason and facts for believing there is significant risk of physical or mental deterioration, details of how the patient should comply and what might happen if non-compliance continues, such as the CTO being revoked and the patient detained in an authorised hospital or given an order to attend.
- 5.9.5 The patient needs to be given a copy of the order so that he or she can take steps to comply with the order. Any written order should also be accompanied either by a telephone call or a visit to give an oral explanation of what the breach means. Effective communication can prevent the situation escalating to an 'order to attend'. If the breach order cannot be personally delivered to a patient then alternatives such as leaving a letter at the patient's address should be considered. If this is not possible then a letter could be sent by mail.
- 5.9.6 How the patient is expected to comply should be clearly set out with specific instructions. For example, the patient could be asked to speak directly to their case manager and a telephone number provided, or to attend the clinic, or arrange a time for a home visit. The compliance process should not be made so difficult or impractical that the patient is bound to fail. There should be an appropriate time gap between the form being provided to the patient and when any further steps are taken, so that the patient is given every opportunity to comply.
- 5.9.7 If, despite all the steps the treating team take to obtain compliance, there continues to be non-compliance resulting in a significant risk of physical or mental deterioration then the psychiatrist can make an order to attend.

5.10 Order to attend (Division 4)

- 5.10.1 Making an order to attend (Form 5F) is a significant step in ensuring compliance with treatment and managing risk. However, it may also have a negative impact on the therapeutic relationship between the patient and the case manager.
- 5.10.2 An order to attend is given to the patient directing them to attend at a particular place and time in order to receive treatment. Any written order to attend should be accompanied by a telephone call or visit to where the patient is and an oral explanation given as to why the order to attend has been implemented. If the order cannot be personally delivered to a patient then alternatives such as leaving a letter at the patient's address should be considered. If this is not possible then a letter could be sent by mail. Involvement of carers or family members may assist in this process.
- 5.10.3 Patients may attend willingly, particularly if a consequence of not attending is that they will be apprehended by police. At this stage of the process there may be some degree of resistance on the part of a patient who has already demonstrated unwillingness to comply. Any direction to attend needs to be done with empathy using persuasion and providing an environment which allows any resistance to be resolved, minimised and managed.
- 5.10.4 The place where the treatment can be given should be a place where it is safe for that treatment (which is usually depot medication) to be provided such as a clinic, a hospital or a nursing post. While there is nothing in the legislation preventing the place being the person's home, the clinician should consider safety and confidentiality issues as well as the patient's dignity when using this option. For example, providing treatment such as depot medication at a hostel may be appropriate as long as there are conditions where such treatment can be given safely, in privacy and hygienically, while maintaining dignity.
- 5.10.5 When the treatment is to be given should be as specific as possible as the patient may well be dissatisfied at having to attend for treatment and being kept waiting for that treatment to be delivered. Poor planning by the mental health service may only exacerbate their feelings.
- 5.10.6 Patients should be given assistance and every opportunity to comply with an order to attend, and listening to the patient's and relatives' wishes would be advantageous for a successful outcome.
- 5.10.7 If a patient fails to comply with an order to attend the psychiatrist has 3 options.
- a) Make a transport order (72 hours)
 - i. This will authorise the police or a transport officer to apprehend the patient and bring them to a specified place for treatment and it should be noted that there is no requirement for the police to remain with the patient once received at the place for treatment.

- II. The place chosen needs to be where the patient can be detained so that the treatment can be provided. For example the place could be an Emergency Department where the patient can be received and detained.
- III. The patient can be detained for up to 6 hours, however, it would be preferable for the treatment to be provided as soon as practicable because it is likely the patient may become distressed having been apprehended.
- IV. Involvement of personal support person may assist in this process, and must be notified of a Transport Order.

b) Make the patient a detained involuntary patient

- I. If it is clear that just providing treatment will not be sufficient to manage the patient's mental illness or the patient fails to attend as directed, the psychiatrist can revoke the CTO and order that the patient be detained at an authorised hospital or with the Chief Psychiatrist's approval a general hospital.
- II. This can only be done following an examination by the psychiatrist and the examination can be done by AV means if the patient is in a non-metropolitan area and a face-to-face examination cannot be conducted. If the patient was originally put on a CTO by AV means and there has not been a face-to-face examination of the patient since then, if the CTO is revoked and the patient taken to an authorised hospital the inpatient order must be confirmed by a psychiatrist within 24 hours by completing a Form 6D. This is to ensure that there is always a face-to-face examination when a person is made an involuntary detained patient.
- III. However if the patient fails to attend and the psychiatrist is unable to carry out an examination then he or she cannot revoke the CTO and make the person an involuntary patient. In those circumstances and if the patient needs to be admitted to an authorised hospital, a medical practitioner or AMHP can, following an assessment, refer the patient for an examination by a psychiatrist at an authorised hospital.
- IV. If there is no safe means to get the patient to the authorised hospital the psychiatrist can complete a transport order authorising police or a transport officer to apprehend the patient and transport them to the authorised hospital.
- V. If this option of making the patient an involuntary detained patient and/or making a transport order is chosen the personal support person must be notified (see 1.24).

c) Revoke the CTO

- I. If the patient does not meet the criteria for involuntary status or suitable arrangements for the care and treatment of the person in the community cannot be made, the psychiatrist can make the person no longer an involuntary patient on a CTO by completing Form 5A.

- II. The patient and Tribunal and the Advocacy Service need to be informed of that decision.
- III. The personal support person must be notified of this decision (see 1.24).

Chapter 6: Treatment, electroconvulsive therapy, psychosurgery, mental health interventions and urgent non-psychiatric treatment (Part 13, 14 and 15)

6.1 Treatment for involuntary patients

- 6.1.1 Treatment means the provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness, but does not include bodily restraint, seclusion (which are deemed mental health interventions) or sterilisation.
- 6.1.2 Patients, carers and families often have concerns about involuntary treatment. Having an open dialogue with patients and carers about what the diagnosis might be and what evidence based treatments are available may address some of these concerns. Clear, jargon free explanations via face-to-face discussion as well as other means of communication such as pamphlets or peer educators will reduce the likelihood of dissatisfaction or concerns about treatment.
- 6.1.3 Allowing patient choice including consideration of any previously completed Advance Health Directive (AHD) as well as having a treatment plan which allows frequent opportunities for review and reconsideration of treatment, may, from the patient's perspective, be more satisfactory and possibly reduce dissatisfaction.
- 6.1.4 Even though a person is an involuntary patient, consent to treatment should still be sought and patient's wishes taken into account when making treatment decisions. This should extend to consulting with carers, family members, previous health professionals and other significant people in a patient's life who may be impacted by any treatment decisions or who can provide the patient or the clinician with advice (see 1.2).
- 6.1.5 With regard to Aboriginal patients consultation should extend to ATSI mental health workers, traditional healers, elders or other significant persons from the patient's community (see Addendum 5).
- 6.1.6 However, while consent to treatment should always be sought, it is not required from involuntary patients or mentally impaired accused (MIA) detained in an authorised hospital. In other words treatment can be given to an involuntary patient without consent (see Chapter 2: Decision making capacity and informed consent, and 1.3 – Best interests and wishes of a patient).

6.2 Electroconvulsive therapy (ECT) (Part 14, Division 1)

- 6.2.1 ECT is treatment involving the application of an electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent.

- 6.2.2 Among mental health professionals ECT is a well-accepted, evidence based and effective treatment for a number of mental illnesses. However because of community concerns it is regulated by this Act and if ECT is not performed in accordance with the Act a person could be subject to a fine of \$15,000 and 2 years' imprisonment.
- 6.2.3 Guidelines on the use of ECT are provided by the Chief Psychiatrist and it is a requirement under the Act to have regard to those guidelines.
- 6.2.4 ECT can only be performed at a mental health service approved by the Chief Psychiatrist.
- 6.2.5 ECT cannot be performed on a voluntary or involuntary patient who is a child under 14 years of age.
- 6.2.6 ECT can be performed on a child between the ages of 14 and 18 who is a voluntary patient, as long as the patient (mature minor), or another person authorised by law to consent on the child's behalf such as a parent, has given informed consent. In addition the Mental Health Tribunal (Tribunal) must approve the treatment. Note that this applies equally to private and public hospitals.
- 6.2.7 ECT can be performed on a child between the ages of 14 and 18 who is an involuntary patient as long as approval has been given by the Tribunal. When deciding whether a child who is an involuntary patient should have ECT the wishes of the child and the views of the parents or guardians must be taken into account (see 1.23).
- 6.2.8 ECT can be provided to adult voluntary patients with the informed consent of the patient, or a person authorised by law to provide consent such as a guardian. If a guardian consents on the patient's behalf to the treatment but the patient is adamant that they do not want the treatment then consideration should be given to the options available.
- 6.2.9 It may not be appropriate to compel a voluntary patient to have treatment just because the guardian consents on the patient's behalf. The treatment has to be delivered by staff who may be placing themselves at risk if a patient is resistive to the treatment and for example restraint is used to provide the treatment. It is possible that if there are poor outcomes the guardian may assert that he or she consented to the treatment on behalf of the patient but did not consent to the restraint. It may be appropriate when discussing consent to ECT to mention the possible need for restraint.
- 6.2.10 If there are doubts as to whether treatment can be provided with the guardian's consent the matter should be discussed with the guardian, senior staff and consideration given to whether it is more appropriate to make the patient an involuntary patient in order to provide the treatment without consent, if they meet the criteria.
- 6.2.11 ECT can be provided to an adult involuntary patient with approval from the Tribunal. The psychiatrist must apply to the Tribunal for approval and cannot

commence treatment until approval has been obtained. If approval is refused then the treatment cannot be given. If there is significant change in the situation and the psychiatrist believes that ECT is required, he or she may make a further application to the Tribunal for approval.

- 6.2.12 The psychiatrist must apply in writing to the Tribunal for approval of ECT, stating why he or she is recommending the treatment and giving an outline of the treatment plan. The plan should include where the treatment will be given, the maximum number of treatments proposed, the maximum period of time during which the treatment will be given and the minimum period between 2 treatments. Other information can also be provided such as the treatment, support and discharge plan and the history of the patient. If the patient is an adult it is likely that the Tribunal will conduct a review of involuntary status within 35 days. For further information on ECT and review by the Tribunal see 9.8.
- 6.2.13 If it is not in the patient's best interests to await a decision by the Tribunal and ECT is required on an urgent basis the psychiatrist may request interim approval from the Chief Psychiatrist.
- 6.2.14 The criteria for emergency ECT are that the patient is an adult (Emergency ECT cannot be given to a child) involuntary patient or MIA who needs to be provided with ECT to save his or her life or because there is an imminent risk of the patient behaving in a way that is likely to result in serious physical injury to the patient or another person. For example, an involuntary patient may be very depressed and not eating and at risk of malnutrition and death or actively at risk of self-harm.
- 6.2.15 In practice seeking approval from the Chief Psychiatrist instead of awaiting review by the Tribunal will only be for a very limited time or number of treatments. The Chief Psychiatrist will provide guidelines on how approval should be sought, and follow-up required.
- 6.2.16 If the patient is a MIA then the provision of any ECT must be reported to the Mentally Impaired Accused Review Board.
- 6.2.17 Every mental health service (private and public) that provides ECT must keep records of the treatment and at the end of every month send the following information to the Chief Psychiatrist:
- a) the number of people who completed a course of ECT including those where the treatment was discontinued
 - b) the number of those who were children
 - c) the number of those people who were voluntary patients
 - d) the number of those voluntary patients who were children
 - e) the number of those people who were involuntary patients
 - f) the number of those involuntary patients who were children

- g) the number of those people who were MIA required under the MIA Act to be detained at an authorised hospital
- h) the number of those MIA who were children
- i) the number of ECT treatments in each of those courses
- j) the number of those courses that were courses of emergency ECT
- k) details of any serious adverse event that occurred, or is suspected of having occurred, during or after any of those courses.

6.2.18 A serious adverse event, includes any of the following:

- a) premature consciousness during a treatment
- b) anaesthetic complications (for example, cardiac arrhythmia) during recovery from a treatment
- c) an acute and persistent confused state during recovery from a treatment
- d) muscle tears or vertebral column damage
- e) severe and persistent headaches
- f) persistent memory deficit.

6.3 Psychosurgery (Part 14, Division 3)

- 6.3.1 Psychosurgery is treatment involving the use of a surgical technique or procedure or intracerebral electrodes to create in a person's brain a lesion intended (whether alone or in combination with one or more other lesions created at the same or other times) to alter permanently the person's thoughts or emotions; or the person's behaviour other than behaviour secondary to a paroxysmal cerebral dysrhythmia; or the use of intracerebral electrodes to stimulate a person's brain (deep brain stimulation) without creating a lesion, with the intention that the stimulation (whether alone or in combination with other such stimulation at the same or other times) will influence or alter temporarily the person's thoughts or emotions or the patient's behaviour other than behaviour secondary to a paroxysmal cerebral dysrhythmia.
- 6.3.2 While psychosurgery has not been used for many years in WA it is felt appropriate to legislate for the treatment, as some recent treatments such as deep brain stimulation are also considered forms of psychosurgery and are currently used for patients with certain physical conditions.
- 6.3.3 Psychosurgery can only be performed in line with the provisions under this legislation which are that psychosurgery cannot be performed on a child below the age of 16 and patients must give informed consent to the procedure which includes informed consent to anaesthesia. A penalty of 5 years imprisonment applies if psychosurgery is not performed in line with the requirements of the Act.

- 6.3.4 In order to give informed consent a patient must have the capacity to consent to treatment and therefore cannot be an involuntary patient.
- 6.3.5 In addition to informed consent the Tribunal must approve the treatment following a special Review Tribunal consisting of 5 people including a neurosurgeon and 2 psychiatrists. If the application is for a child between the ages of 16 and 18 one of the psychiatrists must be a child and adolescent psychiatrist.
- 6.3.6 The application for approval by the Tribunal must include why the psychiatrist is recommending the treatment, a treatment plan and a copy of the informed consent. Further details about the Tribunal's processes are in Chapter 9.
- 6.3.7 The psychiatrist must inform the Chief Psychiatrist about any performance of psychosurgery and, when it is performed on an MIA patient, the Mentally Impaired Accused Review Board must be informed.

6.4 Prohibited treatments (Part 14, Division 4)

- 6.4.1 Deep sleep therapy, insulin coma therapy and insulin sub-coma therapy are all banned treatments.
- 6.4.2 Any person found performing these treatments is liable to imprisonment for 5 years.

6.5 Seclusion (Part 14, Division 5)

- 6.5.1 Seclusion is a mental health intervention that raises concern and has been the subject of investigation and reform. In 2005, it was agreed nationally to act to reduce and where possible to eliminate the use of seclusion of people experiencing mental illness and it is one of the priorities of the National Mental Health Commission.²⁶
- 6.5.2 Western Australia was one of the 11 sites chosen for the Beacon Project by the Commonwealth Department of Health and Aging (2008) and the project in WA has resulted in cultural change and a range of tools, such as the patient feedback form, which have significantly reduced the use of seclusion.²⁷
- 6.5.3 From an international perspective groups such as Recovery Innovations have introduced concepts and practices which have significantly reduced the use of seclusion in certain mental health facilities.²⁸ These ideas include having an active program to avoid and eliminate the use of force, staff training in effective de-escalation techniques, debriefing that includes patients whenever coercion or force occurs and having relationships with patients based on 'risk-sharing' rather than 'risk management' (see Addendum 1: Chief Psychiatrist's standards).

²⁶ <http://www.mentalhealthcommission.gov.au/our-work/national-seclusion-and-restraint-project.aspx>

²⁷ National Mental Health Seclusion & Restraint Project Scholarship Study Tour Report- Chen & Ryan

²⁸ Ashcraft, L. Bloss, M. Anthony, W.A. (May 2012) The Development and Implementation of "No Force First" as a Best Practice, in *Psychiatric Services*, *ps.psychiatryonline.org*, Vol. 63 No. 5.

- 6.5.4 Seclusion as defined in the Act is the confinement of a person who is being provided with treatment or care at an authorised hospital by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave.
- 6.5.5 This definition implies that there is a physical barrier to prevent the patient leaving (such as a locked door or another person, perhaps a staff member) usually a room within the authorised hospital. It can include an outside area or part of a ward but the essential component is that there is a physical barrier to the patient leaving the area. Seclusion occurring in places other than the seclusion room in an authorised hospital is still seclusion. Seclusion does not include a patient being told to remain in an area and psychologically they feel they must remain there even though there is no physical barrier. However this is a contentious issue and it is contrary to good practice to use the threat of seclusion if a person leaves a room or area.
- 6.5.6 Seclusion as defined in the Act can only occur in an authorised hospital. In other settings, a patient may be put into a room for their own or another person's safety from which they cannot leave, for example in an Emergency Department (ED), but that is not defined as seclusion under the Act. However, while it may be necessary at times to place a person in a safe place, it can be distressing. The principles of detention should apply such as intervening for as short a time as possible and being aware of how this may be impacting on the patient, carers, family members and personal support persons. It is important that any intervention such as this is recorded in the patient's medical record.
- 6.5.7 Seclusion applies to any patient (receiving treatment or care) whether they are voluntary patients, referred voluntary patients or involuntary patients. It does not apply to visitors.
- 6.5.8 A person is not in seclusion just because they are alone in a room or area which they are unable to leave because of frailty, illness or mental or physical disability. This applies mainly in authorised hospitals caring for older adults where, for example, an elderly person may have incapacities which include being unable to walk or get out of bed and while alone in their room they are 'unable to leave'. Although it appears they may meet the definition of being in seclusion, they are deemed not to be because of this exception.
- 6.5.9 Seclusion is not a therapeutic intervention and must only be used when the criteria apply and only in accordance with an oral or written seclusion order.
- 6.5.10 The criteria for seclusion is that the person needs to be secluded to prevent them from physically injuring himself or herself or another person, or persistently causing serious damage to property and there is no less restrictive way of preventing the injury or damage other than placing them in seclusion. For example, a patient may be very distressed and angry about being a patient in the authorised hospital and uses furniture to threaten staff. Seclusion should always be the last intervention tried and de-escalation and

other ways of managing the patient such as offering medication or use of a quiet room should be attempted first.

- 6.5.11 If the person needs to be secluded urgently either a medical practitioner, mental health practitioner or the person in charge of the ward can make an oral authorisation for the person to be placed into seclusion. If reasonable force in the form of physical restraint is needed to get the person into the seclusion area and an oral or written authorisation has been made then that is not a separate restraint event and a completion of a restraint form is not required. However, if the person is restrained and then a decision is made to also place the person in seclusion then both restraint and seclusion are occurring and both forms need to be completed. A person prescribed in the Regulations (mental health practitioner, nurse, security staff) can assist the staff by detaining and restraining the patient in order to place them in seclusion.
- 6.5.12 As soon as practicable after an oral seclusion order is authorised the staff member who made the authorisation must record the use of seclusion on the Seclusion Form (Form 11A – Record of Oral Authorisation of Seclusion). That form gives details of the seclusion explaining why it was necessary, outlining the urgency which required an oral authorisation and detailing where the person was secluded.
- 6.5.13 Seclusion is for a maximum period of 2 hours. If the seclusion was authorised by a mental health practitioner or the person in charge of the ward the patient must be examined by a medical practitioner within 2 hours (Form 11C – Record of Informing Medical Practitioner). If a medical practitioner orally authorised the seclusion then the patient must be examined by a medical practitioner (not necessarily the practitioner who authorised the seclusion) within 2 hours. Seclusion can be extended (Form 11E – Record of Examination of Secluded Person) for periods of 2 hours though an examination by a medical practitioner is always required before seclusion is extended.
- 6.5.14 Alternatively a medical practitioner, mental health practitioner or the person in charge of the ward can do a written authorisation for a patient to be placed into seclusion. The seclusion order (11B – Written Seclusion Form) must indicate why seclusion was necessary, where the person was secluded, any specific directions about how the seclusion will be managed and details of any previous oral authorisation which the written authorisation confirms. As with oral authorisation, written authorisation lasts for up to 2 hours but can be extended (Form 11E) for periods of 2 hours by a medical practitioner who examines the patient every time before seclusion is extended.
- 6.5.15 If it was not the patient's psychiatrist who authorised the seclusion, then the practitioner who authorised the seclusion must inform the patient's psychiatrist of the seclusion within 2 hours (Form 11C – Record of Informing Medical Practitioner or Treating Psychiatrist). At times when the patient's

psychiatrist is not on duty the psychiatrist who is on duty becomes the interim 'patient's psychiatrist' and should be informed. It would be good practice for the patient's psychiatrist to be also informed when he or she is on duty again.

- 6.5.16 An essential element to placing a person in seclusion is to provide further treatment and care. At times that treatment may include oral or IM medication. If the person is an involuntary patient then treatment can be provided without consent, though consent should always be sought. If the person is a voluntary patient (including a referred person) and they refuse to consent to treatment then treatment can only be provided as emergency psychiatric treatment (EPT) if they meet the criteria for EPT (Form 9A). It may be advisable at this stage to consider whether the person meets the criteria for involuntary status if further treatment needs to be provided. If the person needs to be bodily restrained to provide that medication then that is bodily restraint under the Act (Form 10A or B).
- 6.5.17 While in seclusion the patient must be observed by a mental health practitioner or a registered or enrolled nurse every 15 minutes. Observation aims to ensure patient safety without placing the staff member at physical risk, therefore it is important to draw up an observation plan indicating how these regular observations will be managed. All staff involved with the observations should be familiar with and keep to the plan. The reason for the regular observations is to note any change in the patient's condition and alert staff if the patient's health suddenly deteriorates while in seclusion. Seclusion can be a very distressing event and patients may attempt to harm themselves while in seclusion. Observing the patient and noting their physical and mental condition on Form 11D and if necessary in the patient's medical record at regular intervals will reduce the chances that patients may harm themselves while in seclusion.
- 6.5.18 The observation can be done from outside the room though it must be direct observation rather than through a closed-circuit television (CCTV) link, as a CCTV link may give a wrong impression of the condition of the patient. If the person cannot be successfully monitored from outside the room then the observation should be undertaken by staff entering the room, or more than one staff member if there are safety concerns. Generally observations should be done by entering the room at regular intervals, if it is safe to do so.
- 6.5.19 A medical practitioner must examine the person at least every 2 hours and more frequently when the condition of the patient indicates more medical intervention. The seclusion cannot be extended unless the medical practitioner examines the patient and any such examination should be as close to the time the seclusion would expire, if not extended.
- 6.5.20 The purpose of the medical practitioner examination is to ensure that the patient's medical condition is satisfactory and to note whether seclusion should continue or be revoked. Details of these examinations should be put on the extending Seclusion Form (Form 11E).

- 6.5.21 While in seclusion the patient must be provided with appropriate bedding and clothing, sufficient food and drink, access to toilet facilities and any other care the patient may need. If the patient's ordinary clothing is a self-harm risk, for example a shirt that can be used to attempt self-strangulation, then special clothing should be provided which cannot be used for that purpose. Patients should never be left naked in seclusion. Likewise appropriate bedding which reduces the risk of self-harm should be used and patients should never be left without means of keeping warm.
- 6.5.22 Because of the distress, patients can become dehydrated and it is important to prevent further physical illness while in seclusion. Many seclusion rooms have ensuite toilets but if that facility is lacking patients should be offered regular opportunities to use the toilet external to the seclusion room. It is not dignified or appropriate to leave a urinal or bed pan in the seclusion room. If restraining a patient has resulted in any physical damage that should be noted, recorded and the damage treated.
- 6.5.23 At any time a medical practitioner, a mental health practitioner or the person in charge of the ward can revoke the seclusion order and the patient must be allowed to exit the seclusion area (Form 11F – Revocation or expiring of seclusion)). Usually patients in seclusion, particularly those provided with medication, do not require seclusion for more than a short time. As soon as a patient is calm enough to leave seclusion they should be allowed to do so, though close observation and contact with staff should be maintained until the patient's calmer mental state is confirmed. Patients can continue to be distressed about being placed into seclusion, believing it was an unnecessary intervention. Recommencing seclusion should not be an automatic response if unacceptable behaviour escalates. Instead other de-escalation interventions should be attempted.
- 6.5.24 If a patient needs to be secluded again after an order is revoked or lapses then it is a new occasion of seclusion. Clinicians should ensure that all the steps as described above are completed again, such as contacting a medical practitioner and the psychiatrist and completing new forms.
- 6.5.25 Following the release of a patient from seclusion he or she must be provided with a physical examination by a medical practitioner within 6 hours to ensure that there are no complications of, or deterioration in, the patient's mental or physical condition that is a result of, or may be the result of, the patient being secluded (Form 11G – Record of post-seclusion examination). This would also be an opportunity for debriefing for the patient and allowing their perspective to be heard.
- 6.5.26 If the patient, whether they were an involuntary patient or not, has been discharged from the hospital or leaves the hospital against medical advice, the patient must be offered a physical examination before leaving. If they do not want to have a physical examination they cannot be compelled to have one. The results of any examination should be entered on Form 11G.

- 6.5.27 A copy of forms used in the seclusion process must be given to the patient. While these forms can be provided at any time prior to discharge it should be done as close as practicable to the seclusion event or when requested by the patient. An opportune time may be when the physical examination is being conducted though it is important to choose a time when the patient is least likely to be offended by the provision of these forms.
- 6.5.28 The carer, close family member and/or nominated person are entitled to be informed and know that a patient has been secluded. There is no requirement to notify them immediately unless they have made a specific request that they be informed immediately.
- 6.5.29 A copy of all seclusion forms must be provided to the Chief Psychiatrist, who will report in his or her annual report details of the use of seclusion in mental health services.
- 6.5.30 If the patient is a MIA person a copy of the seclusion form must be provided to the Mentally Impaired Accused Review Board.
- 6.5.31 This part of the CPG should be read in conjunction with the Chief Psychiatrist's guidelines and standards regarding the use of seclusion, as well as federal and state policies which require adherence.

6.6 Bodily restraint (Part 15, Division 6)

- 6.6.1 Restraint is a mental health intervention that raises concerns and has been the subject of investigation and reform. In 2005, it was agreed nationally to act to reduce and where possible to eliminate the use of restraint of people experiencing mental illness and it is one of the priorities of the National Mental Health Commission.
- 6.6.2 Bodily restraint is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital. It applies to voluntary patients, referred voluntary patients or involuntary patients. It does not apply to visitors. If visitors need to be restrained for any reason it will be as legislated by common law.
- 6.6.3 Physical restraint is the restraint of a person by the application of bodily force to the person's body to restrict the person's movement. For example staff holding a patient down or restraining a patient's arms. Physical restraint should always be applied by more than one staff member in a way that does not cause the patient any pain.
- 6.6.4 Mechanical restraint is the restraint of a person by the application of a device (for example, a belt, harness, manacle, sheet or strap) to a person's body to restrict the person's movement. It does not include the appropriate use of a medical or surgical appliance in the treatment of a physical illness or injury or the appropriate use of furniture that restricts a person's capacity to get off the furniture (for example, a bed fitted with cot sides or a chair fitted with a table across the arms). It also does not include physical or mechanical restraint by a police officer acting in the course of duty or physical restraint by a person

when conducting a search and seizure or the restraint necessary to place a person into seclusion.

- 6.6.5 A patient is not being physically restrained when provided with physical support or assistance necessary to carry out activities of daily living or that is necessary to redirect a person who may be disorientated. These exceptions apply primarily to authorised hospitals which care for older adults, though it can also apply to other patients who are disoriented due to acute symptoms of mental illness (particularly organic illness, or alcohol or drug intoxication). These exceptions therefore allow the sort of minimal restraint required to escort an older person to the showers and assistance to prevent falls.
- 6.6.6 At times a voluntary patient who is being provided with physical support can be resistive and if it reaches the stage that staff feel they may be assaulted then it may be appropriate to use restraint as defined in the Act. If that occurs then all the provisions in the restraint process apply. Essentially this is a judgement call as to whether these exceptions apply. If the patient, a carer or an advocate believe these exceptions are being misused then a complaint may be made to the head of the service or HaDSCO.
- 6.6.7 At times, particularly in authorised hospitals for older adults, patients may wander and enter places where it may not be appropriate for them to be such as another patient's room or the nursing station. It would not be deemed restraint if, in those circumstances, patients were guided out using minimal physical restraint. If a patient refuses to respond and may become physically assaultive then consideration should be given to using the restraint provisions in the Act. If the patient, a carer or an advocate believes these exceptions are being misused with unreasonable force being applied, then a complaint may be made to the head of the service or HaDSCO.
- 6.6.8 Restraint should be, wherever possible, an intervention of last resort when other ways of managing a situation have been explored. When using restraint the degree of force used must be the minimum that is required in the circumstances. Restraint should be achieved without physically injuring the patient. While being restrained there must be the least possible restriction on the patient's freedom of movement and they must be treated with dignity and respect. Use of inappropriate language or force by staff is unacceptable and there is a mandatory requirement to report, the suspicion of unreasonable use of force.
- 6.6.9 The reasons for the use of restraint are that the patient needs to be restrained to:
- a) provide treatment
 - b) be prevented from physically injuring himself or herself or another person
 - c) be prevented from persistently causing serious damage to property.
- 6.6.10 Restraint should only be used if there is no less restrictive way of giving the treatment or preventing the injury or damage and where the use of bodily

restraint on the patient is unlikely to pose a significant risk to their physical health. For example, a referred patient is very distressed, and behaves in a way that is likely to cause serious physical injury to themselves or others. The clinical decision is that the patient requires EPT but the patient is unwilling to cooperate. Staff may then need to physically restrain the patient so that the treatment, usually intra-muscular medication, can be given. However, if then the patient shows any signs of asthma then restraint should cease immediately and other options considered to manage the situation instead. If the patient is known to have a cardiac condition where restraint would pose a significant risk to their physical health, then restraint should not be used and as part of the risk management plan other ways of managing behaviour are explored.

- 6.6.11 If the person needs to be restrained urgently a medical practitioner, a mental health practitioner or the person in charge of the ward at that time, can make an oral authorisation (Form 10A) which allows 30 minutes for the patient to be restrained. A person prescribed in the Regulations (mental health practitioner, nurse, security staff) can assist the staff by detaining and restraining the patient.
- 6.6.12 Mental health practitioners or persons in charge of the ward should only use oral authorisation if the restraint needed is urgent and there is no medical practitioner available to give oral authorisation.
- 6.6.13 The staff member giving oral authorisation must specify whether physical or mechanical restraint is being authorised and, if it is mechanical restraint, the type of device to be used and how it will be applied.
- 6.6.14 As soon as possible and within 30 minutes the person who authorised the restraint must inform a medical practitioner that restraint is being or has been used (Form 10C – Record of informing medical practitioner or treating psychiatrists of restraint order). If it is still being used the medical practitioner must examine the patient and confirm whether the restraint should continue or cease. If restraint has ceased, the medical practitioner must still be informed. It would be good practice and in line with the Act for the medical practitioner to conduct an examination within 6 hours to ensure that the patient has not suffered any complication or deterioration in their mental or physical condition that is a result of, or may be the result of, the patient being restrained (Form 10I).
- 6.6.15 As soon as practicable after the restraint has been applied the person who authorised the restraint must complete a restraint form (10A) which includes details about why the restraint was needed urgently and the form of restraint used.
- 6.6.16 Alternatively, a medical practitioner, mental health practitioner or person in charge of a ward may do a written authorisation for restraint (Form 10B). For example if a restraint is a planned event because a patient will not comply with treatment and needs to be restrained for treatment to be given then it

would be appropriate to use the written authorisation. Written authorisations should include a plan as to how the restraint will be used and how the patient's behaviour will be managed following restraint. Staff involved in the interventions should be aware and contribute to the plan.

- 6.6.17 It is likely that a patient may feel distressed following a restraint and as much planning should go into how the patient will be managed post-restraint as the restraint itself. If a mental health practitioner or person in charge of the ward does a written authorisation, they should contact a medical practitioner as soon as possible (and within 30 minutes) to examine the patient and confirm or revoke (if the restraint is continuing) the authorisation (Form 10C).
- 6.6.18 If the restraint is to be revoked Form 10G – Revocation or expiry of bodily restraint needs to be completed. If the medical practitioner does not examine the patient within 30 minutes the patient must be released from restraint. If the restraint has ceased by the time the medical practitioner arrives to examine the patient it would be good practice and in line with the Act for the medical practitioner to conduct an examination within 6 hours to ensure that the patient has not suffered any complication of, or deterioration in, their mental or physical condition that is a result of, or may be the result of, the patient being restrained (Form 10I).
- 6.6.19 The restraint form (Form 10 A or B) must include for how long the patient can be restrained (which cannot be longer than 30 minutes), the kind of restraint used, either physical or mechanical, and if mechanical the device used and how it was used, why the restraint was necessary and particulars of any directions given by a medical practitioner or mental health practitioner about the treatment and care to be provided to the patient while restrained. For example, the mental health practitioner may be aware that the patient has a medical problem such as asthma which may be exacerbated by the restraint, and give directions as to how that should be managed while the patient is in restraint.
- 6.6.20 As soon as practicable and within 30 minutes the patient's psychiatrist should be informed of the restraint unless it was the psychiatrist who authorised the restraint (Form 10C). This applies within the 30 minutes even if the person is released from restraint. There is no requirement for the psychiatrist to personally examine the patient however he or she may provide directions as to how the restraint should be managed. At times when the patient's psychiatrist is not on duty the psychiatrist who is on duty becomes the interim 'patient's psychiatrist' and should be informed. It would be good practice for the patient's psychiatrist to be also informed when he or she is on duty again.
- 6.6.21 Restraint can be extended beyond 30 minutes for further periods of 30 minutes but only after an examination by a medical practitioner (Form 10E – Record of examination of restrained person). If the restraint continues for more than 6 hours a psychiatrist must review the authorisation for restraint (Form 10H – Review of Bodily Restraint by Psychiatrist). This should be done

by the psychiatrist personally examining the patient and reviewing the restraint plan.

- 6.6.22 A medical practitioner can vary the restraint for example by changing physical restraint to mechanical restraint or changing the device used for mechanical restraint or changing the length of time restraint can be applied for. Any variation must be recorded on Form 10F – Variation of Bodily Restraint Order.
- 6.6.23 While in restraint a mental health practitioner or a registered or enrolled nurse must be with the patient at all times providing ongoing care. The purpose of constant observation is to ensure that the patient's physical and mental health be monitored and any risk managed. Observations should include whether there is a proper airway to allow breathing, that the restraint is not causing pain or that any limbs are not being impacted on in a negative way. Patient safety and care is paramount during a restraint and staff need to fully understand the risks during a restraint and how those risks should be monitored and minimised. A written record of the observations should be maintained on the record of requirements relating to restraint (Form 10D – Record of observations made of restrained person).
- 6.6.24 While being restrained the patient should be provided with appropriate clothing and bedding, sufficient food and drink, access to toilet facilities and any other care appropriate to the patient's needs.
- 6.6.25 At times a patient may need to be restrained in order for them to be placed in seclusion. In those circumstances it is not necessary to complete a restraint form. However if restraint is used and then a decision made to place the person in seclusion then both bodily restraint and seclusion are being used and both forms need to be completed.
- 6.6.26 At any time a medical practitioner or mental health practitioner may revoke a restraint order (Form 10G) and the patient will be released from restraint. If the order is not extended the order will expire within the timeframe noted on Form 10A or B and the patient must be released.
- 6.6.27 Whenever a patient is released from restraint they must as soon as practicable and within 6 hours have a physical examination (Form 10I) by a medical practitioner to ensure no complication of or deterioration in the patient's mental or physical condition that is a result of, or may be the result of, the patient being restrained. If the patient has been discharged or leaves the authorised hospital against medical advice they should be offered the physical examination before they leave.
- 6.6.28 A copy of the forms used in the restraint process must be given to the patient. While this form can be provided at any time prior to discharge it should be done as close as practicable to the restraint event or when requested by the patient. An opportune time may be when the physical examination is being

conducted though it is important to choose a time when the patient is least likely to be offended by the provision of these forms.

- 6.6.29 A carer, close family member or nominated person is entitled to know that a patient has been restrained. This should occur as soon as practicable, though there is no requirement to notify the person immediately, unless they have made a specific request to be informed immediately.
- 6.6.30 A copy of the restraint forms must be provided to the Chief Psychiatrist who will report in his or her annual report details of the use of restraint in mental health services.
- 6.6.31 If the patient is a MIA person a copy of the restraint forms must be provided to the Mentally Impaired Accused Review Board.
- 6.6.32 This part of the CPG should be read in conjunction with the Chief Psychiatrists' guidelines and standards regarding the use of restraint as well as federal and state policies which are required to be adhered to.

6.7 Urgent non-psychiatric treatment for involuntary inpatients and mentally impaired accused (Part 15, Division 2)

- 6.7.1 Urgent non-psychiatric (medical) treatment may be provided to a patient without consent under a duty of care and where consent is unable to be provided or provided by an alternative decision maker such as a guardian or parent.
- 6.7.2 Urgent treatment means treatment urgently needed to:
- a) save the patient's life
 - b) prevent serious damage to the patient's health
 - c) prevent the patient from suffering or continuing to suffer significant pain or distress, but does not include psychiatric treatment as defined in the Act or the sterilisation of a patient (*Guardianship and Administration Act 1990*, Section 110ZH).
- 6.7.3 Where urgent non-psychiatric treatment is provided to an involuntary detained patient or an MIA detained in an authorised hospital, the person in charge of the authorised hospital must, as soon as practicable, provide information about the treatment, in the approved form (Form 9B). Information about involuntary detained patients is provided to the Chief Psychiatrist and information about MIAs is provided to the Mentally Impaired Review Board.
- 6.7.4 The report must include:
- a) the name of the patient provided with the treatment
 - b) the name and qualifications of the practitioner who provided the treatment
 - c) the names of any other people involved in providing the treatment
 - d) the date, time and place the treatment was provided
 - e) particulars of the circumstances in which the treatment was provided

- f) particulars of the treatment provided.
- 6.7.5 The provision of urgent non-psychiatric treatment is an event which requires a personal support person to be notified (see 1.24).
- 6.7.6 The Chief Psychiatrist must publish in his or her annual report data on urgent non-psychiatric treatment provided during the year and reported on under section 242(3)(a).
- 6.7.7 Where non-urgent non-psychiatric treatment is required the patient must either provide informed consent or if the patient lacks the capacity to consent, consent can be provided by an alternative decision maker such as a guardian or parent or through an AHD.

Chapter 7: Complaints (Part 19)

7.1 Background

- 7.1.1 The ability to make a complaint or question treatment and care provided is a fundamental right for all patients, their carers and their families. Working within a recovery focused model of care where the patient and carers are participants in clinical decision making, clinicians need to be aware that there is a process through which complaints can occur.
- 7.1.2 A complaint can be formal, which is an expression of dissatisfaction by, or on behalf of, an individual patient or personal support person, regarding any aspect of a service provided by a mental health service, and is lodged in writing or verbally.
- 7.1.3 A complaint can also be informal, which implies that the issues are often more straightforward and can be resolved at point of contact. Informal complaints should still be documented so they can be monitored for emerging trends that could indicate service improvement is required.
- 7.1.4 There may also be a 'concern expressed', where the contact is inquisitorial in nature rather than an expression of dissatisfaction, or where the patient or personal support person states that they do not wish to lodge a formal complaint or that the issues are minor and can be resolved immediately without going through a formal or informal complaint process.
- 7.1.5 The WA Health Complaints Management Policy (2015)²⁹ (Policy) provides a framework for the reporting and management of health complaints. It notes that effective complaints management is reliant on a number of elements working together including:
- a) a culture that supports reporting of incidents and seeks feedback
 - b) principles underpinning the complaints process that ensure complaints are dealt with in an equitable and objective manner
 - c) the level of skills and experience of staff in managing complaints, supported by ongoing training as well as strong leadership
 - d) standard processes that support efficiency in complaint handling
 - e) analysis of feedback at all levels of the health service to enable effective and ongoing service improvement (WA Department of Health, 2013).
- 7.1.6 The Policy sets out the procedures for the management of complaints and promotes best practice in complaints management advocating for an efficient, proactive approach that results in the best possible outcomes for health consumers and personal support persons. The policy is not intended to apportion blame but strives to resolve the complaint, where possible, and identify any aspects of service delivery which require change in order to effect improvement.

²⁹ Operational Directive 0589/15 – WA Health Complaints Management Policy 2015.

- 7.1.7 Private hospitals and other health services may also have complaints policies which may be relevant to clinicians.
- 7.1.8 While the Act promotes complaints being lodged with local mental health services, the Advocacy Service or the HaDSCO, complaints can also be made to the Western Australian Ombudsman, or through appropriate mental health organisations representing consumer, family and carer interests and professional registration boards (e.g. Australian Health Practitioner Regulation Agency). These organisations may initiate direct contact with the service provider.
- 7.1.9 Any complaints policy must operate within a legal framework. This may impose restrictions and obligations for the management, reporting or escalation of complaints where different legislation operates in different health care settings. This includes the Health and Disability Services (Complaints) Act 1995, the Health and Disability Services (Complaints) Regulations 2010, the Carers Recognition Act 2004, the Freedom of Information Act 1992 and Corruption and Crime Commission Act 2003 as well as this Act.
- 7.1.10 The Policy notes that not all complaints warrant a full investigation and not all complaints are able to be resolved by the health service despite a full investigation. It also notes that the level of response will depend on a number of factors including the complainant's level of participation in the complaint process, the health service's capacity to implement a resolution, the complexity of the incident, and the outcome sought by the complainant.
- 7.1.11 It may be that frontline staff, both clinical and administrative, are competent to manage minor complaints, without the need for a formal complaint.
- 7.1.12 All mental health services provide a complaints process and the Act directs that the person in charge of a service must ensure there is a complaints procedure which is reviewed regularly, with copies of the procedure available free of charge to all stakeholders (s. 308).
- 7.1.13 The patient or the complainant may prefer to go directly to HaDSCO as the agency with the statutory power to investigate and resolve complaints (s. 306).
- 7.1.14 The process for the management of formal complaints is described within 5 broad stages:
- a) acknowledgement
 - b) assessment
 - c) investigation
 - d) response
 - e) service improvement.

For a more detailed description of the process see the WA Health Complaints Management Policy.

7.1.15 To be able to determine the number of complaints made regarding mental health services in any given year, a service provider must, after 30 June of each year, give the Director of HaDSCO a report regarding the complaints received by the service and the action taken. Failure to do so could result in a fine of \$1000 (s. 309).

7.2 Making a complaint

7.2.1 The Act provides for a complaint to be made to a mental health service or HaDSCO. It is not necessary for the complainant to identify themselves as a patient or a carer (s. 306). For details of the complaints management process in relation to health services, see the local policies and procedures provided by the health service which are not part of this guide.

7.2.2 A complaint to HaDSCO may be made by the patient themselves, or on behalf of the patient by a patient's representative such as a relative, carer, mental health advocate, a legal practitioner or a person prescribed by the Regulations (s. 315). If the person is not a mental health advocate, a legal practitioner, a person who is being paid through a funding arrangement with government to provide free advocacy services and is representing a person or a prescribed person, they cannot demand any remuneration for acting on behalf of the patient. If they do they will be liable to a fine \$1000 for a first offence and \$10,000 for a second or subsequent offence (s. 317).

7.2.3 The patient may ask another person to make a complaint on their behalf, or if the patient is unable to make the complaint him or herself, for example because they do not have the capacity to make the complaint, or they have passed away, a complaint may still be lodged by another person if, in the opinion of HaDSCO, that person has a sufficient interest in the matter (s. 316).

7.2.4 At times a complaint might be made to a health service and HaDSCO at the same time. If the complaint made to the health service is resolved, HaDSCO must be informed so that they can cease dealing with the complaint.

7.2.5 It is also possible for a Registration Board of a mental health profession to lodge a complaint on behalf of a patient or carer to a mental health service if the Board becomes aware that the health professional has acted or failed to act in relation to an issue which it is possible to lodge a complaint about (Health and Disability Services (Complaints) Act 1995, section 3(1) schedule 1) (s. 319).

7.2.6 A complaint can allege any of the following (s. 320):

- a) That a service acted unreasonably by providing or not providing a mental health service.

- b) That a service acted unreasonably in the manner the mental health service was provided.
- c) That a service acted unreasonably by delaying, denying or restricting access to records kept by the service.
- d) That a service acted unreasonably in disclosing records or confidential information.
- e) That a service failed to investigate a complaint properly, or take proper action in relation to the complaint or acted unreasonably in charging an excessive fee.
- f) That a service failed to comply with the Charter of Mental Health Care Principles or the Carers Charter.

7.2.7 Complaints must be lodged within 24 months of the event unless HaDSCO allows the complaint because there are valid reasons for the delay (s. 321).

7.3 How to complain to Health and Disability Services Complaints Office

7.3.1 Complaints can be made orally, including over the telephone or in writing, which includes emails.

7.3.2 Health and Disability Services Complaints Office requires that a complaint made orally be confirmed in writing and will also ask for the complainant to identify themselves, or provide other personal information within a particular timeframe.

7.3.3 If a complainant does not wish to comply with this request, HaDSCO could reject the complaint.

7.3.4 If a complaint is about an 'excluded mental health service' such as the Royal Flying Doctors Service, or a crisis call service provided by a non-government organisation, HaDSCO may with the consent of the complainant refer the complaint to an appropriate person or body.

7.3.5 A complaint can be withdrawn at any time by notifying HaDSCO who will notify any other persons involved in looking at the complaint (s. 324).

7.3.6 Health and Disability Services Complaints Office can investigate a complaint which cannot be dealt with by the national board of a professional group (s. 326), but if the complaint is being dealt with by a national board, the Director must inform the complainant within 28 days (s. 327).

7.3.7 A complaint may be rejected for a number of reasons (s. 329), for instance the complaint:

- a) relates to an incident that occurred more than 24 months before the complaint is made
- b) is trivial, vexatious or without substance
- c) does not warrant any further action

- d) has been dealt with by another provision of this Act such as the use of a compliance notice (review by Mental Health Tribunal)
- e) does not comply with the Act
- f) is being dealt with by another law or a court
- g) the complainant has not taken reasonable steps to resolve the matter with the provider.

7.3.8 Within 28 days, though that can be extended for a further period not exceeding 28 days, HaDSCO must make a decision as to whether to accept or reject the complaint and during that period make appropriate inquiries about the matter and inform the complainant about the decision (s. 328).

7.3.9 If the complaint is accepted, HaDSCO must within 14 days commence either attempting to resolve the complaint by negotiation or refer the complaint to conciliation or if those two options are not suitable, consider whether investigating the complaint may be warranted.

7.3.10 A complaint, with the complainant's permission, can be referred to another appropriate body which is not a national board under the Health Practitioner Regulation National Law (Western Australia) or a court. Health and Disability Services Complaints Office has a mandatory obligation under s. 150(2) Health Practitioner Regulation National Law to notify the Australian Health Practitioner Regulation Agency (AHPRA) of complaints relating to the health, performance or conduct of an individual practitioner.

7.3.11 The service who the complaint refers to must within 28 days, respond in writing to the complaint and also indicate if there is a chance of a negotiated settlement or conciliation (though the Director can extend the time for good reasons) (s. 330).

7.4 Resolving complaints by negotiation and conciliation

7.4.1 Having accepted a complaint it is the job of HaDSCO to resolve the matter through negotiation or conciliation or refer for investigation if the matter is not suitable to be dealt with in the negotiated settlement or conciliation process.

7.4.2 If the complaint is not resolved within 56 days, HaDSCO can refer the complaint for negotiation or conciliation, decide it is not suitable for negotiation or conciliation or extend the time of negotiation (s. 331).

7.4.3 The complainant must be informed if the complaint is not to go to conciliation, that no further action will be taken.

7.4.4 If referred for conciliation the Senior Case Manager at HaDSCO who is skilled at conciliation and whose function is to encourage settlement is assigned the matter. He or she may make a recommendation for the most appropriate process for managing the complaint. This could be done either through negotiated settlement, conciliation or investigation. The complaint will

not proceed from negotiated settlement to conciliation in all cases, although it may be appropriate to refer to conciliation if the matter is not resolved.

- 7.4.5 If the complaint is not settled through negotiation, the Director must decide whether the matter should be managed in conciliation. Similarly, if a matter is being managed in conciliation and no agreement has been reached, the Senior Case Manager may recommend that the Director:
- a) should investigate the matter
 - b) make no recommendation
 - c) should not investigate.

7.5 Investigations

- 7.5.1 The purpose of an investigation is for HaDSCO to decide whether a service has acted or failed to act in a reasonable manner. The person undertaking the investigation cannot be the same person who attempted the conciliation. The normal rules of confidentiality apply.
- 7.5.2 In some circumstances the request for an investigation can come directly from the Minister for Mental Health, particularly if it is in the public interest on an important matter related to mental health.
- 7.5.3 In coming to a decision HaDSCO can look at:
- a) any treatment, support and discharge plan
 - b) the quality of service expected from the service
 - c) any standards regarding the provision of treatment including the Chief Psychiatrist's standards and the Charter of Mental Health Care Principles or the Carers Charter.
- 7.5.4 Investigations should be conducted as quickly and with as little formality as possible, and are not bound by the rules of evidence but subject to the rules of natural justice (s. 333).
- 7.5.5 Investigations can include information from the complainant or the complainant's representative, for example a parent if the complaint relates to a child, and any relevant record. A person may refuse to provide information in a relevant document to which issues of legal professional privilege apply (s. 334).
- 7.5.6 If the required information is not provided, without reasonable excuse, the person may be committing an offence for which there are fines.
- 7.5.7 The powers of the Director of HaDSCO extend to applying for a warrant to enter and inspect premises (s. 335).
- 7.5.8 Within 14 days of completing an investigation and coming to a decision HaDSCO must inform the complainant and the service about the decision, which includes the reasons for the decision (s. 337).

- 7.5.9 If the decision is that the service has acted or failed to act in a reasonable manner HaDSCO can recommend, after discussions with the service, what the service should do to remedy the complaint.
- 7.5.10 The service is expected to act on the recommendation within 45 days, though that can be extended for a further 15 days, and then report back to HaDSCO (s. 338).
- 7.5.11 If the service does not report back to HaDSCO or fails to undertake the remedial action the matter can be reported to the Minister for Mental Health, who may then take further action (s. 339).
- 7.5.12 Health and Disability Services Complaints Office must stop an investigation if it becomes aware that the complaint is being dealt with through other lawful means such as:
- a) under another provision of this Act
 - b) under another written law
 - c) under a law of the Commonwealth
 - d) in a court.

If this is the case HaDSCO must inform the complainant and respondent within 14 days.

7.6 Other matters

- 7.6.1 A person commits an offence if they give false or misleading information to HaDSCO for which there is a fine of \$6000 (s. 344).
- 7.6.2 Persons lodging a complaint need to be protected from threats and intimidations such as being dismissed from work, or being persuaded to withdraw or not make a complaint. A person who is found to have engaged in this behaviour can be fined \$2500 (s. 345).
- 7.6.3 Health and Disability Services Complaints Office must establish a register of complaints which will be determined by the Director (s. 346).

Chapter 8: Mental Health Advocacy (Part 20)

8.1 Background

- 8.1.1 This chapter should be read in conjunction with information provided by the Chief Mental Health Advocate (Chief Advocate) as to how the Mental Health Advocacy Service (Advocacy Service) and the mental health advocates will perform their duties prescribed and the interrelationship between the Advocacy Service and clinical services. The information outlines the functions and powers of the Advocacy Service, the requirements of the Act on clinical services in relation to the Advocacy Service, as well as general expectations as to the relationship between clinical services and the Advocacy Service.
- 8.1.2 The mental health advocate's functions relate to anyone who meets the definition in the Act of an 'identified person', who can be any one of the following (s. 348):
- a) an involuntary patient whether detained or subject to a CTO
 - b) a person referred under the Act to be examined by a psychiatrist at an authorised hospital or other place
 - c) a voluntary patient detained in an authorised hospital to be assessed by a medical practitioner or an AMHP
 - d) a person whose detention continues following an examination by a psychiatrist but not made an involuntary patient or released
 - e) a person who is under a hospital order made under the *Criminal Law Mentally Impaired Accused Act 1996* (CLMIAA)
 - f) a MIA who is detained in an authorised hospital or released under a release order on conditions imposed under CLMIAA
 - g) a resident of a private psychiatric hostel
 - h) a voluntary patient who the Minister for Mental Health has deemed an 'identified person'
 - i) a person who may have a mental illness who is being provided with treatment and care by a body or organisation prescribed by the Regulations.
- 8.1.3 The purpose of the mental health advocates' involvement is to inform the identified person about a wide range of issues, promote the identified person's human rights under the legislation and represent them in different settings such as reviews held by the Mental Health Tribunal (Tribunal) or the service. Mental health advocates represent the perspective of the patient and are tasked with working where possible to discern the patient's preferences.
- 8.1.4 In particular the advocacy aspect of the advocacy service will be dedicated to ensuring all patients are informed of their rights, their rights are respected and their wishes known. It will:
- a) Support the person to express their own wishes about their situation and what they want to happen even if from a clinical perspective these wishes do not appear to be in the best interests of the person

- b) Advise the person of their rights, options for and possible consequences of their decision making.
- c) Respect all parties and acknowledge their diverse obligations and responsibilities such as hearing from other parties when given permission to do so.
- d) Consider and address systemic issues that are present or emergent.
- e) In the absence of a patient's capacity to express their wishes, mental health advocates will make every effort to ascertain the patient's life preferences and advocate to ensure their rights are upheld and that their preferences are known to the Tribunal and clinicians providing care.

Mental health advocates will:

- a) not make decisions for the person
 - b) not utilise the concept or practice of 'best interest advocacy' except where required by legislation to do so in relation to children.
- 8.1.5 The style of advocacy provided by clinicians maybe different from the kind of advocacy provided by the Advocacy Service. Clinicians are required to advocate for patients, families and carers utilising a best interest advocacy model. This requires clinicians to elicit and appreciate the views and wishes of all parties and advocate for a care plan that is in the patient's best interest. The care plan should take into account the clinical evidence base, clinical assessment, human rights, and requirements of the Act and should reflect the patient's view while also recognising that patients who lack capacity may be unable to appreciate the current circumstances, risks and consequences of the care options.
- 8.1.6 For clinicians the model promoted by the Advisory Services means that the mental health advocate is a voice for the patient (or other identified persons) and will, to the best of the advocates' abilities, represent exactly what the patient wants. This applies even if at times this way of advocating does not appear, from the perspective of the clinician, to be in the patient's best interests. The role is different from a guardian, who is required by law to act in the patient's best interests, or parents, family members or nominated persons who may also be acting in the patient's best interests.
- 8.1.7 Having mental health advocates assists in ensuring patients' rights are upheld and that each patient has a pathway where they can get their personal concerns raised and addressed. Clinicians must support mental health advocates in the work they do and provide them with all the assistance they need to carry out their duties.
- 8.1.8 A mental health advocate cannot provide advocacy services to an identified person if it is deemed there may be a connection or an association between the advocate and the body or organisation providing treatment or care.
- 8.1.9 It is a fineable offence for anyone, including clinicians, to give false or misleading information to an advocate, for example in a document provided,

as that will be seen as interfering with the exercise of powers that advocates have. The penalty is \$6000 (s. 362).

8.2 Chief Mental Health Advocate

- 8.2.1 A Chief Advocate, appointed by the Minister for Mental Health, will engage persons to be mental health advocates. This will include a youth advocate who must have qualifications, training or experience relevant to young people and other advocates who have experience relevant to particular groups in the community such as Aboriginal people or people with CALD backgrounds (s. 350).
- 8.2.2 The Chief Advocate is in charge of the service and as the mental health advocates are answerable to him or her, he or she is answerable to the Minister for Mental Health.
- 8.2.3 When the Chief Advocate is away on leave or unable to perform his or her duties the Minister may appoint an acting Chief Advocate (s. 368).
- 8.2.4 The functions of the Chief Advocate include (s. 351):
- a) Ensuring identified persons are visited or otherwise contacted. To achieve this outcome the following responsibilities should be noted:
 - i. There is a responsibility on mental health services to notify the Chief Advocate when a person is made an involuntary patient (detained or on a CTO) so that they can be contacted.
 - ii. There is a responsibility on the referring practitioner (medical practitioner or AMHP) to inform the referred person, who is detained under a Detention Order, of their right to request contact from a mental health advocate which must be made within 3 days of the request.
 - iii. There is a responsibility on the person in charge of a ward in an authorised hospital who detains a voluntary patient for assessment by a medical practitioner or AMHP to inform the patient of their right to request contact from a mental health advocate.
 - iv. There is a responsibility on the authorised hospital to notify the Chief Advocate of the admission of a mentally impaired accused (MIA) person detained in an authorised hospital so an MIA can be contacted within 7 days.
 - v. There is a responsibility on the manager of a private psychiatric hostel to inform a resident of their right to advocacy, as the resident may wish to request a visit or contact which must occur within 7 days of the request.
 - vi. There is a responsibility on a mental health service to inform the Chief Advocate if a voluntary patient is in a class of patients that the Minister for Mental Health has directed to be an 'identified person' which places a responsibility of contact from a mental health advocate.
 - b) Other functions of the Chief Advocate include:
 - i. Promoting compliance with the Charter of Mental Health Care Principles.

- ii. Publishing and promoting information about the role of mental health advocates.
 - iii. Developing standards and protocols for the mental health advocates, which should be understood by clinicians, to facilitate good communication between the mental health advocates and clinicians.
 - iv. Arranging training in how to be effective advocates.
 - v. Providing advice, assistance and direction.
- 8.2.5 The Minister for Mental Health may give directions to the Chief Advocate which must be complied with.

8.3 The function of mental health advocates to visit or make contact

- 8.3.1 Mental health advocates will visit or make contact with identified persons, either as required by the Act or in response to a request. The purpose of the visit or contact is to inform a patient about their rights, listen to and act on any complaints the patient may have, advocate for the patient both within the hospital or mental health service (and externally with government and non-government agencies) as well as establish a link with family members and other people important in the patient's life. Mental health advocates may have a particular interest if a patient feels that their rights are not being upheld. The role of the advocate is to represent the views and feelings of the patient when raising these issues with clinicians.
- 8.3.2 If the patient is an adult involuntary patient, a MIA in an authorised hospital, or a patient on a Hospital Order under CLMIAA, the mental health advocate must either visit or make contact within 7 days. If the patient is a child they must contact or visit within 24 hours (s. 357).
- 8.3.3 The advocacy service must be notified as soon as possible once a person becomes an involuntary patient, a MIA in an authorised hospital or is under a Hospital Order, so that they can initiate contact or organise a visit. Clinicians should assist mental health advocates in arranging this initial contact or facilitating a visit.
- 8.3.4 Referred persons, involuntary patients, MIAs in authorised hospitals and persons under a Hospital Order can request that the mental health service contact the Advocacy Service requesting contact. If a clinician receives such a request they must note the request in the patient's medical record and contact the Advocacy Service within 24 hours.
- 8.3.5 Referred persons who are detained can request a visit by a mental health advocate, who must visit or make contact as soon as practicable and, in any event, on or within 3 days after the advocacy service receives or is notified of the request. To assist this request clinicians should provide referred persons with the phone number of the Advocacy Service. In some cases this may include a staff member contacting the Advocacy Service at the request of the patient.

- 8.3.6 Identified persons who are MIAs who have been released by the MIA Act under a release order, on the condition they undergo psychiatric treatment, can request a visit. An advocate must make contact or visit the patient as soon as practicable and, in any event, on or within 7 days after the Advocacy Service receives or is notified of the request. If the patient is a child they must make contact or visit within 24 hours.
- 8.3.7 Identified persons who are residents of private psychiatric hostels can request a visit and an advocate must make contact or visit the patient as soon as practicable and, in any event, on or within 7 days after the advocacy service receives or is notified of the request. If the patient is a child they must make contact or visit within 24 hours.
- 8.3.8 Identified persons who are voluntary patients or in a class of patients that the Minister for Mental Health directs as identified persons may request a visit and an advocate must make contact or visit the patient within a reasonable time after the advocacy service receives or is notified of the request. If the patient is a child they must make contact or visit within 24 hours.
- 8.3.9 Identified persons who may or may not have a mental illness and who are being provided with treatment and care by a body or organisation prescribed by the Regulations can request a visit. An advocate must make contact or visit the person as soon as practicable and, in any event, on or within 7 days after the Advocacy Service receives or is notified of the request. If the patient is a child they must make contact or visit within 24 hours (see Regulations of the Mental Health Act).
- 8.3.10 Every effort should be made to assist the mental health advocate with their work by arranging a confidential contact space and answering questions the mental health advocate has about the patient, including questions about why they were referred or made an involuntary patient, and any treatment they may have been prescribed. Mental health advocates are subject to the same rules of confidentiality as other staff so information should not be withheld from them on that basis.
- 8.3.11 Mental health advocates can visit a patient at any time and for as long as they want. The Advocacy Service has policies and procedures that cover entry onto the ward and safety and risk issues. This may involve letting ward staff know when they come on to the ward and checking with ward staff about any risks on the ward. The mental health advocate's visit needs to be facilitated, so if there are concerns about safety a plan should be drafted in consultation with the mental health advocate. Options might include escorting an advocate or having staff sit nearby but out of hearing range, providing a safe environment away from the ward or perhaps postponing the visit. Ward staff should always be aware of the safety of any visitor on the ward including a mental health advocate.
- 8.3.12 A patient does have the right to refuse to have contact with a mental health advocate, however any refusal should be further investigated. Patients may

confuse a mental health advocate with ward staff or not understand the role of mental health advocates and on that basis refuse contact. All patients must be given information about the Advocacy Service, including a pamphlet which is supplemented with an oral explanation.

8.3.13 While mental health advocates will frequently be on the ward or having meetings with patients' relatives, they are not part of the clinical team. While it is important to involve and share information with mental health advocates, their role is significantly different from the clinical role.

8.3.14 It is part of the mental health advocate's role to raise with staff concerns about a patient's treatment and care and it is expected that staff will address these concerns and if they are in the patient's best interests to act on them. At times there may be a strong concern from a clinical perspective the mental health advocate's support of the patient's wishes may undermine treatment and care. Essentially that is how advocacy works in practice and clinicians should not expect that mental health advocates will take a clinical perspective on contentious matters.

8.3.15 It is important that mental health services and the Advocacy Service develop a mutually respectful understanding of respective roles, with a commitment to working together to promote recovery. This also means that mental health advocates and clinical staff need to use a negotiation process that balances the safety of the person with the person's wishes.

8.4 Access to medical records and other patient documentation

‘(see Regulation 14 of the Mental Health Regulations 2015)

8.4.1 For mental health advocates to provide a comprehensive personal advocacy service they will need access to a patient's medical record and other documentation that may relate to the patient and the Act allows mental health advocates to have such access.

8.4.2 Where the patient is involuntary they can object to the mental health advocate inspecting their medical record. The Advocacy Service has procedures in place about asking patients if they object. There does not have to be anything in writing. It is sufficient if they say something like, “I don't mind”, or they don't object when the issue is raised in their presence. Mental health advocates are subject to the same rules of confidentiality as any other staff member.

8.4.3 An identified person who is a voluntary patient must provide consent before the advocate can access their medical records. If it is clear to the patient's psychiatrist that the identified person lacks even the minimal capacity to provide this consent then someone else authorised by law such as a guardian, a parent, or a family member could provide consent for the advocate to have access to the patient's medical record. In those circumstances either a staff member or a mental health advocate could contact the person authorised by law to seek consent.

- 8.4.4 When the advocate requests access to a patient's medical record, it is the responsibility of clinicians to note if there are parts of the record which are subject to restrictions under section 249 (Restrictions on access). The mental health advocate needs to be made aware of any restrictions in case they inadvertently give the patient information, perhaps of a confidential nature, which has been restricted. If after being informed of these restrictions the mental health advocate discloses restricted information, they may be subject to a financial penalty of \$5000 (s. 361).

8.5 Investigating a matter about conditions

- 8.5.1 It may come to the notice of a mental health advocate - either because it is reported to them by a patient or relative or visitor or by their own observations - that something is occurring which is adversely affecting the health, safety or wellbeing of the patient.
- 8.5.2 These adverse events may include the behaviour of another patient, visitor or staff member, not having dietary needs provided for, or not being able to see a social worker. In fact, adverse events could cover almost anything that impacts on the patient due to general ward rules, clinical practice or any day-to-day ward or clinic activities.
- 8.5.3 The parameters of what constitutes an 'adverse event' are deliberately wide to encompass almost any event on the patient's journey, which can impact on their health, safety and wellbeing. This emphasises the holistic perspective to mental health care where many issues, some not related to care and treatment, can affect the recovery of a patient.
- 8.5.4 Mental health advocates have a specific responsibility to inquire and investigate these events and can do so by speaking to the patient, relatives and staff, reviewing medical records, visiting any part of a hospital or ward or getting information from other government and non-government organisations.
- 8.5.5 It is the responsibility of clinicians to assist mental health advocates as much as possible in their enquiries and investigations.
- 8.5.6 The mental health advocate can try and resolve any issue that comes out of an investigation or inquiry by speaking directly with the staff and clinicians should engage with mental health advocates in this process.
- 8.5.7 If the issue cannot be resolved the mental health advocate should refer the matter to the Chief Advocate if it is appropriate to do so. The Chief Advocate can prepare a report and present it to the person in charge of the mental health service for further action. At the same time the Chief Advocate could send a report to the Minister, the Director General of Health or the Chief Psychiatrist.
- 8.5.8 The person in charge of the service should look into whether a further inquiry is warranted and if it is what the results of that inquiry are and provide the results to the Chief Advocate.

8.6 Inspecting any part of the mental health service

- 8.6.1 When visiting a mental health service a mental health advocate can inspect any part of the service such as the kitchens or toilets or parts of a ward such as the seclusion room or other clinical areas.
- 8.6.2 Clinicians must provide access to any part of a mental health service, however if there are concerns about safety or privacy then those matters should be discussed before access is granted. Safety issues discussed in 8.3.11 also apply in these circumstances.
- 8.6.3 The mental health advocate may ask a number of questions about what they observe, however a clinician should only answer any question they are actually knowledgeable about. Clinicians are expected to know about why a patient has been admitted, detained and treated but may not be aware of other matters related to the ward environment and would not be expected to provide a response to those matters.

8.7 Complaints

- 8.7.1 Mental health advocates have a role in inquiring into and seeking to resolve complaints made by patients, or others who have an interest such as a relative or carer, in regard to treatment and care. The term treatment and care can encompass almost anything that happens to a patient, from the type of medication prescribed to dietary needs to restrictions on visits or phone calls to their experience of being a patient.
- 8.7.2 Clinicians can refer a patient to a mental health advocate if the patient has a complaint or an issue they would like to discuss and as part of any admission process patients must be given a pamphlet detailing services provided by the advocacy service. In addition, best practice would include providing the information verbally.
- 8.7.3 Having received a complaint the mental health advocate is likely to first attempt to resolve the complaint through negotiation with the mental health staff, but this will need to be in line with the patient's wishes. The patient may prefer to send a letter of complaint with the assistance of the mental health advocate, for example. The mental health advocate will advise the patient of their rights, their options and any likely consequences and then act on the patient's wishes. If the patient chooses to negotiate it is always preferable if the patient is present, but the patient may choose otherwise and the mental health advocate can always represent the patient without them being present. The mental health advocate will then notify the patient of actions taken as result of the complaint and the outcome.
- 8.7.4 Complaints about medication or the adverse effects of medication should be dealt with by the psychiatrist or medical officer, however other staff can deal with any of the complaints that arise out of being a patient on a ward or being managed by a clinic.

- 8.7.5 Clinicians should only manage complaints within their area of expertise and all other complaints should be referred to an appropriate person or body. For example a complaint about accommodation may be better managed by the Advocacy Service and the housing department.
- 8.7.6 Mental health advocates can refer any issues to other bodies such as the complaints office of a service, HaDSCO, the Chief Psychiatrist with regard to a treatment matters, a legal service (for legal advice), or the Chief Advocate.

8.8 Mental health advocates and the Mental Health Tribunal

- 8.8.1 Patients or others who have an interest in the matter can request the involvement of a mental health advocate when a review is scheduled by the Tribunal.
- 8.8.2 Mental health advocates will inform patients of their right to request a review or that the Tribunal will schedule a mandatory review. They will outline the various reasons a review can be sought and what might happen at a review.
- 8.8.3 Clinicians must give involuntary patients, carers and other support persons the pamphlet which details the role of the Tribunal.
- 8.8.4 Patients or the person who applied for a review can be represented by anyone they choose (with the approval of the Tribunal). However in most cases it will either be a lawyer (either from the free mental health legal service or privately engaged) or a mental health advocate.
- 8.8.5 If it is a mental health advocate the service should provide as much information to the mental health advocate as possible, including time to speak with the patient and access to the medical records or other documents, and discuss the issues with members of the treating team. They should also be provided with a copy of the psychiatrist's report, preferably within 3 days of the hearing to enable discussion with the patient. It will give the patient time to consider the issues so they can fully participate in the hearing. It is not the role of the mental health advocate to take the patient through and explain the medical report prepared for the Tribunal. The mental health advocate may provide a simple support role in the review or provide detailed submissions on behalf of the patient. There may or may not also be a lawyer present.
- 8.8.6 On the day of the review a mental health advocate may require more time with the patient they are to represent and can attend the review with the patient.

Chapter 9: Mental Health Tribunal (Part 21)

9.1 Background

- 9.1.1 All jurisdictions in Australia have moved from a strict 'medical model' in relation to involuntary care and detention to a 'legal model'. This imposes specific criteria for involuntary status and seeks to ensure the procedural fairness of decisions made through a process of independent review.
- 9.1.2 The Mental Health Act 1996 (MHA 1996) introduced the Mental Health Review Board into legislation, as an independent board to review involuntary status.
- 9.1.3 The Mental Health Act 2014 (Act) continues with the concept of a review function but the name has been changed to the Mental Health Tribunal (Tribunal), with a number of new duties and responsibilities in addition to its function of reviewing involuntary status.
- 9.1.4 This chapter of the guide needs to be read in conjunction with information provided by the Tribunal.

9.2 Establishment and Constitution (Divisions 2, 14, 15, 16)

- 9.2.1 The Tribunal has a President who is appointed by the Governor of Western Australia on the recommendation of the Minister for Mental Health (s. 475).
- 9.2.2 A number of Tribunal members will also be appointed by the Governor on the recommendation of the Minister for Mental Health. Members will include lawyers, adult or child and adolescent psychiatrists and persons colloquially known as 'community members' who are neither lawyers, psychiatrists nor mental health practitioners who are staff members of a mental health service or private psychiatric hostel (s. 476). In relation to the approval of psychosurgery additional members will include a neurosurgeon appointed as a member by the Minister for Mental Health.
- 9.2.3 The Tribunal also has a Registrar who will be the executive officer of the Tribunal, and who is responsible for the following functions (s. 484):
 - a) Keeping particulars of each involuntary patient.
 - b) Making sure that reviews regarding involuntary status are conducted in accordance with the required time frames.
 - c) Making sure that reviews of matters where no specific timeframes are mentioned and any other proceedings are conducted as soon as practicable.
 - d) Being the recipient of documents which must be provided such as reports, treatment, support and discharge plans, approved forms and other forms for approval, for example for ECT to be approved.
 - e) Generally being the executive officer of the Tribunal and carrying out any directions from the President or other functions delegated.

- f) Delegating to a registry officer, who is a public servant appointed to assist the Registrar, any powers the Registrar has except for the power of delegation (s. 487).

9.2.4 In order for the Registrar and the registry staff to undertake their functions as laid down by the Act, the Tribunal must be informed in a timely manner of any involuntary orders made, changes to orders and any other functions the Tribunal has oversight of. In this regard the Tribunal should be made aware of these matters as soon as practicable after their occurrence, using the requisite forms.

9.2.5 The President may delegate to another member, any power or duty that is of an administrative nature (s. 482).

9.2.6 The President may make decisions regarding the rules and management of the Tribunal, its practices and procedures including participation at reviews, representation, how a review is conducted, the way documents and the Tribunal's records are managed and the use of the Tribunal's seal (s. 473). Rules must be published in the Government Gazette and laid before each House of Parliament (s. 474).

9.3 Reviews

9.3.1 The Tribunal reviews a number of decisions made by psychiatrists which are as follows:

- a) Review of involuntary status to determine whether or not an involuntary order should continue (Division 3).
- b) Review of involuntary treatment orders with regard to their validity (Division 4).
- c) Review the application for the provision of ECT for involuntary patients and all children, voluntary and involuntary, over the age of 14, and either approve or not approve the treatment (Division 6).
- d) Review the application for psychosurgery for patients and all children over the age of 16 who provide informed consent, and either approve or not approve the treatment (Division 7).
- e) Review orders restricting freedom of communication (Division 9).
- f) Review decisions affecting rights (Division 11).
- g) Review the admission of long term voluntary inpatients (Division 5).
- h) Review applications in regard to compliance notices for non-clinical matters and decide whether a compliance notice should be made (Division 8).
- i) Review the validity of a nominated person to perform that role (Division 10).

- 9.3.2 The President can decide where a review will be conducted. The usual venues are authorised hospitals, clinics or via the use of audio-visual (AV) means (videoconferencing) (s. 438).
- 9.3.3 Patients or other people such as a representative, guardian, carer, family member, personal support person or any other person who, in the opinion of the Tribunal, has sufficient interest in the matter can request a review in relation to a), b), e), f), g) and h) in 9.3.1.
- 9.3.4 Psychiatrists can request approval of treatments under c) and d), and request reviews under i).
- 9.3.5 If no request is made in regard to a) the Tribunal must conduct a mandatory review.
- 9.3.6 The Registrar will schedule a review within the timeframes required by the Act, for example for an initial mandatory review of an adult involuntary patient, at least 2 weeks before a hearing. The Registrar will inform the patient; the person who applied for the review if it was not the patient; the psychiatrist and the treating team; a carer, guardian, family member, or personal support person whose name has been provided to the Tribunal; in relation to children, parents and where an advocate is not a party to the hearing the Chief Mental Health Advocate; other interested parties such as the patient's representative; and in relation to i) the nominated person with regard to the hearing.
- 9.3.7 If a person who has been invited to attend a hearing is unable to attend at the time scheduled they should contact the Registrar, who will do what can be reasonably done to accommodate their availability when setting the date, time and place.
- 9.3.8 Patients may represent themselves or be represented by another person. The patient can choose who they would like to represent them, but it is usually a lawyer or an advocate from the Advocacy Service. A patient could also ask a carer, friend, family member or nominated person to represent them (s. 449).
- 9.3.9 The person representing the patient must not be paid unless they are a lawyer, an advocate or a person prescribed by the Regulations (s. 454).
- 9.3.10 The Tribunal must also appoint someone such as a lawyer to represent a patient if they think that would be in the best interests of the patient. The Tribunal can also make arrangements for a person to be represented at the request of a patient or other person important in the patient's life (s. 449).
- 9.3.11 Children with capacity to consent can represent themselves or be represented by a lawyer, an advocate, a parent, guardian or any other person who in the Tribunal's opinion is willing and able to represent the child (s. 450).

- 9.3.12 Children who lack capacity must be represented either by a lawyer, an advocate, a parent, a guardian or any other person who in the Tribunal's opinion can represent the child's interests (s. 451).
- 9.3.13 Just because the patient is experiencing a mental illness does not diminish their right to provide instructions to a lawyer or to have the lawyer act on those instructions (s. 453).
- 9.3.14 A review is not open to the public unless the Tribunal orders that the hearing or part of the hearing is open to the public, as confidential matters about the patient and others may be discussed (s. 456).
- 9.3.15 It is recognised that appearing before a Tribunal can be stressful and the patient and other persons may express their distress in ways that could be interpreted as being agitated or offensive to the Tribunal. While taking this into account the Tribunal may exclude the patient and other persons from the hearing if their behaviour is not conducive to the way the review is being conducted. Exclusion can be for the entire or part of the review and the review can be conducted in their absence. If the person being excluded is the patient's representative the Tribunal must appoint another person to act as the patient's representative.
- 9.3.16 The patient may ask for a specific person to be present at the review which the Tribunal can agree or not agree to. If the Tribunal decides the person should not be present at the hearing because they are satisfied that it is not in the best interests of the patient for that person to be present, the excluded person can request reasons for that decision from the Tribunal, which must be provided.
- 9.3.17 Reviews can be conducted without the patient or another party to the hearing being present, as long as they were aware of the review and it would be in the best interests of the patient for the review not to be adjourned. For example patients on CTOs may be reluctant to attend a review if it means they have to take time off work or travel some distance to attend. The decision as to whether to attend or not lies with the patient, though they should be aware that the review could continue in their absence. There is nothing preventing the patient providing information in writing about their issues and concerns to the Tribunal prior to a hearing (s. 457).
- 9.3.18 The Tribunal may also summons a person, including clinicians, to attend a review in order to give evidence (s. 462). If they do not answer the summons without reasonable excuse they could be committing an offence (s. 465). For example the Tribunal may decide that they must hear directly from the patient's treating psychiatrist, who, perhaps due to work pressures, refuses to attend. In those circumstances one option for the Tribunal is to issue a summons obliging the psychiatrist to attend to provide evidence or produce a document.

9.3.19 It is an offence, punishable by a \$10,000 fine, for a person (a psychiatrist working for a mental health service), not to give effect to a decision of the Tribunal. This does not apply to services not complying with recommendations the Tribunal may make (s. 471).

9.4 Conduct of reviews (Division 12)

9.4.1 The Tribunal is a quasi-judicial tribunal and reviews are conducted in as informal a way as possible. This is in order to put the patient and others at ease to enable them to discuss their concerns (s. 439).

9.4.2 The Tribunal is bound by the rules of natural justice or a 'duty to act fairly'. This includes acting without bias, being impartial and allowing those who attend the opportunity to express their view without feeling intimidated. Natural justice also supports the concept of procedural fairness and the right to have legal representation. There should also be transparency in the way the review is conducted.

9.4.3 The Tribunal will have access to a number of documents such as the application for the review, the request for approval in relation to ECT or psychosurgery, the patient's medical record, and documentation given to the Tribunal from any of the persons attending the review or a person who may not be attending but has an interest in the review. The Tribunal can keep these documents for a reasonable period and make copies. The Tribunal usually looks at all the documentation before the review commences.

9.4.4 If a document produced is known by the person producing the document to be false or misleading then that person is committing an offence, for which there is a financial penalty. For example, a person providing a report purported to be from another psychiatrist, which challenges the diagnosis and treatment of the treating psychiatrist and which is found to be a forgery, could be committing an offence. This extends when giving false or misleading information during a review (s. 465).

9.4.5 The Tribunal can engage or appoint a person with specific relevant knowledge or experience to assist them during the review (s. 442). For example if the patient is Aboriginal a person with cultural knowledge may be asked to attend a review and assist the Tribunal. The patient or patient's representative can also ask for a person with specific knowledge or expertise to attend, who with the Tribunal's permission can provide evidence. However the Tribunal does not pay fees for such appearances and each party to a proceeding is expected to bear their own costs.

9.4.6 At times, but quite rarely, the Tribunal may decide that a proceeding is frivolous, vexatious or brought for an improper purpose and they can dismiss such a proceeding and order that no further application can be made without the Tribunal's permission (s. 445).

9.4.7 A review is a hearing 'de novo' which literally means 'afresh' or 'beginning again'. For example, the psychiatrist may have made the person an

involuntary patient based on some specific criteria or behaviour. While that criteria or behaviour can be part of the evidence at the review, new issues not considered before can be considered 'afresh' by the Tribunal (s. 455).

- 9.4.8 How the review is conducted is up to the presiding member of the Tribunal who is the lawyer (s. 440). It is usual to hear from the patient directly as well as the patient's representative and the patient's psychiatrist or other member of the treating team. Other people, with the Tribunal's permission, may also give evidence. Evidence can be given verbally or in writing. Any member of the Tribunal can ask questions of the patient and others who attend the review. While evidence is usually given informally at times the Tribunal can ask for the evidence to be given under oath or affirmation or by affidavit (s. 460).
- 9.4.9 Sometimes verbal evidence may be requested about written information which has been restricted (see 1.5). In those circumstances the evidence cannot be given in the presence of the patient, who may be asked to leave the room while that evidence is being given. If the patient refuses the Tribunal must make an order excluding the patient which allows the patient not to be present when the evidence is given (s. 461).

9.5 Clinician's responsibilities at reviews

- 9.5.1 Clinicians need to understand that the involuntary patient and carer's right to a review is an essential human right and must be supported (Principle 2 of Charter of Mental Health Care Principles).
- 9.5.2 Clinicians need to provide the patient, carers and relatives with information about this right including a copy of the pamphlet available from the Tribunal and answer any questions the patient and others may have about the process. At times patients and carers will need assistance to complete application forms and staff should assist with this task, as well as ensuring that the application form is sent to the Tribunal.
- 9.5.3 When a review is scheduled clinicians should ensure that the patient and others, such as carers, family members and personal support persons, have details of the required information which includes the right to representation from a lawyer, a mental health advocate or another person acceptable to the Tribunal.
- 9.5.4 In relation to Tribunal matters and in other circumstances which involve a patient's representative, the representatives should be provided with access to the patient's medical record and also access to the patient in an environment such as a visitor's room, which allows proper communication. At all reasonable times the patient must have access to the representative by telephone (s. 261).
- 9.5.5 In exceptional circumstances, where there is a serious risk to the safety of the representative and no other steps that could reasonably be taken to reduce the risk, face-to-face access can be restricted. The psychiatrist must

complete a Form 12C and the representative needs to be made aware of the restriction. The restriction lasts for up to 24 hours and if not renewed then the representative can have face-to-face access. If it is renewed then access can continue to be denied. It would be good practice for regular assessments to be made during the period, to ascertain if the risk has abated so that the representative can have access, and for the representative to be informed as soon as practicable of a change in circumstances. Denial of face-to-face visits for a representative does not extend to contact by telephone, emails or letters (s. 262) (see 1.11).

- 9.5.6 If the psychiatrist has completed Form 12B restricting patient access to their clinical record or part of the record, the representative should be made aware of those parts of the file which have been restricted, so that he or she does not disclose to the patient any restricted information. Representatives can be fined for disclosing restricted information to a patient (s. 251).
- 9.5.7 The representative has a right, as does a person nominated by the patient, to access information that a psychiatrist has restricted from a patient. The grounds for restriction are that access poses a risk to the health or safety of the patient or to the safety of another person or poses a significant risk of serious harm to the patient or to another person. Information that would reveal details about an individual other than the patient or information of a confidential nature that was obtained in confidence cannot be disclosed to the patient or a representative (see 1.5).
- 9.5.8 Clinicians should provide a representative with access to a patient's medical record in a timely manner, noting that the representative will need to consider the information before representing the patient at a hearing. It would be advisable to note on any photocopies that the copy was made and provided to the representative, so it is clear that it is not the original documentation. Representatives should be provided with a quiet area in which to review the record, and be allowed to take notes and where appropriate photocopies.
- 9.5.9 The administration of these issues can become complex if, for example, the medical record has not been examined to indicate which parts should be restricted and then the representative has access and may inadvertently disclose information which was going to be restricted. It is not good practice to restrict a medical record to a representative just because the service is unaware of which parts of the record should be restricted. There is a responsibility on the service as an ongoing exercise to identify those parts of the medical record that are restricted (using a stamp or sticker to indicate a restricted passage for instance), and to ensure there is no undue delay in allowing a representative access (see 9.5.7).
- 9.5.10 As noted in 9.3 a review can be conducted without the patient being present and patients may choose not to attend. However it is preferable that they do attend and contribute to the review. Staff should make every effort to understand why a patient may not wish to attend and provide advice and

counselling as appropriate. It may also be necessary in these circumstances to seek the assistance of the Advocacy Service who can also provide advice to the patient and representation at a review.

- 9.5.11 From an administrative perspective, it is difficult for the Tribunal to state exactly when a review will be conducted during a session, a session being either a morning or an afternoon. Some reviews may be completed quickly and others extend for a considerable period, so it is difficult to determine when the patient may be called to the room where reviews are conducted. Staff should ensure the patient and others attending are aware of these processes and be available quickly when called. The closest analogy is a GP's surgery waiting room where a patient arrives having not made an appointment and it is difficult to determine when they will actually be seen. While every person is on the Tribunal list, when they will actually be called for the hearing is uncertain.
- 9.5.12 Waiting for a review can be stressful and staff should make every effort to reduce patient distress, using advocates and representatives to assist where appropriate. Patients should be escorted to a review, though it may not be necessary or appropriate for clinicians to be with the patient in the review room. If a patient is distressed and potentially a risk to the health and safety of others, the Chair of the Tribunal should be informed, so that action can be taken to reduce the risk which may include a staff member sitting with the patient during the review.
- 9.5.13 If the patient is very labile and there is a possibility that he or she may react adversely during the review, the Chair of the Tribunal should be informed so action can be taken to reduce possible distress and manage any adverse behaviours. Whether a staff member remains in the hearing room is at the discretion of the Tribunal.
- 9.5.14 For the Tribunal to make a considered decision as to the patient's status, it is important that they are provided with as much relevant information as required. This could include an up-to-date report on the patient including how the patient is progressing, responding to treatment and what their prognosis is. While some of this information will be in the treatment, support and discharge plan, which must be provided to the Tribunal, additional information may be necessary. It is the Tribunal's preference to receive the report at least 72 hours before the hearing is scheduled. The patient, patient's representative, carer, family member and personal support persons should receive the report at the same time.
- 9.5.15 The patient and the patient's representative should have access to the report and the treatment, support and discharge plan. While it is possible to provide a report to the Tribunal with the request that the report, or part of the report, is restricted to the patient, this needs to be justified and should be the exception. It is the decision of the Tribunal as to whether to restrict patient

access to a report. The report should only be withheld from the patient's representative in exceptional circumstances.

- 9.5.16 It is always preferable for the patient's psychiatrist to attend a review in order to provide answers to questions from the Tribunal members and others such as the patient, the patient's representative, carers, family members and nominated persons. If a psychiatrist is unable to attend, then the most senior person involved in the patient's care should attend, such as a medical practitioner, the clinical nurse specialist or the case worker.
- 9.5.17 Patients can and are encouraged to ask questions themselves as well as provide information regarding their experience of being an involuntary patient. If information presented is contrary to what the staff understand, for example the patient stating that the family are happy to have them home, when the family have disclosed to the staff reluctance in regard to this outcome, then it is appropriate for staff to inform the Tribunal of the issues from their perspective. Claims may be made from all sides, which may need to be verified prior to the Tribunal making a decision.
- 9.5.18 Staff have a responsibility to provide care to a patient who may be distressed following the outcome of a review. At times a patient may place great hope for discharge when their involuntary status is being reviewed and a decision by the Tribunal to maintain the involuntary status can cause distress and disappointment. It may be appropriate for staff to plan beforehand how these matters should be managed, for example which staff member should be available to provide assistance and care in the event of an adverse decision from the patient's perspective.
- 9.5.19 Post-review counselling may be an appropriate intervention for some patients, where they are allowed to express their frustrations and adjust their plans, which could include applying for a further review.

9.6 Reviews of involuntary treatment orders (Division 3)

- 9.6.1 A patient, a carer, close family member, other support person, mental health advocate or another person, such as a patient's legal representative, who in the Tribunal's opinion has sufficient interest in the matter, can request a review of the involuntary status (s. 390).
- 9.6.2 This can be done at any time following the patient being made an involuntary patient, even though another review has just been conducted though then there needs to be a material change in the patient's circumstances to justify a further review. The Tribunal can delay having a further requested review for a period of up to 21 days for an adult or 7 days for a child if the matters to be reviewed are substantially the same as before. If there has been some material change in the patient's circumstances then the Tribunal can schedule another review before those maximum periods.
- 9.6.3 If a person has requested a review or a mandatory review is scheduled and the patient then discharged from involuntary status but made involuntary

again within 7 days, the Tribunal can delay scheduling a review for up to 28 days for an adult or up to 7 days for a child.

9.6.4 The reason for a mandatory or requested review is for the Tribunal to decide whether or not:

a) the patient still needs to be an involuntary patient

b) an inpatient detaining order is still required or whether it can be changed to a CTO

c) the terms of a CTO are appropriate. For example, if the terms include weekly attendance at the clinic and the patient is working, he or she may want to change the reporting expectations. This could be done by the treating team and the CTO could be varied, but if the treating team does not wish to change the terms, the patient may then request the Tribunal to consider the matter

d) a transfer order or refusing to make a transfer order is appropriate. For example a metropolitan authorised hospital may wish to transfer a patient who comes from a rural area to an authorised hospital near where they live and a close relative does not want that to happen, as they can have better contact with the patient in the metropolitan area. The relative can request the Tribunal consider whether given the circumstances such a transfer should occur.

e) a supervising psychiatrist's responsibilities for a patient on a CTO should be transferred to another psychiatrist, whether or not there is a refusal by the supervising psychiatrist to consider such a matter. For example, a patient on a CTO may want a private psychiatrist, who has been their psychiatrist previously to become the supervising psychiatrist but the supervising psychiatrist believes that that would not be conducive to provision of treatment. The patient can request the Tribunal consider the issue and make a decision on the matter

f) the treating practitioner's responsibilities for a patient on a CTO should be transferred to another treating practitioner, or the refusal of the treating team to consider such a matter. For example, the treating team may feel it is more appropriate for the patient's GP to be the treating practitioner, but the patient's carer believes they would receive better care from a case manager at the local mental health clinic. The carer could then apply to the Tribunal for a decision as to how it should be resolved

g) an interstate transfer or refusal of an interstate transfer is appropriate (see Chapter 12: Interstate arrangements).

9.6.5 The Tribunal will schedule a requested review as soon as practicable and inform all those who might want to, or are expected to, contribute to the review. This will include the patient, carer, guardian, close family member, nominated person, the patient's representative and the psychiatrist. With regard to an inpatient, the treating team will need to arrange for

documentation to be made available to the Tribunal and the patient's representative as well as arranging for the patient to attend the review. Involuntary inpatient reviews will be conducted at the authorised or general hospital, either face-to-face or by videoconferencing. Community services also need to provide documentation to the Tribunal and can assist the patient attending the hearing. Community reviews can be conducted at clinics or at times in hospital facilities either face-to-face or by videoconferencing.

- 9.6.6 If there is no request for a review a mandatory review will be scheduled within 35 days for an adult and 10 days for a child, from the time the person was made an involuntary patient (s. 386).
- 9.6.7 The Tribunal may also, on its own initiative, conduct a review, if it considers it appropriate to do so, without there being a request or the need for a mandatory review (s. 391). For example, the Tribunal may be informed that the patient is starting a new course of treatment and would like to review progress under the new course of treatment to assess whether the patient should remain an involuntary patient.
- 9.6.8 The Tribunal can suspend the operation of an order until a review is conducted or a decision is made. The application for suspension can be made by any party such as the patient, the patient's representative, carer, family member or the Tribunal can suspend the operation of an order on its own initiative (s. 392). If an order is suspended until a further review or a decision is made by the Tribunal, then what can normally be done under an involuntary order (such as giving treatment without consent) cannot be undertaken. For example, the psychiatrist may indicate to a patient that their medication may be changed to a drug the patient believes is not appropriate for them. The patient may then request that the decision by the psychiatrist should be suspended until a review is conducted, to enable the patient to put his or her objections to the Tribunal. If the review is scheduled quite soon and the patient puts forward a compelling case for suspending the operation of the order, the Tribunal can order that the change of medication is not implemented so that the issue can be discussed at review. At times the request for suspension can be inappropriate and the Tribunal should consult with the psychiatrist before suspending the operation of the involuntary order. The Tribunal need to provide mental health services with rules as to how these applications will be managed.
- 9.6.9 The Tribunal when conducting a review will consider (s. 394):
- a) the involuntary patient's psychiatric condition, details of which will be in the medical record and the psychiatrist's report
 - b) the involuntary patient's medical and psychiatric history
 - c) the involuntary patient's treatment, support and discharge plan
 - d) the involuntary patient's wishes to the extent that it is practicable to ascertain those wishes

e) the views of other important people in the patient's life such as carers, relatives and personal support persons

f) the views of a medical practitioner or mental health practitioner with qualifications, training and experience relevant to children and authorised by the Chief Psychiatrist, when the involuntary patient is a child and the Tribunal does not have a child and adolescent psychiatrist on the review panel.

9.6.10 The Tribunal will provide specific information about how reviews of involuntary status will be conducted and that will include giving all persons at the review an opportunity to present their case and ask questions. The Tribunal members may also ask questions of any person present at a review or request that a person attend a review so they can be asked questions. At times a review may be suspended when, for example the Tribunal wants to speak directly with the psychiatrist, who is not available on that particular day. The review can then be recommenced at a later date. If necessary the Tribunal can issue a summons for a person to attend a review, either to give evidence and/or produce a document. A person not attending when summoned is committing an offence and could be fined \$5000.

9.6.11 When completing a review the Tribunal may make an order or give directions which they think are appropriate (s. 395). These can include:

a) revoking the inpatient treatment order or the CTO

b) directing a psychiatrist to change an inpatient order to a CTO. This can be implemented within a reasonable specified time period (see 5.2). If the psychiatrist believes this change to be inappropriate, he or she may apply to the Tribunal for a review of their decision. At review the Tribunal may suspend, revoke or confirm their decision

c) varying the terms of a CTO, consistent with section 115 (see 5.2)

d) deciding whether or not a transfer order should be complied with

e) deciding whether or not the responsibilities of a supervising psychiatrist should be transferred to another psychiatrist

f) deciding whether or not the responsibilities of the treating practitioner should be transferred to another treating practitioner

g) deciding whether or not an interstate transfer should occur

h) making non-binding recommendations with regard to the treatment, such as changes to medication, support and discharge plans, which they may also forward to the Chief Psychiatrist.

9.7 Review of the validity of involuntary treatment orders (Division 4) (See also 1.18)

9.7.1 The involuntary patient, the psychiatrist who made the order, a carer, family member or personal support person, an advocate, or any other person, such as the patient's legal representative, who in the Tribunal's opinion has

sufficient interest in the matter can apply for a review of the involuntary treatment order. The Tribunal can also on its own initiative review whether an order is valid or not (s. 398).

- 9.7.2 An application can be made even though the patient is not currently an involuntary patient and has not been one for the last 6 months. This allows a retrospective review for up to 6 months, from the time the patient was made no longer involuntary. If the applicant shows good reason for the delay in applying for a review, the Tribunal will conduct a review past the 6 month period. This provides another pathway for review, if a patient believes they were held under an order that should be invalid and did not challenge the order while an involuntary patient (s. 400). The Tribunal is not required to make a decision regarding validity of the order, but may do so if the matter raises a question of law or public interest.
- 9.7.3 If the Tribunal find the order invalid, the person who made the order will be informed. As the patient is no longer an involuntary patient, the powers of the Tribunal to make the person voluntary do not apply. However the patient can ask for the finding to be noted on the patient's medical record and also seek an apology from the service. Following a finding the patient may wish to lodge a complaint with the service or with HaDSCO. However, a complaint to HaDSCO may be limited, as the Director of HaDSCO can reject investigating a complaint if the matter has already been dealt with by another complaints pathway, such as requesting a review by the Tribunal. A complaint could be made by the patient to the Corruption and Crime Commission if there is a suggestion that a clinician (public officer) has engaged in misconduct. A patient may also wish to bring an action in court for liability. However, there is a protection from liability for clinicians when performing a function of the Act in good faith (s. 583).
- 9.7.4 The review applies to the following orders (s. 397):
- a) inpatient treatment order in authorised hospital (Form 6A)
 - b) inpatient treatment order in a general hospital (Form 6B)
 - c) continuation of involuntary inpatient treatment order (Form 6C)
 - d) Community Treatment Order (Form 5A)
 - e) continuation of a CTO (Form 5C)
 - f) varying a CTO (Form 5D).
- 9.7.5 While the review applies specifically to involuntary treatment orders, in effect it also applies to referral orders (Form 1A) and transport orders (Form 4A to Form 4C), because without a properly conducted and legal referral or transport order, an involuntary treatment order would not be made. For example, when reviewing an inpatient treatment order, it was noticed that the time between when a patient was assessed and the referral order made was

longer than 48 hours, as required by section 40. This would make the referral order invalid and by extension the inpatient treatment order also invalid.

- 9.7.6 This places a responsibility on psychiatrists, medical practitioners, AMHPs and in certain circumstances persons in charge of a ward, to ensure that when completing a form or performing a function under the Act, all legal requirements are complied with.
- 9.7.7 It is the responsibility of the Tribunal to determine the exact criteria they will apply when deciding whether an order is invalid or not. Certainly that will include the legal requirements (i.e., who can perform a function) and time constraints (i.e., how long forms are valid for), but it could also include how an assessment or an examination was conducted, whether people important in the patient's life such as carers and personal support persons were consulted or in relation to Aboriginal people whether an elder or traditional healer was consulted. While it is recognised that contacting elders and traditional healers particularly from remote communities can be difficult and time consuming every effort should be made to consult with them. It may be advisable at the time of admission for a service to discuss with a patient and family members the appropriateness and practicality of involving elders or healers and establish who these persons are and how they can be contacted (see s. 50).
- 9.7.8 In addition to whether or not there has been a failure to comply with the legal and conduct requirements, the Tribunal needs to decide whether the rights or interests of the involuntary patient have been substantially prejudiced. For example, at review they may determine that the order contains a formal defect such as an accidental omission or an error in the description of the patient (section 579) and may order that the defect be rectified.
- 9.7.9 While this provides patients with an avenue of review if they believe that a process has not been conducted properly, it is also important for the treating team to have the opportunity to provide their point of view. Before deciding that an order is valid or invalid the Tribunal will consult with clinicians involved, as there may be justifiable reasons why an action was performed or not performed in a particular way.
- 9.7.10 If the Tribunal makes a determination that an initial inpatient treatment order (Form 6A or 6B) is invalid, then the order is no longer in force, and the patient is no longer involuntary and can leave. However, if the Tribunal reasonably suspects that the patient is in need of an inpatient treatment order, they can make an order for assessment by a medical practitioner or AMHP and if necessary authorise the person's detention until such an assessment is conducted. That assessment may indicate that the patient be referred for examination by a psychiatrist and continue to be detained at the authorised hospital for that examination to occur. Or the assessment may indicate that no referral order should be made and the patient must be released (s. 399). The reason for allowing a further assessment to be conducted is that it may

be detrimental to the patient's or another person's health and safety for the patient to be discharged immediately. As it is an initial order the patient may still be quite acutely unwell and require the protection of involuntary status, despite the order being found to be invalid.

9.7.11 If the Tribunal makes a determination that a continuation order (Form 6C Continuing an inpatient treatment order for up to 3 months) is invalid, then the continuation order ceases to be in force. If the patient is still on an initial inpatient order when a continuation order is made, the continuation order ceases to be in force but not the initial inpatient treatment order. For example, there is a requirement that an examination to continue an inpatient order must be conducted within the 7 days before inpatient treatment order will expire. So a continuation order, which has not actually commenced, may be found to be invalid, even though the patient may still be on the initial inpatient treatment order.

9.7.12 If a CTO or the continuation of a CTO is found to be invalid the patient is no longer an involuntary patient on a CTO.

9.8 Approvals for electroconvulsive therapy (Division 6)

9.8.1 Approval for performing ECT on any involuntary adult patient and any voluntary or involuntary child is a significant task for the Tribunal.

9.8.2 A psychiatrist must seek approval from the Tribunal when deciding that an involuntary patient, whether they consent or not, and any child over the age of 14, whether a voluntary or involuntary patient, requires ECT. If the child is a voluntary patient there must be informed consent either from the child, if they are deemed to have the capacity to make informed decisions, or a parent or guardian. If the child is an involuntary patient, informed consent is not required from a parent or guardian, however they should be consulted and involved in the decision.

9.8.3 The psychiatrist applies in writing, setting out why ECT is being recommended and a treatment plan, which includes where the ECT is to be provided, the maximum number of treatments proposed to be performed, the maximum period over which the treatment will be provided and the minimum period between treatments (s. 410). For example, in the application the psychiatrist notes that ECT is being given because antidepressants have not been effective, that the treatment will be given at a specific hospital, and that 8 treatments will be given over a 4 week period with a minimum of 3 days between treatments. In regard to where ECT can be performed the Chief Psychiatrist must approve all sites.

9.8.4 The application for approval should be sent directly to the Tribunal, with information such as when the proposed treatment will commence, so the Tribunal can schedule a review within a specific time period. The treatment cannot commence without the approval of the Tribunal. In certain circumstances where emergency ECT is required for an adult involuntary

patient, approval can be sought from the Chief Psychiatrist (s. 199) (see 6.2.12).

- 9.8.5 At review the Tribunal can speak to the patient, the patient's psychiatrist and any other person who in the Tribunal's opinion has a sufficient interest in the matter such as the patient's representative, carer or personal support person (s. 411).
- 9.8.6 The Tribunal will be interested in the patient's wishes to the extent it is practicable to obtain those wishes, the view of guardians, parents if it is a child, carers, personal support persons and other important people in the patient's life (s. 414).
- 9.8.7 If the person is a child and a child and adolescent psychiatrist is not a member of the Tribunal considering the approval, then the Tribunal can seek the views of a medical practitioner or mental health practitioner who has qualifications, training or experience relevant to children and who is authorised by the Chief Psychiatrist (see 11.14).
- 9.8.8 The Tribunal will also be interested in why the psychiatrist is recommending ECT, the consequences of not providing the treatment, information on any significant risks the patient might be exposed to, whether the ECT is likely to promote and maintain the health and wellbeing of the patient, whether any alternative treatment such as medication is available and what risks there might be in only giving this alternative treatment and anything else the Tribunal considers relevant to making the decision.
- 9.8.9 Having conducted a review the Tribunal may decide to (s. 415):
 - a) approve the ECT being performed as set out in the treatment plan; or
 - b) approve the ECT subject to fewer treatments being given (for example if the approval was sought for 12 treatments the Tribunal may feel that they only will approve 8 treatments); or
 - c) refuse to approve the treatment.
- 9.8.10 There is nothing preventing a psychiatrist making further applications to give ECT, particularly if the Tribunal have reduced the number of treatments and there has not been significant improvement.

9.9 Approvals for psychosurgery (Division 7)

- 9.9.1 A patient's psychiatrist must apply to the Tribunal in writing for approval of all psychosurgery treatments.
- 9.9.2 The approval document needs to state why psychosurgery is being recommended and details of the treatment plan including the description of the proposed treatment, the name, qualifications and experience of the neurosurgeon who will perform the treatment and where the treatment will be given (s. 417).

- 9.9.3 The Tribunal will want to speak to the patient, the patient's psychiatrist and other people such as carers who, in the Tribunal's opinion, have an interest in the matter (s. 418).
- 9.9.4 For psychosurgery approvals the Tribunal is constituted by a legal practitioner, two psychiatrists, a person who is neither a lawyer, a medical practitioner or a mental health practitioner who is a staff member of a mental health service or private psychiatric hostel (the community member) and a neurosurgeon (s. 384). In relation to children one of the psychiatrists must be a child and adolescent psychiatrist (s. 384(d)).
- 9.9.5 The Tribunal must be satisfied that informed consent has been given, that the treatment has clinical merit, that other types of treatment have been tried and found not to have lasting effect, that the neurosurgeon is suitably qualified and experienced and that the place where it will happen is suitable (s. 419).
- 9.9.6 When making their decision, the Tribunal must take note of the views of carers, family members and personal support persons. They must consider the consequences of not giving the treatment, the sort of risks that may result from the treatment, whether the treatment will promote and maintain the health and wellbeing of the patient and anything else that may be relevant (s. 420).
- 9.9.7 The Tribunal can decide to approve or not approve the psychosurgery. If they do not approve the treatment, further applications can be made where appropriate (s. 421).
- 9.10 Compliance notices for non-clinical matters (Division 8) (See also 1.19)**
- 9.10.1 A patient, a carer, family member or personal support person, a mental health advocate, another person which the compliance issue relates to, or any other person who in the Tribunal's opinion has sufficient interest in the matter can apply to the Tribunal for a compliance notice (s. 424).
- 9.10.2 A compliance notice is relevant where a person, such as a carer, feel they have not been adequately involved in the care of the patient, or have not been consulted about the treatment, support and discharge plan, or have not been given important information. Before making an application it may be appropriate for the applicant to discuss with the Registrar of the Tribunal the appropriateness of the application. It may also be appropriate for the applicant to explore his or her grievance directly with the service so the matter can be resolved without it having to go to the Tribunal. At times the applicant may feel that despite communicating with the service no progress is being made and it would then be appropriate to apply to the Tribunal for a compliance notice.
- 9.10.3 Compliance notices are not about treatment decisions. For example, the Tribunal could not at a review make a notice about medication or ECT, however they could make a compliance notice about a close family member not being informed about a change of medication.

- 9.10.4 Compliance notices are an additional right. This means that with regard to a particular issue, patients and carers can make a compliance notice application as well as lodge a formal complaint and/or or raise it informally with the service at the same time.
- 9.10.5 Before deciding to review a matter or issue a compliance notice, the Tribunal can decide to refer the issue to the Mental Health Commissioner, the Director General of Health, the Chief Psychiatrist or a registration board. However the Tribunal could also refer the matter while conducting a review themselves and making a compliance notice (s. 423).
- 9.10.6 At a review the Tribunal can hear from the patient, or the person to whom the compliance notice relates, the service provider or any other person who, in the opinion of the Tribunal, has sufficient interest in the matter (s. 425).
- 9.10.7 Having reviewed the matter, the Tribunal can decide to take no action, or direct the service provider to take specific action within a time period and report back on the action taken. If the service takes no action within the time period the Tribunal can direct a response from the service as to why a compliance notice has not been complied with (s. 423).
- 9.10.8 A service that fails to act on a compliance notice is committing an offence for which there is a penalty of \$10,000.

9.11 Review of orders restricting freedom of communication (Division 9)

- 9.11.1 The patient, carer, family member, personal support person, mental health advocate or any other person, who in the Tribunal's opinion, has sufficient interest in the matter, can apply for a review of an order prohibiting or limiting a patient's right to freedom of communication (s. 427).
- 9.11.2 Part 1.11 of this guide details the matters regarding freedom and restriction of communication.
- 9.11.3 When a psychiatrist completes a Form 12C restricting the freedom of communication, an application can be made to the Tribunal to overturn the decision. This can be difficult to achieve as the restriction only lasts for 24 hours, though it can be extended and organising a review of the extension may take considerably longer. In effect this applies to restrictions which have continued for a number of days and where it is clear from the actions of the psychiatrist that the restrictions will continue.
- 9.11.4 In the application the applicant can set out their objections to the restriction and the psychiatrist will be expected to justify his or her decision.
- 9.11.5 The Tribunal may make a decision (s. 429):
- a) confirming the order as made or amended; or
 - b) amending, or further amending, the order as made or amended; or
 - c) revoking the order.

9.12 Jurisdiction in relation to nominated persons (Division 10)

- 9.12.1 As noted in 1.14 a patient can nominate a friend or relative to be a nominated person who may support the patient by visiting and keeping in contact with them, as well as being entitled to information about the treatment and care of the patient.
- 9.12.2 The patient, the nominated person, a carer, close family member, mental health advocate or the patient's psychiatrist, may apply to the Tribunal for the nomination to be declared valid or invalid. If the application is because of a defect in the form used to nominate a person, then the Tribunal can declare the nomination valid and vary the terms of the nomination in line with the intentions of the person who made the nomination (s. 431).
- 9.12.3 If the applicant is of the view that the nominated person is inappropriate for the role, for example, the nominated person has significant personal problems, or gives advice to the patient which is detrimental to their mental health, then they can apply to the Tribunal for a review, with the recommendation that the nomination be declared invalid. At review the Tribunal may revoke the nomination if satisfied that the nominated person is not an appropriate person to perform the role. This may be because it is likely the nominated person will adversely effect to a significant degree the interests of the patient, or the person is not capable of performing the role because of mental or physical incapacity, or the person is unwilling or not reasonably able to perform the role.

9.13 Review of admission of long-term voluntary patients (Division 5)

- 9.13.1 This type of review recognises that although a patient may be a voluntary patient, they may have been in hospital for so long that some sort of external review of their treatment and care is required.
- 9.13.2 Long-term is defined for an adult as 6 months continuously in an authorised hospital and for a child 3 months continuously in an authorised hospital (s. 404).
- 9.13.3 It should be noted that this type of review is not mandatory, however the following persons may apply for a review (s. 405):
- a) the long-term voluntary patient
 - b) a carer, close family member or other personal support person of the long-term voluntary patient
 - c) a mental health advocate
 - d) any other person who in the opinion of the Tribunal has sufficient interest in the matter such as the person's legal representative.
- 9.13.4 In making a decision the Tribunal must have regard to the following (s. 407):
- a) the voluntary inpatient's psychiatric condition
 - b) the voluntary inpatient's medical and psychiatric history

- c) the voluntary inpatient's wishes to the extent those wishes can be ascertained
- d) the views of any carer, close family member or other personal support person
- e) if the patient is a child and there is no child and adolescent psychiatrist on the Tribunal panel, the views of a medical practitioner or mental health practitioner who has the qualifications, training or experience relevant to children and has been authorised by the Chief Psychiatrist
- f) any other things that the Tribunal considers relevant to making a decision.

9.13.5 To assist the Tribunal in this review process, clinicians will be expected to provide written and oral information as requested by the Tribunal. For example, the psychiatrist should provide a comprehensive report noting specifically, why it is necessary for the patient to continue to remain in hospital and what the treatment, support and discharge plans are.

9.13.6 The patient may speak on their own behalf or ask a person such as an advocate, carer or a legal representative to represent their views.

9.13.7 Following a review the Tribunal may take no specific action or may make any of the following recommendations (s. 408):

- a) Ask the treating psychiatrist to consider whether or not there is still a need for the admission, in effect recommending that the psychiatrist justify why the patient should remain in hospital.
- b) Recommend that the treatment, support and discharge plan be reviewed regularly. For example, the Tribunal notes that care is reviewed every 6 months and they recommend that it be done more frequently.
- c) Recommend that the patient be discharged from inpatient care.

9.13.8 The Tribunal can only make recommendations if the patient is voluntary. If the recommendation, for example, is discharge, there is nothing preventing the patient initiating their own discharge. If the psychiatrist feels that the recommendation is not appropriate at that time or has interim plans for continued inpatient care leading to discharge at the right time, then they should inform the Tribunal so that that can be taken into account when a decision is made. The purpose of this type of review is to ensure that some long-term voluntary patient's care does have some external scrutiny and they are not left as voluntary inpatients indefinitely.

9.14 Review of decision affecting rights (Division 11) (See also 1.20)

9.14.1 A person whose right is affected, a carer, close family member or other personal support person, a mental health advocate or any other person who, in the opinion of the Tribunal, has a sufficient interest in the matter can apply to the Tribunal for a review of a decision affecting a person's rights under this Act.

9.14.2 The Tribunal will conduct a review, unless it is satisfied that the matter should be or has been heard and a determination made by the Tribunal under another Division of this Part of the Act.

Chapter 10: State Administrative Tribunal (Part 22)

10.1 Background

10.1.1 The State Administrative Tribunal (SAT) in WA deals with a broad range of administrative, commercial and personal matters. These matters span human rights, vocational regulation, commercial and civil disputes, and development and resources issues. The SAT is the primary place for the review of decisions made by government agencies, public officials and local governments. It also makes a wide variety of original decisions which includes guardianship and administration.

10.1.2 The SAT receives its power to hear matters from a large number of different pieces of legislation, such as the Guardianship and Administration Act 1990, or the Mental Health Act 2014. Before the SAT was established, these matters were heard by many different government bodies, and the SAT was established to make the legal process more efficient, flexible, and informal for parties.

10.1.3 The SAT's approach is informal, flexible and transparent. The SAT:

- a) aims to make the correct or preferable decision based on the merits of each application
- b) is not a court and, therefore, strict rules of evidence do not apply
- c) encourages the resolution of disputes through mediation
- d) allows parties to be represented by a lawyer, a person with relevant experience or by themselves
- e) hearings are closed unless the SAT orders that a hearing or part of a hearing is open to the public (s. 501)
- f) provides reasons for all decisions and publishes most decisions on its website.

10.2 Review of decision of the Mental Health Tribunal (Division 2)

10.2.1 If a patient has had a review which has resulted in a decision by the Tribunal and the patient is dissatisfied with the decision they can apply to the SAT for a review of the decision. This extends to any other person who in the opinion of the SAT has an interest in the matter and is granted leave to make the application.

10.2.2 The Tribunal may also apply to the SAT to make a determination on a question of law that arises before the Tribunal (s. 495).

10.2.3 At review the SAT is made up of members similar to a review by the Tribunal. That is, a legally qualified member, a psychiatrist and, if the matter relates to a child, a child and adolescent psychiatrist and a member who is neither a legal member or a psychiatrist or a medical practitioner or mental health practitioner (usually referred to as a community member) (s. 496).

10.2.4 If the matter to be reviewed is in relation to psychosurgery then the panel is constituted by 5 members and, in addition to those in 10.2.3, a neurosurgeon and another community member (s. 497).

10.2.5 The SAT conducts a hearing afresh and is not confined to matters that were before the Tribunal. It may consider new material. The SAT is not restricted to evidence about the patient as considered by the Tribunal. The SAT has similar options in regard to their decision as the Tribunal (State Administrative Tribunal Act 2004, s. 27).

10.3 Procedural matters (Divisions 3 and 4)

10.3.1 The person making an application does not have to pay any fees to make the application.

10.3.2 The patient or any other party to the hearing can represent themselves or be represented by another person such as a lawyer or mental health advocate or any other person with the consent of the SAT (s. 500).

10.3.3 At times the SAT can insist that the person, the subject of the hearing, be represented because they believe that is in the person's best interests, and thus make arrangements for the person to be represented.

10.3.4 At times the person, the subject of the hearing, may want to be represented and request that the SAT arrange for that to happen.

10.3.5 The fact that the person who is the subject of the hearing has a mental illness or is receiving treatment for mental illness is not an impediment to the person instructing a legal practitioner for the purposes of being represented at a hearing.

10.3.6 A hearing is not open to the public unless the SAT permits that the hearing or part of the hearing is open to the public (s. 501).

10.3.7 The SAT can permit a specific person to be present at a hearing or exclude a specific person, including a witness.

10.3.8 It is an offence which can result in a fine or imprisonment to publish information about a proceeding which identifies a party to the proceedings including a witness. The sort of information encompassed would include the names or addresses of people, the physical description or style of dress, the employment or occupation of the person, the relationship of the person to other people, the recreational interests of the person or information about any real or personal property which the person has an interest in (s. 502).

10.3.9 There are times when information can be disclosed or published, such as providing evidence to a body responsible for disciplining members of a profession or occupation.

10.4 Appeals to the Supreme Court of Western Australia (Division 5)

- 10.4.1 A person in respect of whom a decision or order is made who is dissatisfied with a decision of the SAT, may appeal, without leave, to Supreme Court of Western Australia (Supreme Court) (s. 503).
- 10.4.2 Another person can also appeal if in the opinion of the Supreme Court they have sufficient interest in the matter and the court gives leave to appeal.
- 10.4.3 The grounds for the appeal are that the SAT made an error of law or fact, or acted without jurisdiction or in excess of its jurisdiction or that there is another sufficient reason for hearing an appeal (s. 504).
- 10.4.4 An appeal should be applied for within 28 days of the SAT decision, however the Supreme Court or the SAT can extend that time (s. 505).
- 10.4.5 The Supreme Court may make an order that person must be represented if in the Court's opinion it is not in the best interests of the person to represent themselves (s. 506).

Chapter 11: Chief Psychiatrist (Part 23, Divisions 2, 3, 4, 5, 6 and 7)

11.1 Background

- 11.1.1 The Chief Psychiatrist is appointed by the Governor of Western Australia on the recommendation of the Minister for Mental Health (the Minister) for a period not exceeding 5 years, though he or she is eligible for reappointment (s. 508 and s. 509).
- 11.1.2 The Chief Psychiatrist can resign or be removed from office at any time. The grounds for removal are physical or mental incapacity, incompetence, neglect of duty or misconduct (s. 511 and s. 512).
- 11.1.3 The Minister may by instrument appoint for a period of up to 12 months, an Acting Chief Psychiatrist if the incumbent is on leave or unable to fulfil the duties of the office, or if there is a vacancy for the position (s. 513).
- 11.1.4 The tasks and function of the Chief Psychiatrist in the Act are extensive and in effect make him or her the clinical lead for mental health in WA.

11.2 Chief Psychiatrist's role and responsibilities (Division 1, Subdivisions 1 and 2)

- 11.2.1 The Chief Psychiatrist is responsible for overseeing the treatment and care of (s. 515):
- a) all voluntary patients who are patients of a mental health service. In this context patients of a mental health service are those patients at a hospital (general or psychiatric) who have or may have a mental illness and patients of a community mental health service
 - b) all involuntary patients whether detained in an authorised or general hospital or on a CTO
 - c) all mentally impaired accused (MIA) persons detained in an authorised hospital
 - d) all voluntary patients who have been referred under the Act for an examination by a psychiatrist at an authorised hospital or other place.
- 11.2.2 The Chief Psychiatrist must discharge this oversight responsibility by publishing standards for the treatment and care of patients as well as monitoring compliance with those standards through review processes and receiving complaints. Those standards are provided as Addendum 1.
- 11.2.3 The role and responsibilities of the Chief Psychiatrist include:
- a) review of treatment
 - b) visits to mental health services
 - c) directions to mental health services to disclose information
 - d) receiving and review of notifiable incidents

- e) receiving requests for information about patients or persons detained
- f) requesting a list of MIA persons
- g) delegations
- h) responsibility for the process of authorising mental health practitioners as authorised mental health practitioners (AMHPs)
- i) involvement in the authorisation of hospitals to admit involuntary patients
- j) approval for a person to be made a detained involuntary patient in a general hospital
- k) approval of places where ECT can be conducted
- l) approval of emergency ECT
- m) receiving statistics on ECT (6.2.17)
- n) receiving information when a person is secluded (6.5.29), restrained (6.6.30), given emergency psychiatric treatment (3.9) or urgent physical treatment
- o) approval of interstate hospital transfer (Chapter 12)
- p) approval of persons who can provide information to the Mental Health Tribunal (Tribunal) with regard to children
- q) approval and publication of Forms under the Act
- r) development and publication of standards and guidelines
- s) provision of an annual report.

These responsibilities can be carried out either by the Chief Psychiatrist, another psychiatrist delegated by the Chief Psychiatrist or by an officer or agent of the Chief Psychiatrist.

11.3 Review of treatment (Division 2, Subdivision 3, Section 520)

- 11.3.1 The Chief Psychiatrist can review any decision of a psychiatrist about treatment given to an involuntary patient or an MIA patient detained in an authorised hospital. If the issue is about other matters such as involuntary status or involvement of the family or issues during admission the Chief Psychiatrist may request that a review is conducted by the responsible body such as the Tribunal, the mental health service or the Health and Disability Services Complaints Office (HaDSCO).
- 11.3.2 This review could be the result of a request made to the Chief Psychiatrist or another service such as the Mental Health Advocacy Service, regarding a review on behalf of the person who made the request.
- 11.3.3 The review may also be part of clinical governance review or audit conducted by the Office of the Chief Psychiatrist.

- 11.3.4 At times a review may be requested by the treating or supervising psychiatrist as part of good practice when there may be a lack of clarity regarding treatment decisions.
- 11.3.5 Before conducting a review the Chief Psychiatrist must give written notice of the review to the psychiatrist who made the decision.
- 11.3.6 When conducting a review the Chief Psychiatrist will gather information from the person who requested the review, the medical record, the service or any other source which can assist in the review. The Chief Psychiatrist may interview the person who requested the review and his or her family, the psychiatrist or other staff at the mental health service or any other person who can assist with the review.
- 11.3.7 When reviewing the treatment decision of the psychiatrist, the Chief Psychiatrist can:
- a) affirm the decision, deciding the treatment is appropriate and should continue;
 - b) vary the decision, for example changing the dose of a particular medication;
 - c) revoke the decision, in effect cancelling the treatment; or
 - d) substitute another decision, such as changing the medication.
- 11.3.8 The Chief Psychiatrist must advise the psychiatrist involved of the decision in writing, provide reasons for his or her decision and may give directions as to how the decision can be implemented.
- 11.3.9 A psychiatrist is expected to comply with the decision of the Chief Psychiatrist. If the psychiatrist objects to the direction he or she should inform the Chief Psychiatrist so the matter can be discussed. If there is no resolution and the Chief Psychiatrist has decided that the direction must be complied with and the psychiatrist refuses to comply the Chief Psychiatrist must give the psychiatrist reasonable opportunity to withdraw from the role of treating the patient. If the psychiatrist refuses the opportunity to withdraw or comply with the direction of the Chief Psychiatrist they are liable for a fine of \$10,000.

11.4 Visits to mental health services (Division 2, Subdivision 3, Section 521)

- 11.4.1 The Chief Psychiatrist can visit:
- a) an authorised hospital whenever he or she considers it appropriate to do so (for example, to conduct a review, speak to a patient or examine a medical record), without necessarily informing the head of service or other staff
 - b) a mental health service that is not an authorised hospital (for example, a private hospital or a community mental health service), whenever the Chief Psychiatrist reasonably suspects that proper standards of treatment and care have not been, or are not being, maintained by the mental health service. The Chief Psychiatrist will inform the head of the service about a visit and the reasons for the visit.

11.4.2 While visiting an authorised hospital the Chief Psychiatrist can:

- a) inspect any part of the authorised hospital
- b) interview any voluntary or involuntary patient, any referred person and any MIA person detained at the authorised hospital
- c) require a staff member to answer questions or provide information about the treatment or care of the patient
- d) require a staff member to produce any medical record or other document held by authorised hospital
- e) require a staff member to give reasonable assistance to the Chief Psychiatrist when visiting
- f) inspect, or take a copy of the whole or any part of any medical record or other document produced.

11.4.3 It is an offence to interfere, obstruct or hinder a visit to a mental health service by the Chief Psychiatrist or the person assisting the Chief Psychiatrist, by not answering a question or refusing to provide information or knowingly giving false or misleading information without a reasonable excuse. It is an offence which can result in a fine of \$6000 (s. 522).

11.5 Directions to mental health services to disclose information (s. 523)

11.5.1 The Chief Psychiatrist could also issue a written direction to the person in charge of the mental health service to provide any information that, in the Chief Psychiatrist's opinion, is, or is likely to be, relevant to the treatment or care that has been or is being provided to a person. Failure to comply with this direction is an offence and could result in a fine of \$5000.

11.6 Receiving and review of notifiable incidents (Division 2, Subdivision 4)

11.6.1 A notifiable incident is (s. 525):

- a) The death wherever it occurs, of a voluntary or involuntary patient of a mental health service, a referred person, a MIA detained in an authorised hospital or a resident of a private psychiatric hostel (*Hospitals and Health Services Act 1927*, Part IIIB).
- b) An error in any medication prescribed for, or administered or supplied to any person identified in a) that has had, or is likely to have, an adverse effect on the person.
- c) Any other incident in connection with the provision of treatment or care to the person that has had, or is likely to have, an adverse effect on the person.
- d) A reportable incident (s. 254(1)) of the suspicion of unlawful sexual contact or unreasonable use of force (see 1.20).
- e) Any other event that the Chief Psychiatrist declares, by notice published in the Gazette, to be a notifiable incident for the purposes of this definition.

11.6.2 When the person in charge of a mental health service becomes aware of a notifiable incident, he or she must, as soon as practicable, report the incident to the Chief Psychiatrist via the Datix Clinical Incident Management System (Datix CIMS) or Clinical Incident Notification Form. Failure to do so could result in a fine of \$6000 (s. 526).

11.6.3 The report must include:

- a) the date and time when the incident occurred
- b) the place where the incident occurred
- c) the name of the person to whom the incident happened, and their status (voluntary or involuntary patient, a referred person, a MIA).

11.6.4 After receiving and considering the report the Chief Psychiatrist may (s. 527):

- a) investigate the incident using staff from his or her office
- b) refer the incident at any time to the CEO of the mental health service, the Director General of Health or to a Registration Board
- c) decide to take no action and inform the person in charge of the mental health service or private psychiatric hostel of his or her decision.

11.6.5 If the Chief Psychiatrist decides to investigate the incident, he or she will inform in writing the person in charge of the mental health service the results of the investigation and any recommendations (s. 530).

11.7 Receiving requests for information about patients or persons detained (s. 535)

11.7.1 A person may request the Chief Psychiatrist to advise them whether or not a particular individual is admitted by a mental health service as an inpatient or is detained at a mental health service. The person could be a carer or family member, an interstate service, a government department or any other person.

11.7.2 If, in the Chief Psychiatrist's opinion, the person making the request has a sufficient interest in the matter, the Chief Psychiatrist may provide the person with the following information as it applies in relation to that admission or detention of the person:

- a) the date of the admission or detention
- b) the date of the individual's discharge or release from the admission or detention
- c) if the individual died while admitted or detained, the date of death.

11.8 Requesting a list of mentally impaired accused persons (s. 536)

11.8.1 The Chief Psychiatrist may request from the Review Board in writing a list of all MIAs under the MIA Act detained at an authorised hospital.

11.8.2 The Mentally Impaired Accused Review Board must comply with any such request.

11.9 Delegations (s. 537)

11.9.1 The Chief Psychiatrist may delegate to another psychiatrist any power or duty of the Chief Psychiatrist under another section of this Act or under another written law.

11.9.2 The delegation must be in writing signed by the Chief Psychiatrist. A psychiatrist to whom a power or duty is delegated cannot delegate that power or duty to another person.

11.9.3 A psychiatrist exercising or performing a power or duty that has been delegated is taken to do so in accordance with the terms of the delegation unless the contrary is shown. For example, the Chief Psychiatrist may define the extent of the delegation and particular timeframes. The Office of the Chief Psychiatrist will provide a list of delegations on the Chief Psychiatrist's website identifying the task delegated, who the task is delegated to and any limitations or timeframes regarding the delegation.

11.9.4 Apart from the power of delegation the Chief Psychiatrist may perform a function through an officer or agent such as a staff member of the Office of the Chief Psychiatrist.

11.10 Responsibility for the process to authorise mental health practitioners as Authorised Mental Health Practitioners (Division 3)

(see Regulation 17 of the Mental Health Regulations 2015)

This part of the guide needs to be read in conjunction with Addendum 8 – Role of Authorised Mental Health Practitioners.

11.10.1 The Chief Psychiatrist may, by order published in the Government Gazette, designate a mental health practitioner as an AMHP if satisfied that the practitioner has the qualifications, training and experience to perform the functions of an AMHP under this Act (s. 539).

11.10.2 A mental health practitioner has at least 3 years' experience in the management of people who have a mental illness (s. 538) and can be any of the following:

- a) a psychologist, registered with the Health Practitioner Regulation National Law (Western Australia) in the psychology profession
- b) a nurse whose name is in Division 1 of the Register of Nurses kept under the Health Practitioner Regulation National Law (Western Australia) as a registered nurse. This does not include an enrolled nurse, though they do have a role with regard to seclusion and restraint
- c) an occupational therapist, registered with the Health Practitioner Regulation National Law (Western Australia) in the occupational therapy profession

- d) a social worker who is a member of, or is eligible for membership of, the Australian Association of Social Workers.
- 11.10.3 A mental health service or a mental health practitioner may apply to the Chief Psychiatrist for the mental health practitioner, if they meet the criteria, to be designated as an AMHP. The decision to authorise a mental health practitioner is the responsibility of the Chief Psychiatrist.
- 11.10.4 The Regulations to the Act will provide for matters relating to AMHPs, including the following:
- a) the qualifications, training and experience to which the Chief Psychiatrist must have regard when deciding whether to make, amend or revoke an order to authorise a mental health practitioner as an AMHP
 - b) the performance by an AMHP of their functions, such as reporting activity, under this Act
 - c) any matter about which an AMHP must notify the Chief Psychiatrist, such as concerns about the referral process or transportation
 - d) the grounds on which the designation of an AMHP, such as failing to comply with the Act or being unfit to perform the tasks of an AMHP, must or may be revoked.
- 11.10.5 The Chief Psychiatrist may specify in the order any limits within which, or any conditions subject to which, those functions can be performed by the AMHP. For example, the Chief Psychiatrist may limit the role so the person can only function as an AMHP while working for a particular service or in a particular clinical role.
- 11.10.6 The Chief Psychiatrist must keep a register of AMHPs to be determined by the Chief Psychiatrist. The register must include (s. 540):
- a) the AMHP's name
 - b) the date on which the order designating the person as an AMHP was published in the Government Gazette
 - c) any limits within which, or any conditions subject to which, the person can perform the functions of an AMHP that were specified in the order (11.10.5)
 - d) the date on which any order was amended and published in the Gazette with details of the amendments
 - e) the date on which any AMHP status was revoked and published in the Gazette.
- 11.10.7 The Chief Psychiatrist must ensure that the register of AMHPs is available for inspection by members of the public free of charge from the Office of the Chief Psychiatrist during business hours and on the Chief Psychiatrist's website.

11.11 Involvement in the authorisation of hospitals to admit involuntary patients (Division 4)

11.11.1 An authorised hospital is (s. 541):

- a) a public hospital, or part of a public hospital, authorised by the Governor by order published in the Gazette, as a place for the reception of referred persons or the admission of involuntary patients
- b) a private hospital the licence of which is endorsed under the *Hospitals and Health Services Act 1927*, section 26DA(2) following a recommendation of the Chief Psychiatrist.

11.11.2 The Chief Psychiatrist has a process for gathering information about a place that applies to be authorised. Services who apply for authorisation will be provided with a guide to the authorisation of hospitals which indicate standards and adherence to the process required before authorisation is recommended.

11.11.3 Once the Chief Psychiatrist has determined that a public health facility meets the standards to be an authorised hospital, he or she will recommend to the Governor that the facility should be authorised (s. 542). Authorisation commences when the facility is named as an authorised hospital in the Gazette.

11.11.4 Using similar standards the Chief Psychiatrist will recommend to the Director General of Health, at the Department of Health, that a private hospital who applied for authorisation should have their licence endorsed under the Hospital and Health Services Act 1927, to operate as an authorised hospital. Authorisation commences when the licence is endorsed.

11.11.5 At any time the Chief Psychiatrist can recommend that authorisation of a public facility is amended or revoked. The Governor by an order published in the Gazette can then amend or revoke the authorisation of a public facility (s. 542).

11.11.6 At any time the Chief Psychiatrist can recommend that the authorisation of a private hospital is amended or revoked. The Director General of Health at the Department of Health with the approval of the Governor can then amend a licence or revoke certain aspects of a licence of a private hospital.

11.11.7 When a licence is revoked all the involuntary detained patients and referred persons must be transferred to another authorised hospital in accordance with the Regulations (s. 543).

11.12 Approval for a person to be made a detained involuntary patient in a general hospital

This part of the guide needs to be read in conjunction with 4.5.

- 11.12.1 Following an examination of a referred person and if the person meets the criteria for involuntary detained status, a psychiatrist can make the person an involuntary detained patient in a general hospital (Form 6B) (s. 61).
- 11.12.2 However, before completing the Form 6B the psychiatrist must be satisfied that, because of the person's physical health, there is a significant risk in attempting to take the person to, or detaining the person at, an authorised hospital. They may decide this is not a viable option. For example, a patient has made a serious suicide attempt by cutting their wrists and the consequent blood loss leaves them physically at risk. The patient needs physical treatment for their physical illness but also psychiatric treatment for their mental illness (4.5.2). In those circumstances approval by the Chief Psychiatrist is required for admission as an involuntary detained patient at a general hospital.
- 11.12.3 The psychiatrist must contact the Chief Psychiatrist who will require detailed information either in a written or verbal form to determine his or her decision. The Chief Psychiatrist may delegate this power to the head of service.
- 11.12.4 If the Chief Psychiatrist gives approval the person may be detained as an involuntary patient in a general hospital for up to 21 days for an adult and 14 days for a child. All the usual rights and restrictions apply in the general hospital as they would in an authorised hospital, except for seclusion or bodily restraint, which only apply in authorised hospitals.
- 11.12.5 If the Chief Psychiatrist or delegate does not approve the request, he or she will inform the psychiatrist who wished to make the order. The reasons for not approving could be that in the Chief Psychiatrist's view the patient could be taken to an authorised hospital or that involuntary detained status in a general hospital is not required.
- 11.12.6 At least every 7 days the Chief Psychiatrist must be provided with a report (Attachment to Form 6B) detailing the mental and physical condition of the patient, any psychiatric, medical or surgical treatment being provided to the patient and the reasons why the patient needs to remain in a general hospital (s. 65).
- 11.12.7 Once the psychiatrist is satisfied that attempting to take the patient to an authorised hospital no longer poses a risk to the patient's physical health, then he or she may complete a transfer order authorising the transfer to an authorised hospital and informing the Chief Psychiatrist of this decision.
- 11.13 Approval of places where electroconvulsive therapy can be conducted (Division 5)**
- 11.13.1 The Chief Psychiatrist may, by order published in the Gazette, approve a public or private mental health service as a place where ECT can be performed (s. 544).

11.13.2 Places which require approval will provide information to the Chief Psychiatrist in line with the Chief Psychiatrist's ECT Practice Standards and the Chief Psychiatrist's ECT Guide published by the Office of the Chief Psychiatrist. The Tribunal must also have regard to the ECT Practice Standards and the ECT Guide when approving ECT for children and involuntary patients.

11.13.3 The order of approval may specify any conditions as to the performance of ECT at the mental health service specified in the order, such as the number of treatments which can be performed within a particular timeframe or the reporting of certain matters as required by the Chief Psychiatrist.

11.13.4 The Chief Psychiatrist may, by order published in the Gazette, amend or revoke an order approving a place for the provision of ECT.

11.14 Approving emergency electroconvulsive therapy (6.2.12 - 6.2.15)

11.14.1 Emergency ECT can be provided to an adult involuntary patient or a MIA detained in an authorised hospital, with the approval of the Chief Psychiatrist. This does not apply to any children or voluntary patients (s. 199).

11.14.2 The criteria for emergency ECT is that the treatment needs to be provided to save the life of the involuntary patient or because there is an imminent risk of the involuntary patient behaving in a way that is likely to result in serious physical injury to the patient or another person.

11.14.3 The usual process is for a psychiatrist to apply to the Tribunal for approval to perform ECT. However, this may take some days depending on the review processes of the Tribunal. If it is the view of the psychiatrist that ECT needs to be provided in a shorter timeframe and the involuntary patient meets the criteria they can seek the approval of the Chief Psychiatrist to provide the treatment.

11.14.4 The request for approval can be oral or in writing and must include details of the involuntary patient, the criteria for the emergency ECT, where the treatment will be provided, and by whom, and the reasons approval is being sought from the Chief Psychiatrist rather than the Tribunal. It would be good practice when seeking the approval of the Chief Psychiatrist that an application is also made to the Tribunal for ECT to be performed.

11.14.5 If the Chief Psychiatrist does not approve the emergency ECT then the treatment cannot be given. That does not prevent the psychiatrist requesting approval from the Tribunal for non-emergency ECT.

11.14.6 The Chief Psychiatrist will keep statistics on the use of emergency ECT.

11.15 Approval of persons who can provide information to the Mental Health Tribunal with regard to children (s. 394 (2) and s. 414 (2))

- 11.15.1 When a review of involuntary status is being conducted on a child or when a psychiatrist has applied to the Tribunal to provide ECT to a child or when there is review of a long-term patient who is a child (s. 407) and the Tribunal is not constituted with a child and adolescent psychiatrist the Tribunal may seek the views of a medical practitioner or mental health practitioner authorised by the Chief Psychiatrist (9.6.9[f]) (s. 394 and 414).
- 11.15.2 The Chief Psychiatrist will seek expressions of interest from child and adolescent clinicians who would like to provide information to the Tribunal when a child and adolescent psychiatrist is not on the Tribunal and the matter relates to a child.
- 11.15.3 In the information provided by the clinician they will detail the qualifications, training or experience they have relevant to the treatment and care of children who have a mental illness.
- 11.15.4 In discussion with the President of the Tribunal the number of clinicians required for this purpose will be identified and the names and contact details of those clinicians approved by the Chief Psychiatrist will be provided to the Registrar of the Tribunal.
- 11.15.5 The Chief Psychiatrist will require a report on their activities yearly for their annual report.
- 11.15.6 At any time a clinician approved to provide advice can withdraw from the scheme by informing the Chief Psychiatrist and the Registrar of the Tribunal.

11.16 Approval and publication of Forms under the Act (Division 6)

- 11.16.1 The Chief Psychiatrist may approve forms, which may or may not include a statutory declaration, for use under this Act - other than forms for use by police officers under Part 11 Division 2 (s. 545).
- 11.16.2 The Chief Psychiatrist will publish all approved forms as well as guidelines as to the completion of these forms in order to ensure compliance with the Act.
- 11.16.3 The forms and all the information will be available on the Chief Psychiatrist's website.

11.17 Development and publication of standards and guidelines (Division 7)

- 11.17.1 The Chief Psychiatrist must publish standards for the treatment and care to be provided by mental health services to voluntary and involuntary patients, referred persons and MIA persons detained in an authorised hospital.
- 11.17.2 The standards will include the National Mental Health Standards as well as specific standards developed by the Chief Psychiatrist on a range of issues related to treatment and care. The Chief Psychiatrist is not limited to

what guidelines are made available on the Chief Psychiatrist's website and they can be reviewed and added to or removed at any time.

11.17.3 The Chief Psychiatrists standards will be available on the Chief Psychiatrist's website and as addendum to the CPG (Addendum 2).

11.17.4 The Chief Psychiatrist must publish guidelines for each of these purposes (Addendum 2):

- a) making decisions about whether or not a person is in need of an inpatient treatment order or a CTO
- 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 ECT
- g) compliance with approved forms
- h) ensuring compliance with this Act by mental health services.

11.17.5 The Chief Psychiatrist may also publish other guidelines relating to the treatment and care of persons who have a mental illness as the Chief Psychiatrist considers appropriate.

Chapter 12: Interstate arrangements (Part 24)

Note: intergovernmental agreements which will be arranged post commencement of the MHA 2014

12.1 Background

12.1.1 There are a number of occasions when an involuntary patient may seek permission to travel interstate to attend an event, have a holiday or move permanently to a new location.

12.1.2 Likewise involuntary patients in other states may wish to transfer from a mental health service interstate to a mental health service in Western Australia (WA).

12.1.3 In order for interstate arrangements to occur there needs to be intergovernmental agreements and recognition of corresponding mental health law of other states and territories.

12.2 Intergovernmental agreements (Division 2)

12.2.1 The Minister for Mental Health may enter into an agreement with a Minister who administers a similar ('corresponding') law in another state or territory regarding interstate transfers (s. 552).

12.2.2 Agreements will be drafted between WA and the states and territories which will provide guidance to clinicians as to how interstate transfers will be administered and managed.

12.2.3 Once agreed by both parties, the Minister may, by notice published in the Government Gazette, declare that an agreement has been entered into and has effect under this Part of the Act.

12.2.4 The agreement must be in place before the powers in this Part of the Act can be used.

12.2.5 There will be agreements with all the other states and territories organised on a state by state basis as other states and territories have mental health legislation which differs from the WA Act.

12.2.6 The Minister may, by notice published in the Government Gazette declare that an agreement has been revoked.

12.2.7 A person who can perform a function under this Act, such as a psychiatrist, medical practitioner, AMHP or mental health practitioner may perform in another state or territory a similar function conferred on the person under a corresponding law pursuant to an intergovernmental agreement (s. 553 and s. 554). For example, if a patient from WA is absent without leave and goes to Victoria, a WA clinician when apprehending the patient to return them to WA, can provide treatment to the involuntary patient without consent. This is allowable under the WA Act and, if also allowable under the Victorian Mental Health Act, then via the agreement the WA clinician can provide the treatment without consent.

12.3 Transfers from hospital to an interstate mental health service (Division 3)

- 12.3.1 The person in charge of a hospital may, with the written approval of the Chief Psychiatrist, make a Transfer Order (Form 4D) (s. 555). Information must be provided to the Chief Psychiatrist as to the circumstances of the transfer, any significant issues which will impact on the service, the patient and any personal support persons.
- 12.3.2 The Transfer Order applies to an involuntary detained patient at a WA authorised hospital or an involuntary detained patient absent without leave from a WA authorised hospital. Having received approval the person in charge of the hospital can complete the Transfer Order (Form 4D).
- 12.3.3 For example, an involuntary detained patient in WA may wish to attend a family event in another state or territory and this Part of the Act provides for them to be admitted as an involuntary detained patient in that other state or territory.
- 12.3.4 A copy of the form must be sent to the person in charge of the interstate service the patient is being transferred to, and a copy placed on the patient's medical record.
- 12.3.5 The transfer of a patient interstate is an event that requires the patient's carer, close family member or personal support person to be notified (see 1.24).
- 12.3.6 If the person in charge of the hospital is satisfied that there are no other safe means of taking the WA inpatient to the interstate mental health service (reasonably available), they can authorise either police or a Transport Officer to assist by completing a Transport Order (Form 4A) (s. 556).
- 12.3.7 The person in charge of the service can only use the police if:
- a) they are satisfied that there is a significant risk of serious harm to the person being transferred or to another person;
 - b) a Transport Officer will not be available to carry out the order within a reasonable time; and
 - c) a delay is likely to pose a significant risk of serious harm to the person being transferred or to another person.
- 12.3.8 The term police and Transport Officer also applies to a person with a similar function in another state or territory who is recognised as such under a corresponding law or intergovernmental agreement. In effect this means the police or a Transport Officer can hand over responsibility of the patient when the patient has been transported to the other state or territory.

12.4 Transfer from an interstate mental health service to a hospital in Western Australia (s. 557)

- 12.4.1 A person who is an involuntary detained patient in an interstate hospital can be transferred to a WA hospital with the approval of the Chief Psychiatrist. The person in charge of the WA hospital can endorse the transfer of the patient using the Transfer Order (Form 4E).
- 12.4.2 Before completing the Transfer Order (Form 4E), written approval must be sought from the Chief Psychiatrist. Information must be provided to the Chief Psychiatrist as to the circumstances of the transfer and any significant issues which will impact on the service, the patient or any personal support persons.
- 12.4.3 The person in charge of the hospital must send a copy of the form to the person in charge of the interstate mental health service so that the transfer can occur.
- 12.4.4 When the patient is received at the WA hospital they are immediately on an inpatient treatment order under the Act.
- 12.4.5 The transfer of a patient from an interstate hospital is an event which requires the patient's carer, close family member or personal support person to be notified (see 1.24).

12.5 Community Treatment Orders (Division 4)

- 12.5.1 A patient who is on a CTO in WA may wish to spend some time in another state or territory. Just because they are on a CTO does not mean they can be compelled to remain in WA.
- 12.5.2 However, while in another state or territory the terms of the CTO can include attending for treatment at a mental health service in another state or territory (s. 559).
- 12.5.3 If the CTO patient fails to attend for treatment and, despite all attempts by the interstate mental health service, he or she refuses to attend, a medical practitioner or mental health practitioner in WA can make a Transport Order authorising the police or a Transport Officer in the other state to apprehend the patient and take them to a place for treatment.
- 12.5.4 The WA practitioner cannot make the transport order unless satisfied that no other safe means of ensuring the involuntary community patient attends the interstate mental health service is reasonably available.
- 12.5.5 The term police and Transport Officer apply to a person with similar functions in another state or territory and who is recognised as such under a corresponding law or intergovernmental agreement.
- 12.5.6 A person who is a CTO patient under an interstate order can be provided with treatment in WA if there are terms in the CTO which allow the person to receive treatment in WA. Corresponding laws allow interstate CTO patients to be recognised as WA CTO patients and vice versa. Likewise, clinicians who perform functions under the Act can perform similar functions under interstate legislation (s. 562).

Chapter 13: Miscellaneous (Parts 26 and 27)

13.1 Information (Part 26)

- 13.1.1 Patients may move from one area of the state to another and receive services from a variety of different organisations, both public and private. To facilitate holistic, ongoing patient care and treatment it is important that information, including personal information about a patient, such as cultural needs, can be transferred and accessed across different services and organisations.
- 13.1.2 Part 26 of the Act relates to the sharing of information between various authorities and organisations such as the Mental Health Commission, various government state authorities and a range of mental health services, public and private, and private psychiatric hostels. However, this does not include the carer of a person who has or might have a mental illness.
- 13.1.3 The Mental Health Commissioner can make arrangements with overseas authorities who have powers similar to the Commissioner, interstate authorities or mental health services (including managers of private psychiatric hostels), to request or provide relevant information. There is no legal obligation on the Commissioner, the state authorities or mental health services to provide information to another party if they do not wish to do so (s. 572).
- 13.1.4 Relevant information is any of the following information, which in the opinion of the Commissioner, is pertinent to the situation. Information regarding:
- a) the treatment or care of a person, who has or may have a mental illness
 - b) the health, safety or wellbeing of a person who has or may have a mental illness
 - c) the safety of another person who may be exposed to serious risk because of a person who has or may have a mental illness
 - d) the administration or enforcement of this Act
 - e) the implementation and evaluation of programmes managed by the Commission for the purpose of coordinating the care and support of people who have a mental illness
 - f) the planning for, and evaluation of, mental health services
 - g) epidemiological analysis of mental illness and mental health research.
- 13.1.5 A prescribed state authority referred to in section 573 may request or provide relevant information by arrangements with another prescribed state authority. Relevant information includes:
- a) the treatment or care of a person, or the persons in a class of person, who has or may have a mental illness; or

- b) the health, safety or wellbeing of a person who has or may have a mental illness; or
- c) the safety of another person who may be exposed to serious risk because of a person who has or may have a mental illness; or
- d) the performance of a function under this Act by the CEO's of a prescribed state authority.

13.1.6 The CEO of a mental health service, public or private, including managers of private psychiatric hostels, may also request or provide relevant information by arrangements with the CEO of another mental health service. Relevant information would include details of:

- a) the treatment or care of a person who has been, is being, will be or may be, provided with treatment or care by the CEO's mental health service
- b) the health, safety or wellbeing of a person who has been, is being, or will or may be, provided with treatment or care by the CEO's mental health service;

13.1.7 c) the safety of another person who may be exposed to serious risk because of a person who has been, is being, will be or may be, provided with treatment or care by the CEO's mental health service.

13.1.8 For example, a patient may decide to live in another part of the state and in order for treatment and care to be continued relevant information needs to be provided to another mental health service. While the patient may not have left the area, arrangements for the transfer of information can commence because the patient 'will be' moving to a different area. Likewise, a patient may wish to be registered with the Disability Services Commission and the Commission may request information for that process to be initiated. This process is subject to the duty of confidentiality under section 576.

13.1.9 These powers relate to voluntary or involuntary patients and allow patient information to be made available to another agency to facilitate the care and treatment of mental health patients, subject to the duty of confidentiality under section 576 of the Act.

13.1.10 Information provided through this process is subject to the rules of confidentiality. Use of the information should be done in good faith and disclosure is allowed:

- a) in the course of duty, whether under this Act or otherwise
- b) under this Act
- c) under another law
- d) to a court or other person or body acting judicially in the course of proceedings before the court or other person or body
- e) under an order of a court or other person or body acting judicially

f) for the purposes of the investigation of a suspected offence or disciplinary matter or the conduct of proceedings against a person for an offence or disciplinary matter

g) if the information recorded, disclosed or used is personal information, with the consent of the individual, or each individual, to whom the personal information relates

h) in any other circumstances prescribed by the Regulations for this subsection.

13.1.11 Regulations may provide for the receipt and storage of information or access to such information.

13.2 Amendments to approved forms (s. 581)

13.2.1 The Act identifies the need for a number of forms that validate specific functions under the Act. The Chief Psychiatrist is to approve these forms, provide guidelines as to their completion and publish them on his or her website.

13.2.2 A list of these forms are provided at Section 15 of this guide.

13.2.3 A form may contain a formal defect such as a clerical error, an error due to an accidental omission, or an error in the description of a person. For example, the form may have the wrong date of birth or the address may be omitted.

13.2.4 A formal defect does not make the order or anything authorised by the order - such as giving treatment without consent - invalid. However, if a defect is noted, steps should be taken to rectify the defect. The person who notices the defect may ask the person who completed the order to redo the order to rectify the defect. If that request is not complied with, the person who notices the defect can revoke the involuntary treatment order made as a result of an order with a defect. The revocation of the involuntary treatment order does not prevent another referral order or any other order being made.

13.2.5 The management of formal defects is a separate process from the right of a patient, or another person to request the Mental Health Tribunal to consider the validity of an order (see 9.7).

13.3 Medical records to be kept by mental health services (s. 582)

13.3.1 The person in charge of a mental health service, public or private, must keep records of each patient who is admitted to the service, or who is provided with treatment and care by the service.

13.3.2 The medical record must include the following information:

a) the name, address and date of birth of the patient

b) the nature of any illness, or mental or physical disability, from which the patient suffers

- c) particulars of any treatment provided to the patient by the mental health service and the authority for providing the treatment, including details of any order made under this Act under which the treatment was provided
- d) if the patient dies at the mental health service, the date of death and, if known, the cause of death
- e) any other information prescribed by the Regulations for inclusion in the medical record.

13.4 Protection from liability when performing a function under the Act (s. 583)

- 13.4.1 When performing a function under this Act or assisting someone else perform a function, clinicians are protected from liability, if what they do is in good faith. In those situations the State may be liable.
- 13.4.2 People may still take out an action in tort, which is a body of rights, obligations and remedies that are applied by courts in civil proceedings to provide relief for persons who have suffered harm from any wrongful acts of others. However the action must be against the State rather than the individual clinician.
- 13.4.3 If it is shown that the function performed by the clinician was not in good faith, but motivated by other personal reasons, then the clinician may be found liable to an action in tort.
- 13.4.4 If a clinician is informed that an action in tort is being proposed or being taken against them, he or she must immediately inform their line manager, so legal advice and assistance can be sought.

13.5 Protection from liability when detaining a person with mental illness (s.584)

- 13.5.1 At times, particularly in facilities which care for older adults experiencing mental illness, a patient who lacks the capacity to make decisions about their own health and safety can place themselves at risk, for example by leaving or wandering away from a facility.
- 13.5.2 Patients who place themselves at risk may be voluntary patients (or patients where consent is provided by a guardian) and be in facilities which are not authorised to detain patients.
- 13.5.3 In these circumstances the person in charge of the facility may decide, in good faith, to detain the patient who is experiencing or suspected of experiencing mental illness.
- 13.5.4 The justification for detaining the patient is to reduce the identified risk, by preventing them from leaving the particular place.
- 13.5.5 Actions such as locking the door of the facility to prevent the person leaving may be considered, but bodily restraint as defined by this Act cannot be performed to achieve detention.

13.5.6 If a person wishes to take out an action in tort, this section provides protection from liability.

13.6 Review of this Act after five years (s. 587)

13.6.1 The Minister for Mental Health must commence a review of the operation and effectiveness of this Act as soon as practicable after the expiry of 5 years from the commencement of when the Objects of the Act come into force.

13.6.2 The Minister must, as soon as practicable, prepare a report about the outcome of the review and ensure a copy of the report is laid before each House of Parliament.

14: List of addendums

14.1 Addendum 1 – The Chief Psychiatrist’s Standards (s. 547(2))

Standard 1: Assessment Standard

Standard 2: Care Planning Standard

Standard 3: Consumer and Carer Involvement in Individual Care Standard

Standard 4: Physical Health Care of Mental Health Consumers Standard

Standard 5: Risk Assessment and Management Standard

Standard 6: Seclusion and Bodily Restraint Reduction Standard

Standard 7: Transfer of Care Standard

Standard 8: Aboriginal Practice Standard

14.2 Addendum 2 – The Chief Psychiatrist’s Guidelines (s. 547(1))

- 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 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 are obtained
- d. Making decisions about whether or not to comply with requests 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.

14.3 Addendum 3 – Advance Health Directive

14.4 Addendum 4 – Relationship between the Mental Health Act 2014 and the Guardianship and Administration Act 1990

14.5 Addendum 5 – Working with people of Aboriginal and Torres Strait Islander Descent

14.6 Addendum 6 – Managing a child in an adult facility

14.7 Addendum 7 – Use of audio-visual communication

14.8 Addendum 8 – Role of Authorised Mental Health Practitioners

14.1 Addendum 1: Chief Psychiatrist's standards

Standard 1: Assessment Standard

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition:

Assessment: Process by which the characteristics and needs of a consumer and their family or carer are evaluated and determined so that they can be addressed. The assessment forms the basis of treatment, care and recovery planning.^{30,31}

Purpose of the standard

To provide comprehensive individualised assessment of the consumer to ensure holistic care planning.

Context

1. A comprehensive assessment may occur over a number of treatment sessions.
2. The consumer will be involved in all aspects of their assessment.
3. Carers have the right to contribute to the assessment of the consumer.³²
4. An assessment may include components provided by a range of multidisciplinary clinicians.
5. Cultural, language and social diversity will be taken into account in both the process and understanding of the assessment.^{33,34,35,36}
6. Timely and appropriate reassessment will occur as required.³⁷
7. Assessment will be undertaken in the context of trauma informed care principles.
8. If a consumer is under the legal care of a parent or guardian,³⁸ the clinician must involve the parent or guardian in the assessment.
9. There may be an exception to this Standard where an assessment is being conducted for an additional specific or specified purpose.

Criteria:

1. Assessments conducted:
 - 1.1 Are age-appropriate.

³⁰ National Standards for Mental Health Services 2010

³¹ Mental Health Act 2014, Part 6 Division 2

³² Carers Recognition Act 2004

³³ Mental Health Act 2014, Part 4 s.11

³⁴ Schedule 1: Charter of Mental Health Care Principles

³⁵ Mental Health Act 2014, Part 6 Division 2 s50

³⁶ National Standards for Mental Health Services 2010, Standard 4 Diversity responsiveness

³⁷ Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia, Prof Bryant Stokes July 2012

³⁸ Guardianship and Administration Act 1990

- 1.2 Use broadly accepted methods and tools.
- 1.3 Have regard to internationally accepted disease classification systems used in clinical practice.³⁹
- 1.4 Will consider biopsychosocial and cultural aspects of an individual's life.
2. Assessments must:
 - 2.1 Be written in plain English.
 - 2.2 Be legible.
 - 2.3 Be compliant with service documentation standards.
3. A comprehensive assessment must include a mental state examination and documentation.
4. Assessments will contain a succinct summary of prior treatment – it is generally not appropriate to use the phrase “see previous summary”.
5. Assessments are conducted by mental health clinicians and where possible in the consumer's preferred setting with consideration for the safety of all involved.⁴⁰
6. A timely assessment is to be made in accordance with risk, urgency, distress and dysfunction.⁴¹
7. Assessments of consumers will include communication where available with:
 - 7.1 Primary care clinicians.
 - 7.2 Specialist clinicians.
 - 7.3 Other workers involved in the consumer's care.⁴²
 - 7.4 Significant members of the consumer's cultural community with consumer's consent.
8. The assessment must be of sufficient depth and breadth to be able to inform treatment, care and recovery planning.
9. The assessment must include consideration of dependents and commitments of the consumer. This is to include children and other caring roles.
10. The assessment must include consideration of the needs of the carer in the context of their caring role.
11. Physical health care needs will be identified with equal priority.
12. A risk assessment and management must accompany the initial assessment.

³⁹ National Practice Standards for the Mental Health Workforce 2013, Standard 6

⁴⁰ Risk Assessment and Management Standard 2014

⁴¹ National Standards for Mental Health Services 2010, Standard 10 Delivery of Care

⁴² Physical Health Care of Mental Health Consumers Standard 2014

13. Assessments will include a written integrated formulation of the issues and an associated diagnosis.
14. Assessments will consider co-occurring issues particularly alcohol, other drugs and other health issues including physical, intellectual and developmental disability.

Future/Potential Measures:

1. Completion of standardised or equivalent assessment tool.

Review Date: 12 months from the date of publication.

Standard 2: Care Planning Standard

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition:

Care Plan: A written statement developed with the involvement of consumers, carers and relevant others, for consumers, which outlines the treatment and support to be undertaken, the health outcomes to be achieved and review of care which will occur at regular intervals.⁴³

Recovery: *Personal Recovery* – Being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.⁴⁴

Purpose of the standard

To define a holistic, shared care planning process which is personalised and recovery focussed.

Context

1. The consumer will be a partner in the care planning process.
2. A clinician will facilitate carer involvement or contribution to care planning.
3. A clinician will involve consumers in individual, shared or supported decision-making and encourage self-determination, cooperation and choice.⁴⁵
4. *The Consumer and Carer Involvement in Individual Care Standard* is to be used as an overarching standard for treatment, care and recovery planning.

Service:

1. All consumers will have a written care plan using a standardised template or equivalent, taking into consideration their language and literary requirements.
2. Services will recognise the need for the carer to receive a copy of the care plan after taking into consideration consumer consent and risk issues.
3. Services will ensure that the care plan is kept on both the clinical record and on PSOLIS⁴⁶ Where applicable.
4. The care plan will be reviewed, as a minimum, every three months.
5. The care plan will have multidisciplinary team input wherever possible.
6. Services will provide appropriate oversight of the care plan by a psychiatrist.

⁴³ National Standards for Mental Health Services 2010

⁴⁴ A National Framework for Recovery-Oriented Mental Health Services – Policy and Theory

⁴⁵ Charter of Mental Health Principles – Schedule 1 Mental Health Act 2014.

⁴⁶ Review of the admission or referral to and the discharge and transfer practices of public mental facilities/services in Western Australia, Prof Bryant Stokes July 2012

7. Services must use the principles of recovery oriented mental health practice by:⁴⁵
 - 7.1 Upholding a person-centred focus with a view to obtaining the best possible outcomes for consumers, by recognising life experiences, needs, preferences, aspirations, values and skills, while delivering goal-oriented treatment, care and support.
 - 7.2 Promoting positive attitudes towards mental illness, including recognising that consumers can lead full and productive lives and make meaningful contributions to the community.
8. The service will provide access to a range of evidence based treatments.⁴³
9. The service will take into account the cultural and social diversity of its consumers, carers and community.^{45, 47, 48}
10. The service will uphold the rights of the consumer and carer.^{49, 50, 51, 52}

Criteria:

1. The service has a process which includes the commencement of development of a discharge plan from the time the consumer enters the service.⁵³
2. The consumer and their carer are provided with relevant and appropriate information on the range of services and support that are suitable and available in their community.⁵³
3. The clinician has a responsibility to facilitate a pathway to relevant and accessible services.
4. The clinician will, whilst undertaking treatment, care and recovery planning:
 - 4.1 Provide evidence based treatment with ongoing assessments.
 - 4.2 Provide individualised planning on a strength based approach.
 - 4.3 Proactively involve relevant, other service providers (such as non-government organisations, community supports and primary care services).
5. Care planning will consider the issue of continuity and the standard regarding the transfer of care.
6. Care planning will include physical health care assessment and management.
7. Care planning will consider the issues of medication and treatment safety.

⁴⁷ National Standards for Mental Health Services 2010, Standard 4 Diversity Responsiveness

⁴⁸ Mental Health Act 2014, Part 6 Division 2 s 50

⁴⁹ National Standards for Mental Health Services 2010, Standard 1 Rights and Responsibilities

⁵⁰ National Standards for Mental Health Services 2010, Standard 6 Consumers

⁵¹ National Standards for Mental Health Services 2010, Standard 7 Carers

⁵² Carers Recognition Act 2004

⁵³ National Standards for Mental Health Services, Standard 10 Delivery of Care

8. Where there are unresolved differences in perspective, on aspects of the care plan among consumers, carers and clinicians, these differences will be acknowledged in the care plan.

Measures:

1. Review of care plan within three months.

Future/Potential Measures:

1. Care Plans developed with consumers.
2. Care plans developed with carers.

Review Date: 12 months from the date of publication.

Standard 3: Consumer and Carer Involvement in Individual Care Standard

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition**1. Consumer:**

For the purpose of this standard a consumer is referred to under the Mental Health Act 2014 as a “*patient*”.

Patient means -

- a) An involuntary patient; or
- b) A mentally impaired accused person required under the Mentally Impaired Accused Act 1996 to be detained at an authorised hospital; or
- c) A voluntary patient including a referred person⁵⁴

2. Carer:

For the purpose of this standard a carer is a person who is an individual who provides ongoing care or assistance to a person with a mental illness as defined under the Mental Health Act 2014.⁵⁴

Purpose of the Standard:

Create a service that is responsive to consumer and carer input and needs.⁵⁵

Context:

1. Mental health services are required to work collaboratively and in partnership with consumers and/or carers irrespective of whether the consumer is a voluntary or involuntary patient.
2. There should always be an emphasis on recovery orientated care.⁵⁶ This involves active partnership with consumers and carers by services²
3. All services must have regard to the principles in the Charter of Mental Health Care Principles.⁵⁷
4. It is a requirement that consumers, carers, clinicians and other associated staff operate in an environment of mutual respect.

Criteria:

1. The mental health service ensures staff capability in working with consumers and carers through the provision of information, education and supervision.

⁵⁴ Mental Health Act 2014, Part 2, Division 1 Section 4

⁵⁵ Australian Commission on Safety and Quality in Health Care, Partnering with Consumers; Standard 2

⁵⁶ A National Framework for Recovery-oriented mental health services 2013. Page 3

⁵⁷ Mental Health Act 2014, Part 4, Section 11 and Schedule 1: Charter of Mental Health Care Principles, National Standards for Mental Health Services, 2010 Standard 4

2. Consumer

- 2.1. Consumers have the right to comprehensive and integrated mental health care, which meets their individual needs and achieves the best possible outcome in terms of their recovery.⁵⁸
- 2.2. Consumers have the right to receive service free from abuse, exploitation, discrimination coercion, harassment and neglect.⁵
- 2.3. Consumers are partners in the management of all aspects of their treatment, care and recovery planning.⁵
- 2.4. Informed consent is actively sought from consumers prior to any intervention provided or any changes in care delivery.⁵
- 2.5. Consumers are provided with current and accurate information on the care being delivered.⁵

3. Carer

- 3.1. Carers need recognition and respect, and their support is valued and important to the wellbeing, treatment and recovery of consumers.⁵⁹
 - 3.1.1. The mental health service actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.⁶
 - 3.1.2. The mental health service engages carers in discharge planning, involving crisis management and continuing care, prior to transfer of or discharge from all episodes of care.⁶
- 3.2. Where the consumer actively declines carer involvement the service will consider any appropriate strategies to engage the carer.
- 3.3. Clinicians and other associated staff will record significant information provided by carers.
 - 3.3.1. Clinicians will give due consideration to confidentiality regarding information provided by carers.

Measures:

1. Measurement of consumer and carer satisfaction.

Future/Potential Measures:

1. Staff attend training regarding engagement with consumers and carers.
2. Consumer and Carer signatures on Treatment, Support and Discharge Plans.
3. The percentage of staff attending clinical supervision. This measure is under development.

Review Date: 12 months from the date of implementation.

⁵⁸ National Standards for Mental Health Services, 2010; Standard 6. Consumers

⁵⁹ National Standards for Mental Health Services 2010; Standard 7 Carers

Standard 4: Physical Health Care of Mental Health Consumers Standard

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Purpose of the standard

To improve the physical health outcomes of consumers who experience mental illness.

Context:

- 1 All mental health consumers have the right to physical (including dental) health care that is equal to the care provided to the general population.
- 2 Mental and physical health care will be coordinated with equal priority to support individual recovery.
- 3 All mental health clinicians will recognize the role of carers in the assessment and management of physical health care needs.
- 4 All mental health clinicians must consider the impact of mental illness on physical health.
- 5 All mental health clinicians must ensure that the physical wellbeing (including dental) of all patients under their care is regularly assessed and where appropriate referred to appropriate specialist clinicians.⁶⁰
- 6 Appropriate consent must be obtained prior to physical examination of the consumer.

Criteria**1 Systemic Criteria**

- 1.1. The mental health service will have clear pathways for appropriate assessment and treatment of physical illnesses by general practitioners and specialist clinicians.
- 1.2. Mental health clinicians have a responsibility to advocate for and facilitate equity in access to physical health care.
- 1.3. Mental health services will ensure that staff take into account and are informed on matters such as medication adverse effects that will impact the physical health of consumers with mental illness.
- 1.4. Mental health services will recognise the co-morbid use of substances, the use of non-prescribed medications and lifestyle choices in the overall management of the consumer.
- 1.5. There will be a standardized approach to regular physical screening and in particular metabolic screening
 - 1.5.1. Measurement of Body Mass Index (BMI).

⁶⁰ Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health, Professor Stokes B (2012)

1.5.2. Measurement of waist circumference.

1.5.3. Regular age appropriate screening relative to the medications prescribed.

1.6. Treatment, Support and Discharge Plans, and other Care Plans (including transfer of care documents) will specifically address physical health care needs.

2 Personal Criteria

- 2.1 Assessment of consumers will include communication with general practitioners and specialist clinicians involved with their care.
- 2.2 Assessment of consumers will include communication with carers.
- 2.3 Consumers unable to engage with a primary health care provider including a general practitioner will have their ongoing physical health care needs coordinated by the treating community mental health service.
- 2.4 All consumers will have at least yearly physical assessments and appropriate screening.
- 2.5 All consumers will have regular oral health assessments.¹
- 2.6 All consumers will have a physical assessment on admission to an inpatient service.
- 2.7 All consumers and carers will receive timely information on the impact of medications on physical health.¹
- 2.8 Where a consumer with capacity to consent declines assessment of their physical health care needs despite appropriate advice, the clinician must consider what ongoing strategies will best assist that consumer and carer to manage the physical health care in the future

Measures;

- 1. Physical examination documented within 12 hours of admission.

Future/Potential Measures:

- 1 Incorporation of physical health care components in the Care and Treatment, Support and Discharge Plans
- 2 Evidence of appropriate treatment for abnormal physical health states.
- 3 Communication with primary care providers.

Review Date: 12 months from the date of implementation.

Standard 5: Risk Assessment and Management Standard

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition:⁶¹

1. **Risk:** The likelihood of an event occurring, which may have harmful outcomes for the person or others.
2. **Risk Assessment:** A gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to a consumer and their family or carers, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change.
3. **Risk Management:** Clinical risk management aims to minimise the likelihood of adverse events within the context of overall management of a consumer. It provides the opportunity for targeted intervention to minimise the causative factors to achieve the best outcome and deliver safe, appropriate, effective care. Risk management can be both at an individual and systemic level.

Purpose of the standard

To assess, minimise and manage the risks in relation to risk to self, to others and from others.

Context:

Mental health services are never risk-free and clinical risks like suicide and violence cannot be predicted with 100% accuracy. Instead, good clinical risk management is based on effective treatment that is focused on an individual's history and current circumstances.¹

1. Risk may include:
 - 1.1. Risk to self: includes self-harm, suicide and attempted suicide, repetitive self-injury; self-neglect; missing and people absent without leave⁶²; physical deterioration including drug and alcohol misuse and medical conditions (including medical conditions secondary to eating disorders); and quality of life including dignity, reputation, social and financial status.
 - 1.2. Risk to others: includes harassment; stalking or predatory intent; violence and aggression; property damage; and public nuisance and reckless behaviour that endangers others.
 - 1.3. Risk from others, especially considering vulnerable persons: includes physical, sexual or emotional harm or abuse by others and social or financial abuse or neglect by others.¹

⁶¹ Clinical Risk Assessment Management in Western Australia

⁶² Mental Health Act 2014 s. 97

2. Risk assessment and management must be legally, ethically and evidence-based.¹
3. The practice of risk assessment and management is to be person-centred and acknowledge the balance of risk, choice and dignity.¹
4. Risk assessment and management is a shared, systemic responsibility, underpinned by a 'no-blame' culture.¹
5. Sentinel incidents and adverse events are reviewed and considered as opportunities for improvement.¹
6. Risk assessment and management is regarded as a core competency for all mental health clinicians.¹
7. The principles of risk assessment should underpin the practice of all services providing mental health care.
8. The mental health service should conduct risk assessments of all patients throughout all stages of the care continuum, including patients who are being formally discharged from the service, exiting the service temporarily and/or are being transferred to another service.¹
9. Risk management during transportation must be compliant with relevant Commonwealth and state transport policies and guidelines, including the current National Safe Transport Principles.⁶³

Criteria:

1. Staff undertaking risk assessments will seek, consider and respond appropriately to information from:
 - 1.1. The patient.
 - 1.2. Carers, families and personal support persons.
 - 1.3. Other records including referring letters and PSOLIS where applicable.
 - 1.4. Other professional assessments.
 - 1.5. Any other person or body considered relevant.
2. Staff will 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. Noting that actuarial risk assessment tools are of limited predictive value on their own.
3. Staff will use trauma informed care principles.
4. Staff will undertake a holistic risk assessment with consideration of the cultural, diverse and individual needs of the consumer, carer and family as part of the assessment.
5. Staff will always take into account the consumer's views and needs regarding risk including when:
 - 5.1. They lack capacity.
 - 5.2. They are under 18 years of age.
 - 5.3. In the context of an Advance Health Directive.
6. Staff are to include physical health as equal priority in the assessment as outlined in the Standard for Physical Health Care.

⁶³ National Standards for Mental Health Services

7. Risk assessments and reviews of shared management plans will occur regularly and whenever a significant change in the consumer's circumstances is identified which might impact upon risk.
8. Outcomes and changes in risk assessment and management are required to be communicated in a timely way to affected persons and agencies.
9. Following an adverse event, sentinel or critical incident involving serious assault or abuse, injury or death, the restoration and maximisation of the well-being and mental health of all involved is a priority.

Future/Potential Measures:

1. The audit of compliance with the specified risk assessment and management tools.

Review Date: 12 months from the date of publication.

Standard 6: Seclusion and Bodily Restraint Reduction Standard

This Standard applies to all authorised public and private mental health services as defined by the Mental Health Act 2014.

Definition:

1. **Seclusion:** is defined as confinement of a person, who is being provided with treatment or care at an authorised hospital, by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave.⁶⁴
2. **Bodily restraint:** is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital.¹
3. **Physical restraint:** is the application of bodily force to the person's body to restrict the person's movement.¹
4. **Mechanical restraint:** is the application of a device, to restrict the person's movement, such as a belt, harness, manacle, sheet or strap. Mechanical restraint does not include either the appropriate use of medical or surgical appliances or the appropriate use of furniture to restrict a person such as cot sides or a chair fitted with a table. It also does not include physical or mechanical restraint by a police officer.¹

Purpose of the standard:

Reduction of seclusion and restraint events, time spent in seclusion and trauma associated with seclusion and restraint.

Context:

1. Mental health services will endeavour to reduce the use of, and where possible, eliminate seclusion and restraint.⁶⁵
2. Seclusion and restraint are interventions not therapies.
3. Risk of trauma and physical harm to staff and patients can be increased by use of seclusion and restraint.
4. If and when pro re nata (as needed) medication is used, it should be judiciously administered for the purpose of calming and not sedating.
5. Where there are no appropriate alternatives to seclusion or restraint they should be administered in the most safe, dignified and respectful manner as possible by appropriately trained staff.
6. Restraint techniques will be standardised across all Authorised Hospitals to minimise error.

Criteria:

1. Management and staff of all Authorised Hospitals:

⁶⁴ Mental Health Act 2014 Part 14 Division 5 & 6

⁶⁵ National Standards for Mental Health Services Standard 2.2

- 1.1. Will comply with mental health legislation requirements relating to seclusion and restraint.
- 1.2. Will conduct, with all relevant staff, an approved age-appropriate training program for prevention of aggression and early intervention in a crisis situation. The training program will include the following elements:
 - 1.2.1 The majority of time will be focused on strategies such as de-escalation that prevent exacerbation of a crisis.
 - 1.2.2 The training program will incorporate trauma-informed care principles.
 - 1.2.3 Ongoing competency updates will include a training component undertaken in the ward environment.
 - 1.2.4 Peer Support Workers or persons with lived experience will contribute to the training wherever possible.
 - 1.2.5 There will be an explicit differentiation for staff between seclusion and time-out.
- 1.3. Will have a Sensory Modulation or equivalently named area and/or mobile sensory modulation equipment with an appropriate quiet space in which it can be used.
- 1.4. Will utilise a Patient Safety Plan (or equivalently named template identifying patient-driven strategies to prevent or reduce distress or agitation) drafted collaboratively between a patient and staff and where appropriate the carer, as soon as possible after admission.
- 1.5. Will debrief patients, relevant support persons and staff after seclusion and restraint events, and document this process.
- 1.6. Will not use neck holds.
- 1.7. Will avoid the use of prone restraint whenever possible to minimise the risk of respiratory compromise.
- 1.8. Will ensure monitoring and recording of physical observations and wellbeing during restraint.
- 1.9. Will, where appropriate and/or requested, advise the patient's carer, and/or personal support person of the seclusion and restraint event.
2. Medical staff will take a proactive role in seclusion and restraint minimisation:
 - 2.1. The Treating or Duty Psychiatrist will take an active leadership role in facilitating strategies for an individual patient that reduces seclusion and restraint.
 - 2.2. Medical staff will attend a clinical unit, at the earliest possible time, when there is evidence of escalating risk not settling with remote support.
 - 2.3. Medical staff will take an active decision making role early in the Seclusion and Restraint process.
3. Mental Health Units will hold a Service Executive Review of all seclusion and restraint events:
 - 3.1. Focusing on collaborative reduction, and not a blaming process.

- 3.2. Held at least weekly with the staff involved in the seclusion and restraint events participating, whenever possible.
- 3.3. Include the presence of a Peer Support Worker or individual with lived experience at the Review, whenever possible.
- 3.4. Will publish local quarterly de-identified seclusion and restraint data at the service which is available to staff, patients and the general public.
 - 3.4.1 This data will be forwarded to the Chief Psychiatrist.

Measures:

- 1. Episodes of seclusions and restraint (Per 1000 bed days as denominator)
- 2. Designated time periods in seclusion and restraint.

Future/Potential Measures:

- 1. Compliance with the Service Executive Reviews of seclusion and restraint. This measure is under development.

Review Date: 12 months from the date of implementation.

Standard 7: Transfer of Care Standard

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition:

A person centered, recovery focused process used for the timely, safe and effective discharge and handover of care between all service providers.

Service providers may include clinical and nonclinical services.

Purpose of the standard

To ensure continuity, safety and quality of care for consumers and carers is maintained during transfer either between or within services.

Context

1. Consumers may be at higher risk during transfer of care.
2. The consumer, and where relevant the guardian, will partner in the drafting and ownership of the transfer information is essential.
3. Carer collaboration in this process must always be actively sought.⁶⁶
4. Different service providers in the continuum of care may require different aspects of information.⁶⁷ Transfer of information will recognise other relevant privacy legislation and policy.
5. The referring service retains the responsibility for the consumer until the receiving service or practitioner has accepted the referral or the consumer decides on an alternative process.
6. The mental health service, in conjunction with the treating clinician, will facilitate appropriate follow-up for all consumers within seven (7) days after transfer.
7. When a consumer does not keep the planned follow up arrangements there must be active consideration and management of risk in accordance with *the Risk Assessment and Management Standard*.
8. Referral and provision of handover information should occur prior to transfer from the referring service, exceptional circumstances permitting.
9. In the context of appropriate assessment and risk assessment duplicate triaging will be avoided.
10. Any unresolved debate regarding clinical responsibility or appropriateness of transfer, must be resolved in a timely manner and must not impact on safety and access to care.
11. Multiple care plans should be merged wherever possible.
12. Agencies will make every attempt to work collaboratively with each other, in a person-centered approach.

⁶⁶ Consumer Carer Involvement in Individual Care Standard, Chief Psychiatrist 2015

⁶⁷ National Standards for Mental Health Services 2010 Standard 10 6.2

13. The use of standardised transfer of care documents is recommended.

Criteria

Discharge, transfer and equivalent plans will include reference to:

1. A case formulation, including a brief summary of those factors which are essential for understanding the patient as an individual and within their social and cultural environment.
2. Standardised clinical diagnoses.
3. Mental state examination changes from admission to discharge.
4. Therapies used and ceased, including reasons for this, adverse effects and any significant clinical incidents.
5. Physical healthcare assessment and management.⁶⁸
6. Risk assessment and management.
7. Known signs and symptoms which indicate potential mental health deterioration (relapse signature).
8. Contingency strategies/ crisis plans.
9. Post discharge follow-up arrangements.
10. Contact details for consumer, carer and guardian where relevant.

The plans must be clear, directive and suitable for the needs of the consumer and receiving services involved in the individual's care including general practitioners, and other clinical services. Transfer information to nonclinical services should reflect the needs of the consumer within that service.

Measure:

1. Transfer summary provided to receiving service.

Future/Potential Measures:

1. Documented relapse signature and contingency strategy.
2. Information handover prior to consumer exiting the service.

Review Date

12 months from the date of publication.

⁶⁸ Physical Health Care of Mental Health Consumers Standard, Chief Psychiatrist 2015

Standard 8: Aboriginal Practice Standard

Definition

All Western Australian mental health services and service providers are within scope for this Practice Standard, which defines the service context, criteria and measures for best practice in responding to the cultural needs of Aboriginal people with mental illness and their carer's, families and communities.

Purpose

To facilitate equitable access and improved mental health outcomes for Aboriginal people with mental illness, and their carer's, families and communities, by defining Practice Standards for:

- Delivering mental health services that take into account the cultural and social diversity of Aboriginal people with mental illness and meeting their needs and those of their carer's and community throughout all phases of care.⁶⁹
- Actively and respectfully reducing barriers to access, providing culturally secure systems of care, and improving social and emotional wellbeing.⁷⁰

Context

Mental health services and providers should:

- Work collaboratively and in partnership with Aboriginal people with mental illness and their carers to improve the safety and quality of care.⁷¹
- Practice in accordance with the National framework for recovery-oriented mental health services.⁷²
- Have regard to the Charter of Mental Health Care Principles.⁷³
- Recognise the potential value of traditional healing practices in the treatment of mental health and social and emotional problems; understand the mental health implications of the history of contact between Aboriginal communities and Australia's mainstream society; and acknowledge that understanding of mental health within Aboriginal communities involves a holistic construct of social, emotional, cultural and spiritual wellbeing.^{74,7,8,9,10}
- Provide trauma-informed care and practice in a strengths-based framework.¹¹

Criteria

1. Access

69 Australian Government (2010) National Standards for Mental Health Services.

70 Australian Government (2013) National Practice Standards for the Mental Health Workforce.

3 Australian Commission on Safety and Quality in Health Care (ACSQHC) (September 2011), National Safety and Quality Health Service Standards, ACSQHC, Sydney.

4 [A National Framework for Recovery-oriented mental health services 2013.](#)

5 Western Australia Mental Health Bill 2014.

74 RANZCP Principles and Guidelines for Aboriginal and Torres Strait Islander Mental Health 2014

7 [Working Together: Aboriginal and Torres Strait Islander Mental health and Wellbeing Principles and Practice.](#)

8 [WA Aboriginal Health and Wellbeing Framework 2015-2030](#)

9 [National Aboriginal and Torres Strait Islander Health Plan 2013 - 2023](#)

10 [Social and emotional wellbeing framework 2004-2009](#)

11 Mental Health Coordinating Council (MHCC) 2013, Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA)

- 1.1. Enhancing access to and engagement with mental health services for Aboriginal people and communities
- 1.2. Culturally appropriate resource development (Aboriginal community education and awareness, clinical resources).
- 1.3. Interpreter services (well-resourced and readily accessible).
- 1.4. Interdisciplinary care.⁷⁵
2. Governance
 - 2.1. Leadership in Aboriginal mental health service delivery
 - 2.1.1. Dedicated Aboriginal leadership positions in mental health.
 - 2.1.2. Community engagement in the development, planning, delivery and evaluation of services
 - 2.1.3. Consumer and carer involvement in the development, planning, delivery and evaluation of services
 - 2.2. Partnership to deliver coordinated culturally capable health care
 - 2.2.1. Traditional Healers
 - 2.2.2. Consumer, family, carer and community
 - 2.2.3. Interagency and intersector partnerships in service delivery
3. Workforce
 - 3.1. Cultural supervision for all mental health workers
 - 3.2. Interpreter services training for all mental health workers
 - 3.3. Cultural competence for non-Aboriginal mental health workforce
 - 3.3.1. Cultural awareness training
 - 3.3.2. Organisational culture that is supportive of cultural competence
 - 3.4. Aboriginal mental health workforce development
 - 3.4.1. Maximise the potential for providing culturally responsive, safe and capable services through the recruitment and retention of Aboriginal mental health workers.
 - 3.4.2. Mental health workforce competency framework⁷⁶
 - 3.4.3. Participation in an Aboriginal Mental Health Network (for peer mentoring and support)
 - 3.4.4. Workplace/organisational support to obtain clinical qualifications
 - 3.4.5. Establish a cross-sectoral career structure for Aboriginal Mental Health Workers
4. Data and information collection, use and analysis
 - 4.1. Identification of Aboriginal consumers
 - 4.2. Culturally-informed information collection for epidemiological and clinical purposes
 - 4.3. Culturally-informed clinical assessment, care planning and review
 - 4.4. Monitoring, analysis and use of such data and information in health service planning, patient safety and continuous quality improvement.

⁷⁵ Schultz C, Walker R, Bessarab D, McMillan F, MacLeod J & Marriott R (2014) Interdisciplinary Care to Enhance Mental Health and Social and Emotional Wellbeing. In Australian Government (2013) National Practice Standards for the Mental Health Workforce.

Measures

Criterion	Measure
Access	The number of Aboriginal consumers accessing and engaging with alcohol, drug and/or mental health services; the proportion of cases with input from an Aboriginal mental health worker, family member, carer, elder, community member and/or traditional healer; and expressing satisfaction with the level of cultural appropriateness of service delivery.
Governance	Number and proportion of Aboriginal leadership position(s) reflected in the organisational chart and influencing service delivery through cultural supervision/mentoring contracts/plans developed and successfully acquitted.
Workforce	Proportion of Aboriginal workforce retained, the number of workforce development initiatives/opportunities for Aboriginal staff provided by organisation and the proportion of Aboriginal staff completing/demonstrating satisfactory progress.

Review Date

12 months from the date of publication

Addendum 2: Chief Psychiatrist's guidelines, Section 547(1)

Section 547 requires the Chief Psychiatrist to publish guidelines on specific matters as detailed in the section. Section 191 **notes that** mental health service must take guidelines into account. The person in charge of a mental health service must ensure that, in the provision by the mental health service of treatment and care to persons who have a mental illness, regard is had to any guidelines published under section 547(1) or (3) applicable to that treatment and care.

Guideline (a) (s. 547(1)(a))

Making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order

1.0 *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.

2.0 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.

3.0 (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 (l) 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.

4.0 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 include-

- 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 include-

- 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 include-

- 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.

5.0 (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.

6.0 (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.

7.0 (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.

8.0 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.

9.0 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.

Review Date: 12 months from the date of commencement.

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.

1.0 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.

2.0 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 an 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 their 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.

Review Date: 12 months from the date of commencement.

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.

1.0 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.

2.0 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.

Review Date: 12 months from the date of commencement.

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.

Review Date: 12 months from the date of commencement.

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.

1.0 Introduction and purpose

1.1 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.

1.2 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.

1.3 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)**

1.4 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.

1.5 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.

2.0 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.

3.0 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.

4.0 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.

Review Date: 12 months from the date of commencement.

Guideline (f): Chief Psychiatrist's guidelines (s. 545(1)(f))

The performance of electroconvulsive therapy.

This has not yet been included, but will be added to a later Edition of the CPG.

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).

1.0 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)

2.0 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.

3.0 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.

Review Date: 12 months from the date of commencement.

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).

1.0 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:
 - a) Provide the best possible treatment and service to people experiencing mental illness
 - b) Provide a service which upholds and protects the basic human rights of people experiencing a mental illness
 - c) Provide the service in the safest but least restrictive environment
 - d) To treat all people experiencing a mental illness with dignity, equality, courtesy and compassion
 - e) To include the patient, and their personal support person in decisions and planning regarding their treatment and care
 - f) To optimise the safety of the person experiencing mental illness as well as the community.

2.0 Agencies which check Compliance with the Act

There are various agencies which share responsibility for oversight of compliance with 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.

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.

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.

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.

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.

Review Date: 12 months from the date of commencement.

Addendum 3: Advance Health Directives

1.0 Introduction

1.1 The Mental Health Act 2014 (MHA 2014) directs psychiatrists and other clinicians to involve a person in their treatment decisions and to provide treatment according to the person's wishes, as far as is practicable.

1.2 An Advance Health Directive (AHD) is an important way that a person is able to communicate and indicate what their wishes are regarding treatment, especially at those times when they may be unable to communicate their needs effectively. (s.8).

1.3 An AHD is a document that an adult develops to direct their decisions about further treatment, and the situations in which those decisions should apply. The person can either provide consent or refuse consent to treatments in the AHD. The person's AHD comes into effect if they are unable to make reasonable judgements about a treatment decision when treatment is required.⁷⁷

1.4 An AHD is developed when the person has capacity and is capable of making treatment decisions. It must therefore be given due regard by all clinicians.

1.5 As a general rule, AHDs are legally binding (Guardianship and Administration Act 1990 (GAA)). An AHD can be made under the GAA or can be made under common law.

2.0 The legal implications

2.1 To write an AHD a person does not have to have legal or medical advice, but it is advisable where possible to obtain legal and/or medical advice. The AHD is still valid without legal or medical advice. (GAA s.110Q(1))

2.2 The AHD has to be witnessed by 2 people, at least one of whom must be authorised to witness statutory declarations. (GAA s110Q(1)(d))

2.3 There is a template provided in the Guardianship and Administration Act Regulations 2009, but a person can draw up their own template as long as it is substantially in the format prescribed.

2.4 AHDs may be overruled where the MHA 2014 permits psychiatric treatment to be provided without consent (for example if the person is subject to an involuntary treatment order).

2.5 Even when a person is on an involuntary order the psychiatrist and treatment team should still have regard for the patient's treatment wishes, as far as is practicable.

2.6 There are some circumstances that the treatment wishes of a person could be overridden by a psychiatrist but this is a decision that should be made with deliberation and careful decision making.

⁷⁷ Preparing an Advance Directive, Department of Health 2010.

2.7 Some of the circumstances which may warrant an AHD of an involuntary patient being overridden would include:

- a) If the treatment decisions specified within the AHD are illegal or contrary to a Clinical Code of Conduct
- b) If the treatments requested within an AHD are not indicated for the patient's condition
- c) If the person requires urgent treatment following a suicide attempt
- d) if the person is at immediate risk of harming themselves or others
- e) if the person's chosen treatment option has been tried for a reasonable period of time and has been shown to be ineffective and the person has not improved.

2.8 If a person in need of non-urgent treatment has made an AHD and the directive covers the treatment required, the health professional will need to proceed in accordance with the directive. (Refer to CPG Addendum 3 for additional information on making treatment decisions under the GAA.)

2.9 If the psychiatrist chooses to override the AHD of an involuntary patient, the psychiatrist must document and record in the patient's clinical record the reasons the decision was made to override the AHD. (s.179)

2.10 Additionally, if the psychiatrist chooses to override the AHD of an involuntary patient, then a copy of the reasons for overriding the AHD must be provided to:

- a) the patient,
- b) their 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)).
- c) the Chief Psychiatrist, and
- d) the Chief Mental Health Advocate.

2.11 If a person is a voluntary patient, an AHD can only be overridden if

- a) If the treatment decisions specified within the AHD are illegal or contrary to a Clinical Code of Conduct
- b) If the treatments requested within an AHD are not indicated for the patient's condition
- c) With a decision from the State Administrative Tribunal.

3.0 Best practice implications

3.1 The psychiatrist should always specifically ask the patient if they have an AHD and make all practicable efforts to obtain this information before making a treatment decision.

3.2 If at all practicable, it should be established at admission whether a patient has an AHD.

3.3 If there is an AHD this should be clearly documented and noted in the patient's clinical notes. Best practice would be to ensure there is a copy of the AHD placed at the front of the file or there is a tab or sticker on the patient's clinical notes denoting there is an AHD on file.

3.4 An Alert should also be placed on PSOLIS that alerts all clinicians that the patient has an AHD.

3.5 Following a decision not to follow an AHD, it is good practice for the psychiatrist or a member from the treatment team to spend some time communicating with the patient about why the decisions to override an AHD was made.

3.6 It is also recommended that discussion occurs regarding changes that could improve outcomes in future situations – for both the patient and the psychiatrist or treatment team.

3.7 The psychiatrist or another clinician from the treatment team could offer to assist the patient to update their AHD for a better outcome in the future.

Review Date: 12 months from the date of commencement.

Addendum 4: Relationship between the Mental Health Act 2014 and the Guardianship and Administration Act 1990

1.0 Introduction

1.1 The purpose of this addendum is to provide information on the links between mental health legislation, guardianship law and how persons with mental illness who require detention and treatment but lack capacity can be best managed.

1.2 The Mental Health Act 2014 (the Act) deals primarily with detention and treatment of involuntary patients with mental illness while the *Guardianship and Administration Act 1990* (GAA) provides a generic substitute decision making regime for people with impaired capacity, including because of mental illness.

2.0 The Guardianship and Administration Act 1990 (GAA)

2.1 GAA creates the following for adults:

- Guardian
- Enduring Power of Guardianship
- Administrator
- Enduring Power of Attorney
- Advance Health Directive.

3.0 Guardian

3.1 The State Administrative Tribunal (SAT) can appoint a guardian for an adult, usually because of a mental disability such as mental illness, intellectual disability, acquired brain injury or dementia. The person under the guardianship order is called the “represented person”.

3.2 A guardianship order may be plenary, or limited to certain functions.

3.3 A plenary guardian can make most personal, lifestyle and medical treatment decisions in relation to the represented person.

3.4 A guardian, however, cannot:

- make financial decisions;
- consent to a sterilisation without the approval of SAT;
- consent to a termination of pregnancy; or
- consent to anything unlawful (e.g. euthanasia).

3.5 A guardian is also not required to consent to something for which a person’s consent is not needed (e.g. emergency psychiatric treatment). A guardian can, however, advocate on behalf of a represented person and be consulted.

3.6 A guardian must also be an adult. Sometimes a statutory office holder, the Public Advocate, is appointed when the SAT determines that there is no-one else suitable and willing to act. The Public Advocate may delegate his or her tasks to other people in the office. In some cases, joint guardians are appointed.

4.0 Enduring Power of Guardianship

4.1 An Enduring Power of Guardianship is a document in which an adult with full legal capacity can appoint an enduring guardian. The enduring guardian has similar powers to a guardian, but can only exercise them if and when the adult loses legal capacity.

5.0 Administrator

5.1 SAT can appoint an administrator for the estate of an adult with a mental disability. An administration order can be plenary, or limited to certain functions. Although administrators cannot make personal, lifestyle and medical treatment decisions *per se*, they may decide whether or not to finance these decisions, so may indirectly have some say in them.

6.0 Enduring Power of Attorney

6.1 An Enduring Power of Attorney is a document in which an adult with full legal capacity can appoint an attorney to make financial decisions on behalf of the adult. Again, although attorneys cannot make personal, lifestyle and medical treatment decisions *per se*, they may decide whether or not to finance these decisions.

7.0 Advance Health Directive

7.1 An Advance Health Directive (AHD) is a document that enables an adult to direct now about the treatment they would want – or not want – to receive if they became sick or injured and were incapable of communicating their wishes. An AHD can be made under the GAA. It is also possible to have a common law version of an AHD.

8.0 Some important sections of the Act

8.1 s.7 says that whenever a person or body is making a decision about what is in a person's best interests, they must have regard to:

- the person's wishes to the extent that it is practicable to ascertain them; and
- the views of certain other people including any enduring guardian or guardian. In this situation a guardian or enduring guardian may fulfil an advocacy role on behalf of the incapable person.

8.2 s.8 says that whenever a person or body is required under the Act to ascertain the wishes of a person, they must have regard, amongst other things, to any advance health directive and any term of an enduring power of guardianship.

8.3 s.9 says that when communicating with a person under the Act (e.g. giving advice, explanation, information notification or reasons), it must be done in a manner that the person is likely to understand, using any practicable means. An interpreter must be used if necessary and practicable.

8.4 s.17 says that if informed consent to treatment is needed, this can be given by:

- the person, if he or she is capable of giving it; or
- by someone authorised by law to make the treatment decision on the person's behalf, including the person's guardian or enduring guardian or person responsible for treatment decisions. The term "authorised by law" includes these people set out in the hierarchy of treatment decision makers

for non-urgent treatment decisions as defined under the GAA. An adult can also give informed consent by making an AHD.

8.5 s.202 defines “emergency psychiatric treatment” as treatment that needs to be provided to a person who is not an involuntary patient to save the person’s life, or prevent the person from behaving in a way that is likely to result in serious personal injury to the person or another person.

8.6 Also s.203 says that a medical practitioner may provide a person with “emergency psychiatric treatment” without informed consent being given to the provision of the treatment (but not including electroconvulsive therapy, psychosurgery and deep sleep and insulin coma and sub coma therapy). Therefore, a guardian or enduring guardian is not required to give informed consent to it.

9.0 Making treatment decisions under the GAA

9.1 'Treatment' under the GAA refers to any medical, surgical or dental treatment or other health care, including life-sustaining measures and palliative care.

9.2 A treatment decision is a decision to consent or refuse consent to providing any treatment.

9.3 When seeking a treatment decision for a person who lacks the capacity to make their own judgements, health professionals must follow a set order of decision-makers, as specified in Section 110ZJ and 110ZD of the GAA.

9.4 Sterilisation is a procedure for which consent can be given only with the authority of the SAT.

10.0 Urgent treatment

10.1 Treatment is regarded as urgent if it is needed to save a person's life or prevent the person from suffering significant pain or distress.

10.2 Where a person requires urgent treatment and it is not practicable for the health professional to determine whether an AHD has been made or to obtain a treatment decision from anybody in the hierarchy, the health professional may provide the necessary treatment.

11.0 Urgent treatment following attempted suicide

11.1 In cases where a person is in need of urgent treatment that the health professional believes is the result of attempted suicide, the health professional may administer the necessary treatment even:

- if the person has made an AHD in which consent for the required treatment is withheld;
- the person's guardian, enduring guardian or person with authority to make a decision withholds consent.

12.0 Non-urgent treatment

12.1 If a person in need of non-urgent treatment has made an AHD and the directive covers the treatment required, the health professional will need to proceed in accordance with the directive.

12.2 There are some circumstances where the AHD may be considered invalid, in which case the health professional may not follow the directive.

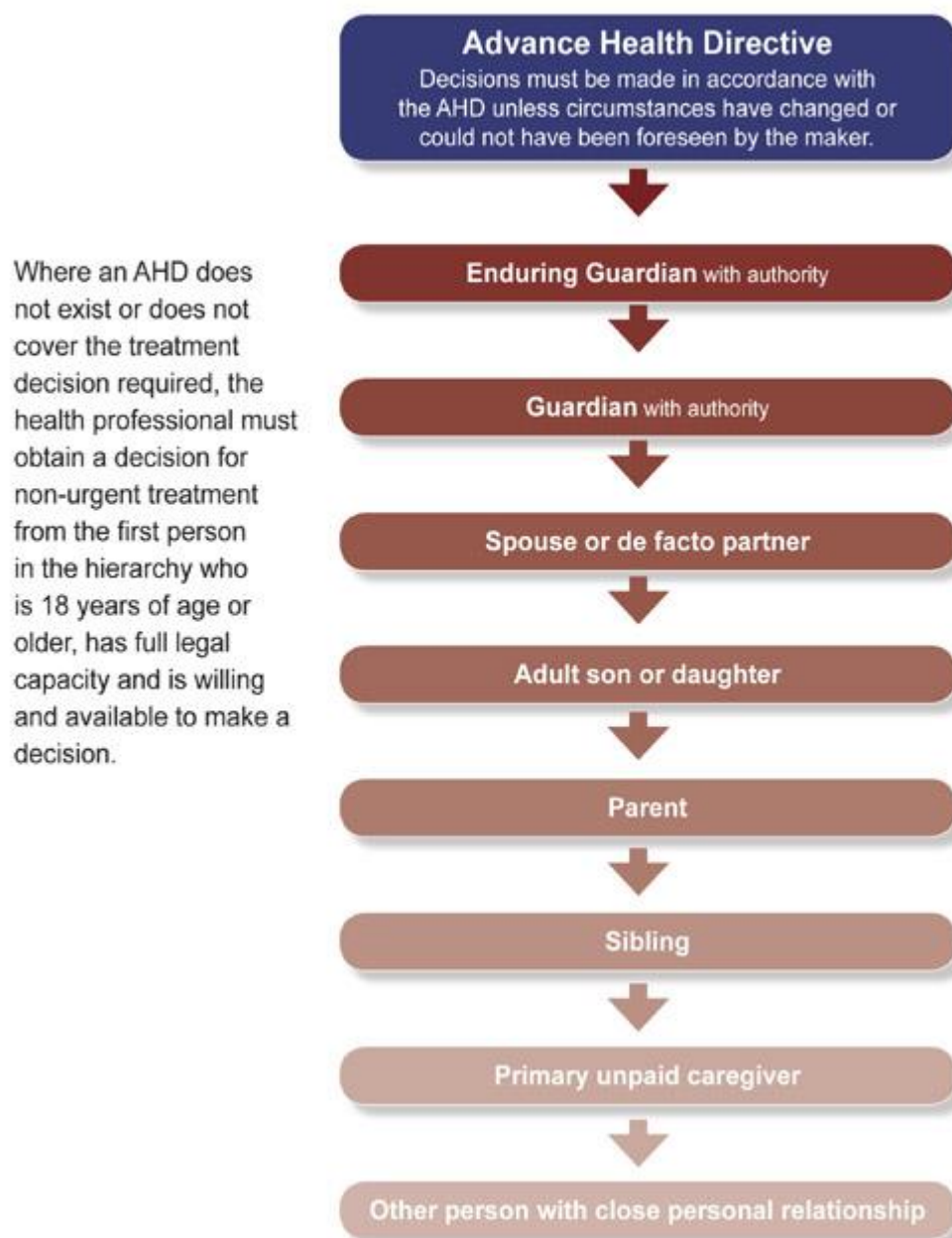
12.3 If for some reason the AHD is invalid, or if a person has **not** made an AHD, the legislation sets out the order of people who the health professional will need to obtain a treatment decision from. This order is contained in sections 110ZJ and 110ZD of the GAA and has been summarised for ease of understanding as 'the hierarchy of treatment decision-makers'.

12.4 When obtaining a treatment decision the health professional must go to the first person on the hierarchy, who is 18 years of age or older, has full legal capacity, is reasonably available and willing to make the decision.

12.5 If all of these conditions are not met, for example the first person in the hierarchy does not have capacity or is not available; the health professional can go to the next person in the hierarchy.

12.6 The hierarchy of treatment decision-makers is:

Figure 1: Hierarchy of treatment decision-makers



12.7 A health professional must consult the nearest relative in the order above, before moving onto a primary unpaid carer. There is no distinction in relation to age, therefore all adult children of a person have equal priority, and a health professional does not have to seek a treatment decision from the eldest child.

12.8 A person is to be regarded as maintaining a close personal relationship with the person needing treatment if the relationship is maintained through frequent personal contact and a personal interest in the welfare of the person needing the treatment.

Review Date: 12 months from the date of commencement.

Addendum 5: Working with people of Aboriginal and Torres Strait Islander Descent

1.0 Introduction

1.1 In order to provide effective and culturally safe mental health services for Aboriginal and Torres Strait Islander people, families and communities, a number of issues need consideration. The following discussion is to alert the clinician to some of the many complexities when working with Aboriginal and Torres Strait Islander people, families and communities in mental health services. In general, understanding the historical legacy, the cultural and contemporary context of Aboriginal and Torres Strait Islander mental health and applying a culturally safe and trauma informed approach will assist in improving outcomes.

2.0 Historical Legacy

2.1 The history of colonisation in Australia has contributed to the ongoing disparities for the Aboriginal and Torres Strait Islander population in regard to most outcomes across the life span. In particular, the shortened life expectancy; increased rates of illness, child removals, unemployment and incarceration; poorer educational outcomes and higher rates of poverty, disability and disadvantage are still significant today.

2.2 This has resulted in an altered population structure with most of the population being under 25 years. With fewer elders, healthy adults and community resources available to support families, the burden of care often falls to children and young people and this in turn creates additional stress in development.

2.3 When assessing and treating mental illness, clinicians must consider the higher rates of developmental disability, trauma and chronic disease as they influence not only the presenting symptoms but also complicate the course of any illness.

2.4 The family and community resources, levels of poverty, disadvantage and burden of care must also be considered within this context for successful outcomes to be achieved.

2.5 In addition, the historical legacy has contributed to an exclusion from as well as a mistrust of services and a high level of concern for the safety of Aboriginal and Torres Strait Islander people within mental health services. This may contribute to difficulties in engaging initially as well as for follow up with mental health services.

2.6 It is important for clinicians and services to engage in culturally safe practices and consider the views of the Aboriginal and Torres Strait Islander groups with which they work to improve services. This may include the development of local cultural safety training, employment of Aboriginal and Torres Strait Islander mental health workers, developing a collaboration or partnership with Aboriginal or Torres Strait Islander groups or services, reviewing how services are delivered, having material translated into local language groups and considering the design of services to include culturally appropriate material such as paintings and language.

3.0 Identity

3.1 The currently accepted definition of an Aboriginal or Torres Strait Islander person in Australia has three components. The person must be

- A descendant of an Aboriginal or Torres Strait Islander group in Australia
- Identify as an Aboriginal or Torres Strait Islander person
- Be recognised as an Aboriginal or Torres Strait Islander person by other Aboriginal and Torres Strait Islander people

3.2 Identity is not determined by skin colour, physical appearance, percentage of inheritance nor adoption practices. Aboriginal and Torres Strait Islander identity is about descent, cultural knowledge and beliefs, upbringing and experiences. However, for Aboriginal and Torres Strait Islander people who were part of the Stolen Generations and forcibly removed from their families and communities, identity can remain an ongoing issue.

3.3 For clinicians, it is important to understand the cultural identity of any person presenting to mental health services. The person's cultural identity cannot be assumed and should be asked about in a sensitive and appropriate way. This may include general questions about where they are from, who they are related to or which group they associate with. This may assist in informing the clinician about cultural beliefs, behaviours and experiences as well as who should be contacted regarding assistance with assessment, treatment and second opinions.

3.4 If the person is unable to give the information at the time of presentation, this should be sought from family, community members or other service providers working with the person.

4.0 Cultural Beliefs and Experiences

4.1 Aboriginal and Torres Strait Islander groups across Australia have a diverse range of beliefs, knowledge, practices and experiences.

4.2 Although some general principles can be applied, the specific manifestations of cultural experiences and understanding can only be sought from the individual group. This is particularly so in regard to the use of language, ceremony, healing practices and rituals around grief and loss. For example, in regard to the use of language, although the word may sound the same, the meaning may be quite acceptable in one cultural group and be quite offensive in another.

4.3 Understanding the level of diversity and the limits to the application of specific cultural knowledge is important. Hence consulting with the person's community may be the only way to understand a particular behaviour or symptom.

4.4 Cultural beliefs and experiences can influence a person's development and behaviour in a number of ways including:

- Understanding and ascribing meaning to symptoms, illness and recovery
- Development of coping and defence mechanisms
- Development of symptoms particularly in the context of mental illness including culture bound syndromes

- Acceptability of treatment and outcomes
- Development and understanding of social relationships, communication styles and responsibility

4.5 For example, lack of eye contact must be seen within a cultural context for understanding behaviour otherwise this could be misjudged in a mental status examination. This is even more important when assessing phenomenology such as hearing the voices of ancestors, seeing deceased persons or travelling in spirit form.

4.6 In general, for many Aboriginal and Torres Strait Islander groups, cultural experiences may occur within visual and auditory modalities as part of normal cultural life, as a response to stress and within the course of an illness.

4.7 Different styles of language and communication may also be present including speech sounds such as clicks; Aboriginal forms of English; use of body language and cultural rules governing social behaviour. For example, an Aboriginal person may answer yes to questions to be polite during an assessment interview or may not answer questions at all if the wrong people are in the room in relation to gender, age or cultural relationship.

4.8 English may well be a second, third or fourth language. As well due to the increased rates of language and development disorders in the Aboriginal and Torres Strait Islander population, assessment of speech and language may be difficult particularly in combination with poor education.

4.9 There are often strong spiritual beliefs present such as communicating and travelling with ancestors which may become apparent during a clinical consultation. Knowing how to explore, understand and assess these experiences may require additional training and supervision.

4.10 The clinician must be careful in balancing what may be acceptable cultural experiences with what constitutes illness. Whilst it is important not to pathologise cultural beliefs and experiences, it is also vital not to miss significant illness within the cross-cultural context, in the presence of significant disadvantage or disability.

4.11 The clinician may need to seek further assistance from family, community members, elders, traditional healers or Aboriginal and Torres Strait Islander mental health workers to determine the nature and significance of the person's experiences and symptoms. In some cases, ongoing cultural supervision may be required over the course of an illness with discussion about what may be appropriate outcomes.

4.12 If there are significant cultural experiences as part of illness, there may also need to be an understanding and treatment plan from a cultural perspective to gain rapport and develop a therapeutic relationship, improve compliance as well as outcomes. For example, an Aboriginal person from a remote community admitted to an inpatient unit in the city may well develop a worsening of symptoms due to the grief response to removal from country. This may warrant a different treatment or early discharge plan that would otherwise be expected. As well if there is an unresolved cultural issue such as a spiritual wound or curse, this can cause significant distress and anxiety which is not amenable to mainstream treatment. The

assistance of an Aboriginal or Torres Strait Islander mental health worker or Traditional Healer may be required.

4.13 In general a combined cultural and clinical approach is likely to produce the best outcomes.

4.14 The following questions are presented as a guide to assist clinicians in assessing and treating Aboriginal and Torres Strait Islander people in mental health services:

- Have you considered the presentation, assessment and treatment within the context of the person's culture?
- Does the impact of the historical legacy, levels of disadvantage or community issues require additional consideration?
- Are there aspects of the presentation that require further exploration from a cultural or trauma informed framework?
- How have you engaged the Aboriginal or Torres Strait Islander community or workers in providing advice, support or gaining a second opinion for this person?
- Has there been sufficient screening for developmental disability?
- Has there been sufficient screening for underlying health problems especially diabetes and cardiovascular disease?
- On reflection, was the service able to provide a culturally safe environment, assessment and treatment process?
- What could be done to improve outcomes for Aboriginal and Torres Strait Islander people?

Resources

[Australian Government \(2010\) National Standards for Mental Health Services.](#)

[Australian Government \(2013\) National Practice Standards for the Mental Health Workforce.](#)

[Australian Commission on Safety and Quality in Health Care \(ACSQHC\) \(September 2011\), National Safety and Quality Health Service Standards, ACSQHC, Sydney.](#)

[A National Framework for Recovery-oriented mental health services 2013.](#)

[Western Australia Mental Health Bill 2013](#)

[RANZCP Principles and Guidelines for Aboriginal and Torres Strait Islander Mental Health 2014](#)

[Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Second Edition](#)

[WA Aboriginal Health and Wellbeing Framework 2015-2030](#)

[National Aboriginal and Torres Strait Islander Health Plan 2013-2023](#)

[Social and emotional wellbeing framework 2004-2009](#)

[Mental Health Coordinating Council \(MHCC\) 2013, Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C \(MHCC\) Kezelman, C \(Adults Surviving Child Abuse, ASCA\)](#)

[AIMHI](#)

[Australian Indigenous Health Infonet](#)

Review Date: 12 months from the date of commencement.

Addendum 6: Managing a child in an adult facility

1.0 Introduction

1.1 The Mental Health Act 2014 (Act) contains a number of provisions specific to children. It offers safeguards to protect children recognising that children experiencing mental illness are extremely vulnerable.

1.2 A child is defined by the Act as a person who is under 18 years of age.

1.3 When young people under the age of 18 require inpatient treatment the needs of each individual young person are paramount and should be central to determining the care he or she receives.

1.4 Where young people require admission, in all instances every effort should be made to admit them to mental health services that normally provide treatment or care to children and adolescents. Every effort should be made to avoid admitting children to facilities that do not normally provide treatment or care to children.

1.5 If a child is admitted to an adult or youth ward, then special consideration must be given to ensure the safety and wellbeing of the child, and this must be consistent with the Mental Health Act, the Clinicians Guide to the Mental Health Act and Department of Health Policy and Procedural Documents.

2.0 Important considerations and guidance

2.1 The following sections provide guidance to managing a child on an adult or youth ward consistent with the Mental Health Act and Department of Health Policy and Procedural documents:

- Managing Referral of a child to an Adult Facility
- Managing a Child in an Adult Facility
- Informed Consent
- Provision of Developmentally Appropriate Care
- Mental Health Act Management of Involuntary Treatment Orders of Children
- Mental Health Advocacy Service and Access to Personal Support Persons
- Responsibilities to the Chief Psychiatrist

2.2 Managing Referral of a Child to an Adult Facility

When a child is deemed to require admission to an inpatient facility, clinicians should contact the bed-flow coordinator for Child and Adolescent Mental Health Services (CAMHS). Guidance to the management of children in all non-CAMHS emergency and inpatient facilities is covered by the “Guidelines for the management of under 18 year old young people in all non CAMHS emergency and inpatient settings”⁷⁸.

⁷⁸ Guidelines for the management of under 18 year old young people in all non CAMHS emergency and inpatient settings. Acute Services – Guidelines. Child and Adolescent Mental Health Service. Department of Health. Reviewed 2014.

The person in charge of admitting a child to a mental health service that does not normally provide treatment or care to children must be compliant with s.303 of the Act.

2.3 Managing Safety of a Child in an Adult Facility

The Act is explicit in how children should be managed on an adult inpatient facility. This is covered in Section 303:

s.303 Segregation of children from adult inpatients.

- 1) This section applies in relation to a mental health service that does not ordinarily provide treatment or care to children who have a mental illness.
- 2) A child cannot be admitted by a mental health service as an inpatient unless the person in charge of the mental health service is satisfied that:
 - (a) The mental health service can provide the child with treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual beliefs; and
 - (b) The treatment, care and support can be provided to the child in a part of the mental health service that is separate from any part of the mental health service in which adults are provided with treatment and care if, having regard to the child's age and maturity, it would be appropriate to do so.
- 3) When a child is being admitted by a mental health service as an inpatient, the person in charge of the mental health service must –
 - (a) Give to the child's parent or guardian a written report setting out –
 - i) the reasons why the person in charge is satisfied of the matters referred to in subsection (2)a. and b.; and
 - ii) the measures that the mental health service will take to ensure that, while the child is admitted as an inpatient, the child is protected and the child's individual needs in relation to treatment and care are met; and,
 - iii) File a copy of the report and give another copy to the Chief Psychiatrist.”

2.4 Additional advice in the management of safety of children in an adult inpatient setting is in Chapter 1 of the Clinician's Practice Guide to the Mental Health Act (CPG), Section 1.22.

All children admitted to an adult inpatient facility need to be either physically separated from adult inpatients at all times or provided with a level of observation / supervision that will address their vulnerability and ensure continuous protection from others.

2.5 Informed Consent

The Mental Health Act creates a presumption, consistent with that in general health, that children do not have decision making capacity unless the child is shown to have that capacity. The concept of capacity is explained in detail in the Mental Health Act

(s.14, s.15). Chapter 2 of the CPG also provides guidance to clinicians on decision making capacity and informed consent. Where a child does not have capacity, the child's parent or guardian may consent on their behalf. If the child shows that they do have capacity, then they can make decisions for themselves and the parent or guardian cannot override the child's decisions.

Whether or not the child has capacity, their wishes have to be considered, and the views of their parents or guardian must be taken into account. The best interests of the child are a primary consideration, however this can be overridden in circumstances such as where the child is a risk to another person, a risk which cannot be ignored.

When assessing the capacity of children under 18 for informed consent, clinician's should refer to the document "Assessing Capacity to Consent in Minors: A Clinician's Guideline"⁷⁹.

2.6 Provision of Developmentally Appropriate Care

Special consideration needs to be given to the needs of children when they are admitted to an adult inpatient facility. This includes:

- Mental health clinicians assessing and managing children in an adult facility should seek collaborative advice and support (directly or indirectly) from CAMHS or Youth Mental Health staff in order to best assist and support the young person and their family.
- Risk assessment should include vulnerability of the young person in a non CAMHS setting and Management/Care Plans should address and mitigate any identified risks, including that posed by the ward environment. The plan should include ongoing risk assessment.
- Where possible, the provision of a single room with ensuite bathroom facilities/access to single-sex bath/shower room.
- All elements of care that apply to an adult unit, such as welcome packs, ward orientation, involvement of appropriate others and communication, will apply to the admission of a young person.
- Every effort should be made to provide developmentally and age appropriate activities and educational opportunities to children.
- Transfer of the patient when bed is available to a CAMHS or Youth Inpatient Unit.

Section 1.22.5 of the CPG provides further guidance to clinician's in the provision of developmentally appropriate care to children.

2.7 Mental Health Act Management of Involuntary Treatment Orders of Children

There are a number of provisions in the Act that have different approaches or timeframes for children, in comparison to the treatment of adults. This includes:

⁷⁹ Assessing Capacity to Consent in Minors: A Clinical Guideline. Child and Adolescent Mental Health Service. Department of Health. 2014.

- Inpatient Treatment Orders – 14 days for children, 21 days for adults.
- Continuation Orders – 28 days for children, 3 months for adults.
- Involuntary Patient Leave – the child's parent or guardian needs to be involved.
- Treatment, Support and Discharge Plan – a copy must be provided to child's parent or guardian.
- The Mental Health Tribunal will review the involuntary treatment order within 10 days.
- The Mental Health Advocate must contact the child within 24 hours after the time the involuntary treatment order is made (see 2.8 below).

2.8 Mental Health Advocacy Service and Access to Personal Support Persons

When a child is being made an involuntary patient the Chief Mental Health Advocate and Mental Health Tribunal will be immediately notified so the child can be contacted by a mental health advocate within 24 hours. A review of the involuntary status of the child will be held by the Tribunal within 10 days.

Section 350 outlines that the Mental Health Advocacy Service has at least one youth advocate with qualifications, training or experience relevant to children or young children.

Section 357 outlines that the mental health advocate must visit the child within 24 hours after the time an involuntary treatment order is made.

Section 1.21 of the CPG recognises the role of close family members, carers or personal support persons in the care of the patient and obliges treatment teams to include and consult with important people in the patient's life. Every effort should be made to ensure that all children admitted to adult facilities have access to a carer, close family member or support person of their nomination.

2.9 Responsibilities to the Chief Psychiatrist

There are a number of responsibilities outlined under the Act when children are admitted to adult inpatient facility. These include but are not limited to the following:

- s.303 outlines that the Chief Psychiatrist must be informed when a child is admitted to an adult inpatient service, refer to point 2 above: "Managing Children in an Adult Facility". Specific reporting requirements are detailed in Section 303 of the Mental Health Act.
- s.304 outlines the off-label prescription of medication to involuntary young patients. This is covered by Section 1.22.13 and 1.22.14 of the "Clinician's Guidelines of the Mental Health Act". This includes that a copy of the report needs to be sent to the Chief Psychiatrist.

Review Date: 12 months from the date of commencement.

Addendum 7: Use of audio-visual communication

1.0 Introduction

1.1 In non-metropolitan areas: a) an assessment for referral or b) examination by a psychiatrist under the Mental Health Act 2014 (Act) (s.48 and s.79c) can be conducted by the use of audio-visual (AV) communication.

1.2 This addendum refers only to the use of AV communication for the purposes specified in 1.1. All relevant provisions of the Act, clinical practice standards and policies apply as if the patient were being assessed or examined in person.

“The basic standards of professional conduct governing each health care profession are not altered by the use of Telehealth technologies to deliver health care...”⁸⁰

1.3 For the purposes of this addendum the assessment or examination will be referred to as the consultation.

1.4 There will be no AV or audio recording of the consultation without written informed consent of the patient and any third parties present.

1.5 It is expected that clinicians will read the Chief Psychiatrist’s Assessment Standard (Clinician’s Practice Guide, Addendum 1) in conjunction with this Addendum.

2.0 Definitions

2.1 “Audio-visual communication”: for the purpose of the Act refers to the use of videoconferencing to provide *“real-time, synchronous video and audio transmission between locations to bring people together”⁸¹*.

Audio-visual communications for the purpose of the Act does not include audio-only telecommunications.

2.2 Health Professional: is a medical practitioner, nurse, occupational therapist, psychologist, social worker or Aboriginal or Torres Strait Islander Health or Mental Health Worker (in relation to an Aboriginal or Torres Strait Islander patient) that will accompany the patient throughout the consultation.

2.3 Consulting practitioner: The medical practitioner or authorised mental health practitioner providing the assessment for referral or the psychiatrist providing the examination.

2.4 Providing site: is the site at which the consulting practitioner is located and from which the consultation will be conducted.

2.5 Receiving site: is the site at which the patient, the health professional and (where appropriate and possible) a carer or personal support person are present. In the case of a child, parent or guardian must also be present.

⁸⁰ Statewide Telehealth Service Use Policy V1.0. December 2012

⁸¹ WA Department of Health. Statewide Telehealth Service: Introduction to Telehealth v1.1 Nov 2013

2.6 Additional site: is the site from which a third party (e.g. carer or personal support person or in the case of a child, parent or guardian) joins the videoconference.

3.0 Responsibilities

3.1 Health Professional:

- Determines whether the patient's clinical state allows for safe and effective assessment or examination by videoconference.
- Provides the consulting practitioner all relevant information relating to this presentation along with available medical and psychiatric history.
- Provides the patient with written and verbal information and makes every effort to ensure that the patient understands (as far as is practicable) the information about the process, privacy, confidentiality and relevant technical aspects of assessment by videoconference.
- Provides the patient with written and verbal information and makes every effort to ensure that the patient understands, as far as is practicable, their rights under the Act.
- Includes any personal support persons as far as is practicable.
- Makes every effort, as far as is practicable, to ensure that the patient is involved in all decisions.
- Clearly documents the consultation in the clinical record noting at a minimum:
 - That it was conducted by videoconference, why the decision to use videoconference was made and which section of the Act permits this.
 - The sites that were linked and names of those in attendance at all sites.
 - Any factors impacting on the quality of the communication.
 - The outcome of the videoconference assessment and resulting treatment plans.
 - That the patient was provided with written and verbal information in relation to the process, privacy, confidentiality and relevant technical aspects of the assessment.

3.2 Consulting practitioner:

- Will ensure the patient receives an explanation and understands, as far as is practicable, the process of conducting the consultation via videoconference and their rights under the Act as outlined in 3.1.3 and 3.1.4 above.
- Will determine if an adequate consultation with the patient can be made using videoconferencing.
- Will conduct the consultation and determine if the assessment (s 48) or examination (s79c) is adequate for the purposes of the Act.
- Makes every effort, as far as is practicable, to ensure the patient is involved in decision making.
- Will provide immediate verbal advice, as far as is practicable and with consideration of the safety of the patient and the health professional,

about the outcome of the consultation, including orders to be made under the Act, to the patient, health professional and where appropriate, carer or personal support person.

- Will provide a detailed written assessment, treatment recommendations and case specific information to facilitate local care providers in:
 - Ongoing provision of care or
 - Safe transfer of care in line with the Act and relevant clinical practice standards and policies.
- Will liaise with appropriate local care providers to support implementation of the treatment plan and promote the ongoing safety and care of the patient.

4.0 Prior to the consultation

4.1 Make arrangements for any additional clinical support and where practicable clerical support which may be required to assist.

4.2 The health professional and consulting practitioner will have a preliminary discussion about:

- Relevant clinical information
- Who will be present, what the relationships are
- Risk factors and appropriate strategies and additional support available should it be required
- Make a final decision as to whether a videoconference consultation is the best way to proceed.

4.3 If required to assist the additional support person may be used to:

- Determine the equipment and locations to be used for the consultation and ensure that they are suitable and available.
- Book the videoconference consultation and provide dial in details to all parties.
- Ensure all involved are aware of the appointment time.
- Ensure equipment at all sites is working.
- Ensure mobile phone and phone coverage is available at all sites for use in the event of equipment failure (mobile phone is essential in the event of power failure) and that all parties have the correct phone numbers.

5.0 Conduct of the consultation

5.1 The consultation with the patient can commence once all equipment is working, the call connected and all attendees are present.

5.2 The consulting practitioner at the providing site will identify each person present and facilitate introductions, outline the process and manage the consultation ensuring all parties have adequate time and opportunity to contribute.

5.3 The consultation can be terminated by the patient, the Health practitioner or the consulting practitioner for reasons of safety, call quality or any other factor likely to impede a successful consultation. Third parties can leave the consultation at any time but not terminate it.

5.4 In the event of unplanned termination of the consultation for any reason the consulting practitioner will remain on standby and the treating practitioner will:

- First ensure the safety and well-being of the patient and any others present.
- Contact the consulting practitioner to determine:
 - The need for further information
 - The best course of action to ensure safety of the patient and others.
 - Whether adequate consultation has occurred to make an order under the MH Act 2014.

6.0 Following the consultation

6.1 In line with the outcome of the consultation and in accordance with relevant sections of the MH Act 2014 the health professional and the consulting practitioner will liaise with relevant clinical staff to ensure appropriate support and treatment is provided to the patient.

6.2 Documentation is to be completed as outlined in responsibilities (3.1 and 3.2 above) and in line with clinical practice standards and policies.

6.3 All related paperwork is to be completed, placed in the clinical record and forwarded as per the requirements of the Act and relevant clinical practice standards and policies.

Relevant Policies and Guidelines

Statewide Telehealth Service Use Policy. OD 0489/14. 29th January 2014

References

The Royal Australian and New Zealand College of Psychiatrists. Position Statement #44: Telepsychiatry. Feb 2009

WA Department of Health. Statewide Telehealth Service: Introduction to Telehealth v1.1 Nov 2013

Review Date: 12 months from the date of commencement.

Addendum 8: Role of Authorised Mental Health Practitioners

1.0 Introduction

1.1 Patient's rights are the cornerstone of the Mental Health Act 2014 (Act) and consequentially there are a number of clinical duties which ensure that these rights are upheld.

1.2 Clinicians are expected to comply with the Objects of the Act, the Charter of Mental Health Care Principles, the Chief Psychiatrist's Standards and consider the Chief Psychiatrist's Guidelines. There is also an expectation that when clinicians are performing functions under the Act they do so from an ethical and legal position.

1.3 It is important that AMHPs have:

- Appropriate working knowledge of the Act and associated legislation
- Knowledge of the role and functions of the AMHP
- Knowledge of and experience in assessment procedures
- Sufficient information and training to ensure that the AMHP adopts practices which are clinically and legally safe in carrying out their functions.

1.4 It is expected that authorised mental health practitioners (AMHPs) will read the Clinician's Practice Guide to the MHA 2014 in conjunction with this Addendum, especially those chapters which have particular relevance to their day to day roles.

2.0 Intent of the Act

2.1 The Objects of the Act (s.10) are:

- to ensure that people who are experiencing mental illness are provided with the best possible treatment and care, with the least possible restriction of their freedom and with the least possible interference with their rights in an environment which has respect for their dignity
- to recognise the role of carers, families and others in the treatment, care and support of people who have a mental illness
- to recognise and facilitate the involvement of people who have a mental illness, their nominated persons and their carers and families in the consideration of the options that are available for their treatment and care
- to help minimise the effect of mental illness on family life
- to ensure the protection of people who have or may have a mental illness
- to ensure protection of the community

3.0 Charter of Mental Health Care Principles (Schedule 1)

3.1 The Charter of Mental Health Care Principles is a rights-based set of 15 principles focusing on recovery, patient centered care, and carer involvement that mental health services and clinicians must make every effort to comply with in providing treatment, care and support to people experiencing mental illness.

4.0 The role of an AMHP

4.1 Referral of a person for an examination by a psychiatrist can be the first step in ensuring that a person experiencing mental illness receives treatment, but also may result in the person becoming an involuntary patient. It is therefore a process which needs to be carefully considered and only used when it is clear that less restrictive options are not available or suitable.

4.2 The purpose of the AMHP role is to facilitate the referral process to a psychiatrist when a person is suspected of having a mental illness for which the person needs treatment. Additionally, because of this mental illness there is a significant risk to the health and safety of the person or another person, or significant risk of serious harm to these individuals. Section 25 of the Act sets out the criteria for involuntary status which informs the AMHP in their decision to refer or not refer the person for an examination by a psychiatrist.

4.3 AMHPs can, following an assessment, refer a person they reasonably suspect is in need of an involuntary treatment order or is on a CTO, and is in need of an inpatient order, to be examined by a psychiatrist. The referral can be to an authorised hospital or another place that in the AMHPs opinion is appropriate place for the examination to be conducted. The Chief Psychiatrist will provide a guideline identifying the nature of appropriate places where examinations may occur, such as EDs or clinics.

4.4 A psychiatrist will then make a person an involuntary patient only if the person meets the criteria under section 25 (s.25).

4.5 The Act, while shaping the decisions clinicians make does not dictate what decision to make. This also applies to the role of AMHPs, who are required to make judgements as to whether to refer a person for examination by a psychiatrist and whether to use transport officers or the police in the process.

4.6 Consequently there is an expectation that AMHPs work to an acceptable standard and make responsible informed decisions.

4.7 The Chief Psychiatrist will designate as AMHPs only those mental health practitioners who in the opinion of the Chief Psychiatrist have the qualifications, training and experience appropriate for the performance of the functions as detailed in the Act:

- **s.26: referral for examination by a psychiatrist (CPG 3.3 – 3.5)**
- s.28: detention order to enable person to be taken to authorised hospital or other place (CPG 3.8)
- s.28: extension of a detention order (CPG 3.8)
- ss.29, 148, 150: transport order (CPG 3.10)
- **s.31: revocation of referral order (CPG 3.6, 3.12.8)**
- **s.36: referral of a voluntary inpatient subject to a Form 1A to be examined by a psychiatrist (CPG 3.12.7)**

- **s.37: revoking referral** made for a voluntary inpatient referred on a Form 1A (CPG 3.12.8)
- **s.45: extension of a referral order (non metropolitan areas) (CPG 3.7)**
- **s.46: changing the place of examination (CPG 3.11)**
- s.151: extension of transport order made under s.29 if referral is extended
- s.152: extension of transport order (**non metropolitan areas**) (CPG 3.10)
- ss.153, 154: revocation of transport order (CPG 3.10)

4.8 AMHPs must also ensure that the client is aware of and understand their rights. They must also ensure that the rights of the client and their support persons are met at each stage of the above processes.

4.9 AMHPs must notify carers, close family members or other personal support person when a person is subject to a detention order, transport order or is subject to revocation of a referral order, detention order.

5.0 Eligibility for nomination (s.538)

5.1 Mental health practitioners seeking to become AMHPs must:

- be a psychologist, Division 1 registered nurse, an occupational therapist whose name appears in the Australian Health Practitioner Regulation Agency or a social worker who is a member or eligible for membership of the Australian Association for Social Workers (s.4); and
- have a minimum of 3 years' experience in the management of mental health patients (s.538); and
- provide evidence that their service supports their nomination as a competent practitioner with comprehensive skills in the assessment, management and treatment of mental health patients or, in the case of independent practitioners, other information that supports their application as required by the Chief Psychiatrist; and
- provide evidence of completion of the mandatory MHA 2014 online training module for clinicians; and
- attend AMHP training as specified by the Chief Psychiatrist; and
- voluntarily agree to become an AMHP on successful completion of the training course

6.0 Authorisation and revocation of AMHPs (s.539)

6.1 Once the Chief Psychiatrist is satisfied that the practitioner has the qualifications, training and experience appropriate for performing the functions of an authorised mental health practitioner under this Act he may designate a mental health practitioner as an AMHP by an order published in the *Western Australian Government Gazette (Gazette)*.

6.2 This order may specify any limits or any conditions to the functions that can be performed by the AMHP as described in the order.

6.3 The Chief Psychiatrist may also amend or revoke an authorisation order by publishing a subsequent order in the *Gazette*.

7.0 Competencies for an AMHP

7.1 To act in the role of an AMHP, a mental health practitioner must be a competent health professional ***with comprehensive skills in the assessment, management and treatment of mental health patients.***

Line managers should only nominate mental health practitioners to be AMHPs if the service requires clinicians to act in that role.

7.2 Line managers should only nominate mental health practitioners who are competent in their clinical role and willing to be an AMHP.

7.3 This competency is obtained through experience, supervision, education and training and is demonstrated in the knowledge, skills and attitude of the authorised mental health practitioner.

7.4 AMHPs should have a good understanding of the AMHP role and a detailed knowledge of the MHA2014.

7.5 Supervision of practice should be undertaken by all AMHPs as part of professional development and good practice. AMHPs are also required to undertake regular, ongoing supervision in their role as an AMHP which may include review of the issues that arise when making decisions in crisis situations and dealing with conflict.

7.6 Each mental health region, service or AMHP employer is required to support and facilitate supervision of practice for all AMHPs operating within the region or service.

7.7 In addition to the requirements for nomination the practitioner will be required to:

- complete a comprehensive initial AMHP training course approved by the Chief Psychiatrist
- undertake formal clinical supervision of their practice as an AMHP
- complete an AMHP refresher training course approved by the Chief Psychiatrist within the prescribed period

8.0 Reports to the Chief Psychiatrist

8.1 It is mandatory for AMHPs to provide reports to the Chief Psychiatrist as prescribed in the MHA 2014 Regulations.

Review Date: 12 months from the date of commencement.

15: List of Forms

LIST OF *MENTAL HEALTH ACT 2014* FORMS

1 – Referral of person for an examination by a psychiatrist

Form Number	Form Name	Sections of the Act referred to
1A	REFERRAL FOR EXAMINATION BY PSYCHIATRIST ATTACHMENT TO FORM 1A – INFORMATION PROVIDED BY ANOTHER PERSON IN CONFIDENCE	26, 31, 36, 37, 41, 42, 43
1B	VARIATION OF REFERRAL	45, 46

2 – Order for assessment of a voluntary inpatient

Form Number	Form Name	Sections of the Act referred to
2	ORDER FOR ASSESSMENT OF VOLUNTARY INPATIENT	34, 35

3 – Detention of a person to enable a person to be taken to a place, or to enable an examination by a psychiatrist

Form Number	Form Name	Sections of the Act referred to
3A	DETENTION ORDER	28, 62
3B	CONTINUATION OF DETENTION	28, 59, 62
3C	CONTINUATION OF DETENTION TO ENABLE A FURTHER EXAMINATION BY A PSYCHIATRIST	55, 56
3D	ORDER AUTHORISING RECEPTION AND DETENTION OF PERSON IN AUTHORISED HOSPITAL	61
3E	ORDER THAT PERSON CANNOT CONTINUE TO BE DETAINED	72

4 – Detention of a person to enable a person to be taken to a place, or to enable an examination by a psychiatrist

Form Number	Form Name	Sections of the Act referred to
4A	TRANSPORT ORDER	29, 63, 67, 92, 112, 129, 133, 148, 154
4B	EXTENSION OF TRANSPORT ORDER	152
4C	TRANSFER ORDER	66, 91

Form Number	Form Name	Sections of the Act referred to
4D	INTERSTATE TRANSFER ORDER	555
4E	APPROVAL OF INTERSTATE TRANSFER ORDER	557

5 – Community treatment order

Form Number	Form Name	Sections of the Act referred to
5A	COMMUNITY TREATMENT ORDER ATTACHMENT TO 5A – TERMS OF CTO	55, 56, 61, 72, 75, 76, 89, 90, 120, 123, 131
5B	CONTINUATION OF COMMUNITY TREATMENT ORDER	121
5C	VARIATION OF COMMUNITY TREATMENT ORDER	122, 135, 137
5D	REQUEST FOR A PRACTITIONER TO EXAMINE PATIENT	118, 119
5E	NOTICE AND RECORD OF BREACH OF CTO	127
5F	ORDER TO ATTEND	128

6 – Inpatient treatment order

Form Number	Form Name	Sections of the Act referred to
6A	INPATIENT TREATMENT ORDER	55, 56, 72, 120, 123, 131
6B	INPATIENT TREATMENT ORDER IN GENERAL HOSPITAL ATTACHMENT TO FORM 6B – INPATIENT TREATMENT ORDER IN GENERAL HOSPITAL: REPORT TO CHIEF PSYCHIATRIST	61, 89, 90, 131
6C	CONTINUATION OF INPATIENT TREATMENT ORDER	89
6D	CONFIRMATION OF INPATIENT TREATMENT ORDER	68, 124

7 – Grant of leave of absence and absence without leave

Form Number	Form Name	Sections of the Act referred to
7A	GRANT OF LEAVE TO INVOLUNTARY INPATIENT	105
7B	EXTENSION OR VARIATION OF LEAVE	106, 110

Form Number	Form Name	Sections of the Act referred to
7C	CANCELLATION OF LEAVE	110
7D	APPREHENSION AND RETURN ORDER	98, 101

8 – Search and seizure of articles

Form Number	Form Name	Sections of the Act referred to
8A	RECORD OF SEARCH AND SEIZURE	165, 166
8B	RECORD OF DEALING WITH SEIZED ARTICLES	167

9 – Emergency treatment

Form Number	Form Name	Sections of the Act referred to
9A	RECORD OF EMERGENCY PSYCHIATRIC TREATMENT	204
9B	REPORT TO CHIEF PSYCHIATRIST ABOUT PROVISION OF URGENT NON-PSYCHIATRIC TREATMENT	242

10 – Bodily restraint

Form number	Form name	Sections of the Act referred to
10A	RECORD OF ORAL AUTHORISATION OF BODILY RESTRAINT	230
10B	WRITTEN BODILY RESTRAINT ORDER	231
10C	RECORD OF INFORMING MEDICAL PRACTITIONER AND TREATING PSYCHIATRIST OF BODILY RESTRAINT	230, 231, 233
10D	RECORD OF OBSERVATIONS MADE OF RESTRAINED PERSON	238
10E	RECORD OF EXAMINATION OF RESTRAINED PERSON AND POSSIBLE EXTENSION OF BODILY RESTRAINT	234, 238
10F	VARIATION OF BODILY RESTRAINT ORDER	234
10G	REVOCATION OR EXPIRY OF BODILY RESTRAINT ORDER	235, 237
10H	REVIEW OF BODILY RESTRAINT ORDER BY A PSYCHIATRIST	238
10I	RECORD OF POST-BODILY RESTRAINT	239

Form number	Form name	Sections of the Act referred to
	EXAMINATION	

11 – Seclusion

Form number	Form name	Sections of the Act referred to
11A	RECORD OF ORAL AUTHORISATION OF SECLUSION	214
11B	WRITTEN SECLUSION ORDER	215
11C	RECORD OF INFORMING MEDICAL PRACTITIONER AND TREATING PSYCHIATRIST OF SECLUSION	214,215, 217
11D	RECORD OF OBSERVATIONS MADE OF SECLUDED PERSON	222
11E	RECORD OF EXAMINATION OF SECLUDED PERSON AND POSSIBLE EXTENSION OF SECLUSION	218, 222
11F	REVOCATION OR EXPIRY OF SECLUSION ORDER	219, 221
11G	RECORD OF POST-SECLUSION EXAMINATION	223

12 – Communication and Information

Form Number	Form Name	Sections of the Act referred to
12A	NOMINATION OF NOMINATED PERSON	275
12B	REFUSAL OF REQUEST TO ACCESS RECORDS	262
12C	RESTRICTION ON FREEDOM OF COMMUNICATION	248

Other

Form Number	Form Name	Sections of the Act referred to
13	STATISTICS ABOUT ECT	201

16: Glossary

Aboriginal: The use of the term 'Aboriginal' within this document refers to Australians of both Aboriginal and Torres Strait Islander people. In line with the WA Health Writing Style Guide the shorter term 'Aboriginal' is used at times (see also [Operational Directive OD 0329/11: Using the term 'Aboriginal' in all forms of communication for WA Health](#)).

Absent without leave: When person is absent without approved leave (AWOL) from a hospital or other place (s. 97).

Advance health directive (AHD): A document in which a person is able to indicate what their wishes are regarding treatment, especially at those times when they may not be able to communicate their needs effectively (s. 4).

AHPRA: AHPRA is the Australian Health Practitioner Regulation Agency. AHPRA is the organisation responsible for the implementation of the [National Registration and Accreditation Scheme](#) across Australia.

Apprehension and return order: The person in charge of a hospital or other place or a medical practitioner may make an apprehension and return order in respect of a person who is absent without leave from the hospital or other place if satisfied that no other safe means of ensuring that the person returns to the hospital or other place is reasonably available (s. 98).

Audio-visual communication: is a form of communication which has both a sound and a visual component, such as a video conference.

Authorised hospital:

a public hospital, or part of a public hospital, in respect of which an order is in force under section 542;

a private hospital the licence of which is endorsed under the Hospitals and Health Services Act 1927 (s. 541).

Authorised mental health practitioner (AMHP): The Chief Psychiatrist may, by order published in the Gazette, designate a mental health practitioner as an authorised mental health practitioner if satisfied that the practitioner has the qualifications, training and experience appropriate for performing the functions of an authorised mental health practitioner under this Act (s. 539).

Bodily restraint: is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital (s. 227).

Case Manager: is a mental health professional employed by a mental health service to help the patient to attain their recovery goals and act on the patients behalf while the patient is a client of the mental health service.

Charter of Mental Health Care Principles: is a set of 15 rights-based principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness (s. 4).

Chief Mental Health Advocate (Chief Advocate): The Chief Mental Health Advocate appointed by the Minister for Mental Health (s. 349).

Chief Psychiatrist: is responsible for overseeing the standards of treatment and care of all involuntary and voluntary patients of a mental health service, mentally impaired accused persons detained in an authorised hospital and those referred under the MHA 2014 for an examination by a psychiatrist (s. 508).

Chief Psychiatrists' guidelines and standards: Clinicians must comply with the Chief Psychiatrist's Standards and have regard to the Chief Psychiatrist's Guidelines when performing functions under the MHA 2014. The guidelines provide advice on issues related to the MHA14.

Community treatment order: is an order in force under this Act under in which a person can be provided with treatment in the community without informed consent being given to the provision of the treatment (s. 23).

Complaint: is a statement that a service or treatment is unsatisfactory or unacceptable. A complaint can include a description of the problem and all the procedures that have been followed in order to resolve it before reaching the point of lodging a complaint (s. 305).

Continuation order: The supervising psychiatrist may, on or within 7 days before the day on which a treatment period ends, make a continuation order, continuing the current treatment order from the end of the treatment period for the further treatment period (not exceeding 3 months) which is specified in the continuation order (s. 121).

Culturally and linguistically diverse backgrounds (CALD): CALD is the term used as a modern descriptor for ethnic communities. CALD people are defined as people born overseas, in countries other than those classified by the ABS as "main English speaking countries".

Delegations: Where a person in a position or office assigns responsibility or authority to another person.

Detention Order: A medical practitioner or authorised mental health practitioner may make an order authorising the person's detention for up to 24 hours from the time when the order is made if satisfied that the person needs to be detained to enable the person to be taken to the authorised hospital or other place (s. 28).

Detention under MHA 2014: To keep a person in an area where they cannot leave to enable an assessment, examination, transport or provision of treatment to a person (s. 170).

Electroconvulsive therapy (ECT): is treatment involving the application of electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent (s. 192).

Enduring power of guardianship: a guardian can be appointed to make personal, lifestyle and treatment decisions in the best interests of an adult who is not capable of making well-structured decisions for themselves due to their mental illness (s. 4).

General hospital: A General hospital is a hospital (as defined in the Hospitals and Health Services Act 1927) where overnight accommodation is provided to patients, other than any of these hospitals - an authorised hospital, a maternity home and a nursing home.

Government Gazette: The Western Australian Government Gazette (official gazette, official journal, official newspaper or official diary) is a publication that records the business and proceedings of a government and has been authorised to publish public or legal notices.

Guardianship administration: The *Guardianship and Administration Act 1990* recognises that people who are not capable of making reasoned decisions for themselves may need additional support and assistance not only to ensure their quality of life is maintained, but also to protect them from the risk of neglect, exploitation and abuse.

Health and Disability Services Complaints Office (HaDSCO): An independent body which handles complaints regarding health services – which includes mental health services. Refer to *Health and Disability Services (Complaints) Act 1995* Section 6.

Identified person: A person specified in the Act as having access to the Mental Health Advocacy Service. Refer to s. 348 for a complete list of those included.

Informed consent: Informed consent means consenting to the provision of treatment or care to a patient (whether he or she or another person is the patient) (s. 16).

Involuntary patient: An involuntary patient is a person who is under an involuntary inpatient treatment order or an involuntary community (outpatient) treatment order (s. 21).

Involuntary treatment order: An order under this Act:

Inpatient treatment order - where a person can be admitted to and detained at a hospital, to enable the person to be provided with treatment and detained, at an authorised hospital or general hospital without informed consent being given.

Community treatment order - where a person can be provided with treatment in the community without informed consent (s. 22).

Leave of absence: Means leave of absence granted under section 105 and includes leave of absence as extended or varied under section 106 (s. 104).

Mandatory reporting: refers to the compulsory reporting of a 'notifiable incident'. If a person in charge of a mental health service becomes aware of the occurrence of a notifiable incident of a person being provided with treatment or care by the service,

the person must report the occurrence to the Chief Psychiatrist as soon as practicable.

Medical practitioner: A person registered under the Health Practitioner Regulation National Law (Western Australia) in the medical profession (s. 4).

Mental Health Advocate: The Chief Mental Health Advocate or a mental health advocate is engaged under the Act to provide a mental health advocacy service to an identified person. Services will be provided by mental health advocates under the direction of a Chief Mental Health Advocate (s. 4).

Mental Health Commission (MHC): Responsible for policy, planning and purchasing of services for mental health services in WA and does not provide direct mental health services.

Mental health practitioner: A person who, as one of the following, has at least 3 years' experience in the management of people who have a mental illness:

a psychologist;

a nurse whose name is entered on Division 1 of the Register of Nurses kept under the Health Practitioner Regulation National Law (Western Australia) as a registered nurse;

an occupational therapist;

a social worker (s. 538).

Mental Health Tribunal: An independent review body established under the Act. The Board's primary statutory role is to review involuntary patients, in accordance with the Act (s. 380).

Mental illness: Is a condition that is characterised by a disturbance of thought, mood, decisions, perception, orientation or memory and impairs (temporarily or permanently) the person's judgement or behaviour.

Mentally Impaired Accused Review Board: Established by the MIA Act section 41 (s. 4).

Minister for Mental Health: The Minister responsible for the administration of this Act.

Natural justice: Is the rule against bias and the right to a fair hearing.

Nominated person: Is someone who is formally nominated by a person experiencing mental illness. The nominated person can be any adult the patient chooses (s. 274).

Non-metropolitan: Areas outside of Perth administered by the Western Australian Country Health Service.

Notifiable Incident: Can be any of the following within a Mental Health Service:

- The death of a person, wherever it occurs.

- An error in medication prescribed to or administered to, a person that has had or is likely to have an adverse reaction.
- Any incident that is likely to have an adverse effect on the person in treatment or care from the mental health service.
- A reportable incident as defined in section 254 of the act
- Any other event that the Chief Psychiatrist declares to be a notifiable incident, published in the Gazette (s. 525).

Objects of the Act: The object and ethos that underlie the provisions in the Act (s. 10).

Order to attend (Form 5F): An order following a breach order (Form 5E) requiring a patient to attend at the time and place specified in the order to be provided with treatment.

Parliamentary Commissioner: Western Australian Ombudsmen. The Ombudsman serves Parliament and Western Australians by resolving complaints about the decision making of public authorities and improving the standard of public administration.

Patient: An involuntary patient, a mentally impaired accused required under the MIA Act to be detained at an authorised hospital or a voluntary patient.

Personal support persons: Can be any of the following people who are supporting someone who is experiencing mental illness - close family member, carer, nominated person, the parent or guardian of a child and any guardian or enduring guardian of an adult (s. 7).

Private psychiatric hostel: A private premise where 3 or more people who are socially dependant because of mental illness are residing and being cared for/treated in the hostel.

Psychiatric Online Information System (PSOLIS): Psychiatric Online Information System (PSOLIS) is the patient database used by WA public mental health services.

Referral: A medical practitioner or authorised mental health practitioner may refer a person for an examination conducted by a psychiatrist if the practitioner reasonably suspects that:

the person is in need of an involuntary treatment order; or

if the person is under a community treatment order — the person is in need of an inpatient treatment order (s. 26).

Referrer: A medical practitioner or authorised mental health practitioner (s. 26).

Registration Board: Meaning given in the *Health and Disability Services (Complaints) Act 1995* section 3. A complaint about a service provider referred to in section 320 may be made by a registration board (in relation to those professions which are governed by one) on behalf of a person who has or may have a mental illness or a carer of a person who has or may have a mental illness if:

the service provider is a health professional or other person for whose professional or occupational registration the registration board is responsible; and

the registration board becomes aware that the health professional or other person has acted, or failed to act, in a manner referred to in section 320(2) in relation to the person who has or may have a mental illness or the carer.

Regulations: Refers to the *Mental Health Regulations 2015* to the *Mental Health Act 2014* (s. 586).

Revocation: The cancelling or annulment of something by some authority. A medical practitioner or mental health practitioner may make a revocation order, revoking a previous order made in respect of a person, if satisfied that the order is no longer needed (s. 154).

Seclusion: Seclusion is the confinement of a person who is being provided with treatment or care at an authorised hospital by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave (s. 212).

Serious adverse event: In relation to a course of treatments with electroconvulsive therapy, includes any of the following:

premature consciousness during a treatment;

anaesthetic complications (for example, cardiac arrhythmia) during recovery from a treatment;

an acute and persistent confused state during recovery from a treatment;

muscle tears or vertebral column damage;

severe and persistent headaches;

persistent memory deficit (s. 201).

State Administrative Tribunal (SAT): If a person whom the Mental Health tribunal make a decision for is dissatisfied with the decision, the person may apply to the SAT for a review of the decision (s. 493).

Statutory declaration: Is a written statement that allows a person to declare statements within the statement to be true. Intentionally making a false statement in a declaration is an offence.

Traditional healer: In relation to an Aboriginal or Torres Strait Islander community, Traditional healer means a person of ATSI descent who uses traditional (including spiritual) methods of healing and is recognised by the community as a traditional healer (s. 4).

Transfer Approval Order: The person in charge of a hospital may, with the written consent of the Chief Psychiatrist, make a transfer approval order, approving the transfer of an interstate inpatient who is detained at, or who is absent without leave as described in section 551(3) from, an interstate mental health service to the hospital (s. 557).

Transfer order: Once the treating psychiatrist is satisfied that attempting to take the involuntary inpatient to, or to detain the involuntary inpatient at, an authorised hospital no longer poses a significant risk to the inpatient's physical health, then as soon as practicable, the treating psychiatrist must make a transfer order authorising the inpatient's transfer to the authorised hospital specified in the order (s. 66).

Transport officer: The Regulations may authorise a person (a transport officer) to carry out a transport order (s. 4/ s. 147).

Transport order: An order which is made under this Act to transport a patient from one place to another (s. 146).

Urgent non-psychiatric treatment: Urgent treatment is defined in the GAA Act section 110ZH as treatment urgently needed by a patient:

to save the patient's life; or

to prevent serious damage to the patient's health; or

to prevent the patient from suffering or continuing to suffer significant pain or distress, but does not include the sterilisation of the patient (s. 242).

Varying order (Form 5C): The supervising psychiatrist may, at any time while a community treatment order is in force under this Act, make an order varying the terms of the community treatment order in any way that is consistent with section 115 and which the supervising psychiatrist considers appropriate (s. 122).

Voluntary patient: A person who is proposed to be, or is being treated, by a mental health service voluntarily.

17: List of contacts

Service Name	Contact number	Service provided
Abbotsford Private Hospital	(08) 9381 1833	Abbotsford Private Hospital is a private hospital located in West Leederville, inpatient/outpatient services are available for patients experiencing mental health difficulties.
Albany Mental Health Unit	(08) 9892 2440	Authorised hospital - Adult, Child and Adolescent, Older Adult and Aboriginal Mental Health services
Alcohol & Drug Information Service (ADIS)	(08) 9442 5000	Information, referral and counselling for substance users and family members
Arbor	(08) 9266 1029	Free outreach counselling service for those bereaved by suicide or sudden death
Banksia Ward	(08) 9391 2300	Authorised hospital - Mental Health Service for Older People
Bentley Older Adult Mental Health Services	(08) 9416 3925	Authorised hospital - Older Adult Mental Health Services
Beyond Blue	1300 224 636	Information on a wide variety of mental health problems for sufferers, carers and professionals
Child Protection Unit	(08) 9340 8646	Within Princess Margaret Rose Hospital. Ensures that children are protected whilst in hospital and on discharge. Covers child abuse, injury,

		neglect and well being
Crisis Care Family Helpline (Country)	1800 199 008	Problems within the family, including domestic violence, homelessness, child welfare and general arguments
Crisis Care Family Helpline (Metro)	(08) 9223 1111	Problems within the family, including domestic violence, homelessness, child welfare and general arguments
Crisis Care Helpline	(08) 9223 1111	Crisis Care Helpline. Available: 24 hours a day, seven days a week.
Fiona Stanley Hospital Mental Health Unit	(08) 6152 2222	Authorised hospital - Adult Mental Health Service Youth Mental Health Service
Graylands Hospital	(08) 9347 6600	Authorised hospital - Adult Mental Health Services
Joondalup Hospital	(08) 9400 9400	Adult Mental Health Services
Kalgoorlie Hospital Mental Health Inpatient Unit	(08) 9080 5310	Authorised hospital - Adult, Child and Adolescent, Older Adult and Aboriginal Mental Health services (Anxiety, bipolar, depression, emergency MH intervention, schizophrenia, suicide prevention)
Karri Mental Health Rehabilitation Unit	(08) 9391 2300	Authorised hospital - Adult Inpatient rehabilitation and sub-acute unit

King Edward Memorial Hospital for Women/Women & Newborn Health Service	(08) 9340 2222	Authorised hospital - Women & Newborn Health Service
Leschen Unit - Armadale Impatient Unit	(08) 9391 2300	Authorised hospital - Adult Mental Health Services
Life Line	13 11 14	Telephone crisis support, suicide intervention and prevention, mental health support service
Mabu Liyan Broome Hospital, Mental Health Unit	(08) 9194 2222	14-bed acute psychiatric unit at Broome Hospital
Men's Domestic Violence Helpline	(08) 9223 1199 (1800 000 599)	Telephone information, referral and counselling service for men to help them change their violent behaviour towards female partners
Men's Line	1300 789 978	Dedicated service for men with relationship and family concerns
Mental Health Emergency Response Line	1300 555 788	Rapid response to mental health emergencies, including advice for carers
Mental Health Law Centre	(08) 9328 8266	Provides a free and confidential legal service to people who are involved involuntarily in the mental health system of Western Australia.
Mimidi Park	(08) 9599 4901	Authorised hospital - Rockingham General Hospital Mental Health Unit
Office of Chief Psychiatrist	08) 9222 4462	Chief Psychiatrist is responsible for overseeing the standards of treatment and care of all involuntary and

		voluntary patients of a mental health service, mentally impaired accused persons detained in an authorised hospital and those referred under the MHA 2014 for an examination by a psychiatrist.
Parenting WA	(08) 6279 1200	Information, support and referral services to parents, carers, grandparents and families with children up to 18 years
Perth Clinic	(08) 9481 4888	Perth Clinic is a private hospital located in West Perth, inpatient/outpatient services are available for patients experiencing mental health difficulties.
Police Liaison	131 444	Call this number when police assistance or attendance is needed and when it is not an emergency
PSOLIS help	http://psolis.health.wa.gov.au/las	It is best to ask for your local PSOLIS Administrator – search the link attached. Search by Org>click hour glass next to Org>
Royal Flying Doctor Service	1800 625 800	An aeromedical health service for those who live, work or travel in outback and regional Australia
Rural Link	1800 552 002	Specialist after-hours telephone service for the rural communities of WA. Deals with depression, mental

		health issues, and suicide
Sexual Assault Resource Centre (SARC)	(08) 9340 1828	Free assistance and support to any male or female, aged 13 years and over, who has experienced unwanted sexual contact or behaviour. Counselling also available.
Shelter WA	(08) 9325 6660	Crisis Accommodation assistance
South West Area Health Service – Acute Psychiatric Unit (Bunbury)	(08) 9722 1300	Authorised hospital - Mental Health Service
St John of God Midland Public Hospital	(08) 9462 4000 (central switchboard)	Authorised hospital – Mental Health Service
The Alma Street Centre	(08) 9431 3555	Authorised hospital - Adult Mental Health Services
The Frankland Centre	(08) 9347 6960	Authorised hospital - State Forensic Mental Health Service Services
The Mills Street Centre	(08) 9416 3666	Authorised hospital - Adult Mental Health Services
The Selby Older Adult Mental Health Service	(08) 9382 0800	Authorised hospital - Older Adult Mental Health Service
The Ursula Frayne Unit	(08) 9370 9786	Older Adult Mental Health Services
Transport Officers	TBA	To carry out a transport order
Women's Domestic Violence Helpline	(08) 9223 1188	Free telephone support and counselling for women experiencing family and domestic violence
Youth Axis	(08) 9287 5700	Early intervention mental health service for young people 16-24 yrs in the Metro area

		who are at risk of psychosis or have emerging Borderline Personality Disorder.
Youth Focus	(08) 9266 4333	Working with young people, aged 12-18 yrs who show signs of depression, self-harm and suicide. Also supports families
YouthLink	(08) 9227 4300	Specialised mental health service for young people aged 13-24 yrs in the North Metro area who are homeless or experiencing other significant barriers to accessing mainstream mental health services.
YouthReach South	(08) 9499 4274	Specialised mental health service for young people aged 13-24 yrs in the South Metro area who are homeless or experiencing other significant barriers to accessing mainstream mental health services.