COVID-19
FREQUENTLY ASKED QUESTIONS
Mental Health Services

Version 3 released 24 August 2022

The Chief Psychiatrist initially issued these FAQs in February 2022 to assist mental health services to appropriately discharge their duty of care to patients during the COVID-19 pandemic. These FAQs are intended to assist with clinical translation of the various COVID-19 related statutory requirements and local policies relevant to mental health care and should not be considered legal advice. They do not override the need for services to seek legal or other advice about individual clinical situations. This document will be updated, and further FAQs added as required.

Frequently Asked Questions

Q1. What is the interface between the Mental Health Act 2014 and the Public Health Act 2016?

- The *Mental Health Act 2014* (MHA 2014) remains in force.
- The MHA 2014 can only be used if the person meets the criteria for being a voluntary, referred or involuntary patient in regard to treatment and care for their mental illness.
- The MHA 2014 cannot be used to deal with primary public health issues.
- The *Public Health Act 2016* (PHA 2016) is used to protect, promote and improve the health and wellbeing of the public and to reduce the incidence of preventable illness.
- The PHA 2016 identifies 'serious public health incident' powers, which may be carried out by the Chief Health Officer (or formally appointed delegate.) They include the power to direct a person to do various things, including to remain quarantined for a certain period, and to undergo medical observation, examination or treatment for their physical illness (e.g. COVID-19).
- Whilst a state of emergency is in force, an Emergency Officer, such as the Chief Health Officer, can issue written Directions under the PHA 2016, which must be complied with even if they are not consistent with the MHA 2014, and there is a financial penalty for not doing so.
- The current Mental Health Infection Control Directions issued by the Emergency Officer on 2 March 2022, apply to MHA 2014 sections 48 & 79 and are in force statewide. However, the Directions do not negate or override any of the other provisions of the MHA 2014.

  https://www.wa.gov.au/government/publications/mental-health-infection-control-directions-no-4

Q2. When do the Mental Health Infection Control Directions apply to my clinical work?

The Mental Health Infection Control Directions apply when:

- An authorised mental health practitioner (AMHP), medical practitioner or psychiatrist has been directed to self-isolate for any reason, or
- The patient has:
  - a confirmed COVID-19 diagnosis,
  - within the last 7 days had contact with a person who has a confirmed case of COVID-19, or
  - had any COVID-19 symptoms

and the practitioner is required to conduct an assessment under section 48 or an examination under section 79 of the MHA 2014.

Therefore, you must ensure that you ask the appropriate COVID-19 screening questions to determine whether the patient meets any of these criteria before commencing a MHA 2014 assessment or examination.

The specific assessments and examinations under sections 48 and 79 are:

- **Assessments for completion of:**
    - Form 1A referral for examination by a psychiatrist
- **Examinations for completion of:**
    - Form 6A, 6B or 6C inpatient treatment orders
    - Form 3C continuation of detention for further examination
    - Form 3D further examination in an authorised hospital
    - Form 6D Confirmation of an inpatient treatment order
    - Form 5A community treatment order (CTO)
    - Monthly CTO reviews
    - Form 5D monthly CTO reviews
    - Inpatient treatment order made from a CTO
    - Form 5A CTO revocation order
    - Form 5B CTO continuation order
    - Further Opinions

However, of these examinations audiovisual communication is not recommended for:

- Form 6D confirmation of an inpatient treatment order
- Inpatient treatment order made from a CTO

The Mental Health Infection Control Directions do not apply in any other circumstance.

For more information please refer to: https://www.wa.gov.au/government/publications/mental-health-infection-control-directions-no-4.

Q3. How must I conduct an assessment or examination if the patient meets the COVID-19 criteria described in the Mental Health Infection Control Directions?

If the patient meets the risk factors for COVID-19, or has confirmed COVID-19 (see the criteria in question 2) then the statewide Mental Health Infection Control Directions apply, and the AMHP, medical practitioner or psychiatrist **must** conduct that MHA 2014 assessment or examination using **one or more** of the following infection control measures:

- wearing appropriate and adequate personal protective equipment (PPE) in accordance with the current recommendations published on the WA DoH COVID-19 internet page
- through a physical barrier such as a door, window or perspex screen, whilst still able to see and hear the patient
- the use of physical distancing by taking all reasonable steps to avoid coming within 1.5 metres of the patient
- using audiovisual equipment (you must be able to see and hear the person at the same time). **Note: telephone alone is not enough.**

A practitioner who has been directed to self-isolate for any reason **may only** conduct the assessment or examination using audiovisual communication.

Q4. Can I use audiovisual communication to carry out a MHA 2014 assessment or examination in the metropolitan area?

Regarding assessments and examinations required under the MHA 2014 – audiovisual communication can only be used if the following criteria are met:

- The Mental Health Infection Control Directions are still in force; **and**
- the AMHP, medical practitioner or psychiatrist is directed to isolate for any reason; **or**
- the patient meets the risk factors for COVID-19, or has confirmed COVID-19 (see the criteria in question 2); **and**
- you are required to conduct a MHA 2014 assessment or examination listed in question 2.
- The audiovisual communication platform used allows for the patient and the practitioner conducting the assessment or examination to be able to see and hear one another at the same time (NB: telephone alone is not enough).

The use of audiovisual communication (telehealth) for other clinical purposes is not affected by the Mental Health Infection Control Directions.

Q5. What is the process for conducting MHA 2014 assessments using audiovisual means?

If the requirements in question 2 are met then, when conducting a MHA 2014 assessment or examination using audiovisual communication, the AMHP, medical practitioner or psychiatrist must ensure that they have regard to the Chief Psychiatrist's Audiovisual Communication Guidelines, which include information on:

- the current clinical standards, which continue to apply, including the Chief Psychiatrists Clinical Care Standards
- the requirements for engaging with the patient and carers
- that secure data and audiovisual communication integrity is continuously maintained throughout the interview to ensure that a quality assessment occurs
- the requirement for confidentiality, privacy and consideration of the physical environment
- maintaining clinical records
- the requirement for practitioners to have education and training in the etiquette and use of audiovisual communication platforms
- the requirement for mental health services to have policies and standard operating procedures in place that meet the required standards

You will also need to ensure that you use appropriately secure Department of Health approved audiovisual platforms. Here is a link to the WACHS Telehealth webpage: http://wachs.hdwa.health.wa.gov.au/?id=3562

Q6. Can an AMHP or medical practitioner write a Form 1A Referral Order based on collateral information only?

No. The AMHP or medical practitioner must still conduct an assessment of the person.

However, if the patient meets the risk factors for COVID-19, or has confirmed COVID-19 (see the criteria in question 2) then the Mental Health Infection Control Directions apply, and you **must** conduct that assessment using one or more of the following infection control measures:

- wearing personal protective equipment (PPE)
- through a physical barrier
- from the mandated safe physical distance
- using audiovisual equipment (you must be able to see and hear the person at the same time). **Note telephone alone is not enough.**

Q7. In the metropolitan area if a patient is unvaccinated, or refuses to disclose their vaccination status, can an AMHP or medical practitioner do the assessment and complete a Form 1A by using audiovisual communication?

While the Public Health state of emergency continues and the Mental Health Infection Control Directions are in place, the use of audiovisual communication to conduct assessments for the purposes of completing a Form 1A Referral Order in the metropolitan area is limited to when the:

- medical practitioner, AMHP or psychiatrist (practitioner) conducting the assessment has been directed to self-isolate for any reason,

or

- the patient has had:
  - a confirmed COVID-19 diagnosis, or
  - within the last 7 days had contact with a person who has a confirmed case of COVID-19, or
  - had any COVID-19 symptoms
- **and** the practitioner is required to conduct an assessment under s.48 or an examination under s.79 of the MHA 2014.

A refusal to be vaccinated, or to disclose a vaccination status, is not one of the criteria for an interview to be conducted by audiovisual communication in the metropolitan area if the purpose of the assessment is to determine whether a Form 1A should be completed.

Therefore the practitioner is required to ask the relevant COVID-19 screening questions prior to the assessment to determine whether the patient meets any of the MH Infection Control Directions criteria before considering whether conducting that assessment by audiovisual communication meets the requirements of the law.

If none of the MH Infection Control Directions criteria are met then the AMHP or medical practitioner is required to conduct the assessment face to face in person, following infection control advice in accordance with the WA Health COVID-19 Framework for System Alert (SAR).

Q8. If a patient attending ED declines to comply with COVID-19 testing, what is the role of mental health services? Does the MHA 2014, the PHA 2016 or any other legislation have a role?

All health facilities have protocols in place for screening and testing for COVID-19 in accordance with the current phase of the WA Health COVID-19 Framework for System Alert (SAR.)

When requesting that a patient takes a COVID-19 test, the usual principles of capacity and consent for medical tests or procedures apply.

Regardless of a person's MHA 2014 status, the MHA 2014 does not have a role in providing or enforcing COVID-19 testing in the ED setting.

Only a formally appointed authorised officer, including the Chief Health Officer (or delegate) can make an order under the PHA 2016 requiring a person to have a test. It must not be assumed that hospital staff can do this.

The Guardianship and Administration Act 1990 (GAA) provides that in an emergency, where a person cannot give valid consent, treatment that is *necessary to save the person's life or prevent serious injury to their health* may be provided without consent. It is the position of the OCP that RAT (or other) COVID-19 testing should only be done without a person's consent in circumstances that clearly satisfy the criteria specified in the GAA, and that this would have to be carefully assessed on a case by case basis prior to such a test being carried out.

It therefore cannot be assumed that routine screening for COVID-19, for example prior to an admission to hospital, can be carried out without a person's consent.

If a patient attending a hospital for a mental health concern declines to comply with screening and recommended testing, every effort should be made to support and encourage adherence, and an assessment made of the level of urgency of the presentation. It may be appropriate for a mental health team to negotiate other means of accessing care with the patient, if this meets their needs and level of risk. Where there are significant risks, and a patient leaves the ED in an unplanned way due to concerns re testing, a home visit may need to be organized, in accordance with home visiting infection control requirements.

Mental health services are likely to have a cohort of patients whose COVID-19 status is unknown because they have declined testing. Since this is predictable, in order to avoid delays in access to definitive care for this group, HSPs should aim to identify in advance where this group can be most safely managed (including choice of ward, room, use of air filters etc.), based on infection control advice.

Q9. What are the considerations if a voluntary inpatient does not agree to be tested for COVID-19?

All patients should be provided with accessible information and supported to understand and follow the screening and testing protocols in place. Family members and carers should also be involved in encouraging their family member to adhere to the requirements.

If the person's current mental state is impacting their decision making, it may be appropriate to provide de-escalation, psychiatric treatment and review.

If the person is Aboriginal, then an Aboriginal Mental Health Worker or other suitable cultural support person should be engaged to assist wherever possible.

In a situation where a voluntary inpatient repeatedly declines to follow the hospital's COVID-19 protocols despite all efforts, **and** therefore puts themselves and others at risk, then their treating team may need to review their management plan and reach a decision about whether it is appropriate for them to remain as a voluntary inpatient. This process should involve their family, carers and other supports.

If a patient is discharged from the hospital, suitable follow up plans must be put in place, and all usual discharge and transfer of care processes followed. Any isolation requirements will need to be considered in this plan.

The Chief Psychiatrist has published a guide to support planning for mental health consumers who may need to isolate, the Chief Psychiatrist's Good Practice Guide: Providing mental health care when there is community transmission of COVID-19.

The OCP is available to discuss individual scenarios and support decision making.

Q10. If an involuntary inpatient on an authorised unit refuses COVID-19 testing, can the service enforce testing?

Only a formally appointed authorised officer, including the Chief Health Officer (or delegate) can make an order under the PHA 2016 requiring a person to have a test. It must not be assumed that hospital staff can do this.

If a patient is admitted to an authorised unit as an involuntary patient, section 241(2) of the MHA 2014 provides that the person in charge of the hospital must ensure that a medical practitioner examines the patient, and this examination can occur without the person's consent.

As part of the physical examination, the MHA 2014 allows for various samples to be collected from the person in order for investigations to occur. As one of the samples allowed in the MHA 2014 is saliva, the use of a type of RAT test that involves the collection of saliva may be carried out in the course of a physical assessment under section 241 of the MHA 2014.

However, section 241 of the MHA 2014 does not allow for restraint to be used to carry out the physical

examination. Bodily restraint under section 232(1)(a)(i) of the MHA 2014 can occur for the purposes of 'treatment'. The MHA 2014 definition of 'treatment' cannot be considered to include COVID-19 testing.

Therefore while the MHA 2014 may allow for RAT testing without consent when a person is admitted to an authorised unit as an involuntary patient, it does not allow physical restraint to be used to carry this out.

Services should continue to work with the patient, families and other supports, provide accessible information, and support them to understand their rights and options. De-escalation and psychiatric treatment may be helpful if the person's mental state is affecting their decision making. If the person is Aboriginal, then an Aboriginal Mental Health Worker or other suitable cultural support person should be engaged to assist wherever possible.

The OCP is available to discuss individual scenarios and support decision making.

Q11. Can patients have leave from inpatient wards during the COVID-19 pandemic?

The principle of least restrictive care remains in place, and voluntary patients continue to have the right to leave the ward.

Decisions about leave should be made on a case by case basis, as part of an individual's care plan. Leave can be an important part of an admission and assist a person's successful transition to the community. Blanket restrictions on leave are not appropriate, and all measures need to be proportionate to the current prevalence of COVID-19 and the SAR. However treating teams also need to weigh up whether the benefits of leave from the inpatient ward outweigh the risks of exposure to COVID-19 for an individual and other patients on the ward. When a patient is well enough to consider leave, a discussion should be had with the patient and their supports about whether it would be preferable and safer to continue their care at home.

If voluntary patients cannot follow reasonable infection control advice despite support, education and encouragement then their status as voluntary inpatients and management plan may need to be reviewed.

The therapeutic needs of involuntary patients should be considered on a case by case basis, including leave, ground access etc. Decisions should be discussed and negotiated with the patient and family, should meet the criteria set out in the MHA 2014 and be proportionate to the current situation. Where restrictions are in place for an individual under the MHA 2014, teams should work with the individual and family to find alternative strategies to reduce frustration and distress.

The OCP is available to discuss individual scenarios and support decision making.

Q12. Can a ward become authorised under the MHA 2014 for the treatment of involuntary patients who also have COVID-19 or suspected COVID-19?

In some cases, WA Hospitals have reconfigured the location of specialty wards to ensure compliance with infection control requirements.

Given the dynamic nature of the COVID-19 response, there may be the need for the authorisation of a facility to be expedited to meet infection control needs. Consideration has therefore been given as to how to appropriately translate the Chief Psychiatrist's Standards for Authorisation of Hospitals during COVID-19.

The key principles for authorisation of facilities remain the same: wards must be safe, suitable, therapeutic and appropriate for the intended cohort.

The authorisation process for hospitals is defined under the MHA 2014. Updated advice on authorisation in the COVID-19 context is provided on the Chief Psychiatrist's website:

Authorisation of mental health units under the MHA 2014 during the COVID-19 pandemic.

Q13. In an authorised hospital, if a patient needs to isolate due to COVID-19, and is required to stay in their room to limit contact with uninfected patients, is this considered seclusion?

If a patient is isolating in their room due to COVID-19, or has restrictions placed on their freedom of movement to limit the spread of COVID-19, then this is an action taken in accordance with public health measures and seclusion forms do not need to be completed.

Any patients being managed in this situation should also have close oversight to monitor both their COVID-19 status and mental health presentation, and they should continue to receive timely treatment and care for their mental illness.

However, when the primary reason for confining a person alone in a place, that is not within their control to leave, is directly related to their treatment and care for their mental illness, then this is seclusion under the MHA 2014 and seclusion and, where applicable, restraint forms must be completed.

Q14. If a patient without capacity to make medical treatment decisions has refused a COVID-19 vaccination, but their guardian has consented to the patient receiving the vaccination, can the vaccine be administered using restraint under the MHA 2014?

A patient who lacks capacity to make medical decisions may have guardian consent for vaccination. Under the MHA 2014 restraint can be used in an authorised hospital to provide treatment to patients for their mental illness. However, provision of a vaccine does not meet this criterion.

It is recommended that the mental health team discuss the terms of the guardianship order with the guardian to determine whether they have been given explicit authority to consent to restraint for medical treatment. If this is not the case, suggest that the guardian consider making an application to the State Administrative Tribunal to seek this authority.

Q15. Where a patient is under guardianship, should guardian consent be sought for COVID-19 testing and treatment?

If a patient has a guardian, it is recommended that consent is sought for COVID-19 testing as it is unlikely that testing will be mandated or enforced under the PHA 2016.

It is also advised that guardian consent is sought for COVID-19 treatments where a patient is likely to be eligible for such treatments.

COVID-19 treatment can improve outcomes for people at high risk of poor outcome from COVID-19. It is important to note that the treatment window after symptoms emerge for most of COVID-19 medications is limited, and therefore delaying this process while awaiting consent may result in a missed opportunity to treat.

Q16. If local protocols include detaining a COVID positive patient in a ward until a suitable bed is available, can the timeframe in which the legal forms are valid for change?

No. There are no changes to the time frames for legal orders under MHA 2014 at present, and the process for assessment, determining if a person meets criteria and the duration of each form remains the same.

Q17. In an acute workforce shortage, could doctors who don't currently meet the definition of psychiatrist under s.4 of the MHA 2014 carry out examinations under the MHA 2014?

In an acute workforce shortage, where the capacity to maintain services is compromised, the Chief Psychiatrist will consider individual medical practitioners for their suitability, based on their demonstrated skills and experience in psychiatry, for the purpose of prescribing them in the regulations for the definition of psychiatrist under the MHA 2014. Further guidance on this matter will be developed.

Q18. What approach should mental health services take to vaccination and boosters?

Vaccination rates among people with severe mental illness are lower than the general population rate, and this group has high levels of comorbidities. This leaves people with severe mental illness at increased risk of serious illness from COVID-19.

All mental health patients should be supported to access vaccination wherever possible to reduce their risk. All mental health clinical services should have well developed processes in place to enquire about vaccination, record vaccination status, and facilitate timely access to vaccines and boosters.

Vaccination needs to continue to be a priority throughout the pandemic as a key part of the provision of physical healthcare.

The usual principles of capacity and consent for routine medical interventions apply to vaccinations, including, where a person lacks decision making capacity, consideration of any Advanced Care Directive, and guardianship/ substitute decision making. There is no role for the MHA 2014 in the consent process for vaccination.

Q19. Can a *Form 9B – Report to the Chief Psychiatrist about provision of urgent non-psychiatric treatment* be used to administer vaccinations?

No.

A Form 9B is only used when an involuntary patient in an authorised hospital urgently requires treatment, other than psychiatric treatment or sterilisation, to either:

- save the person's life
- prevent serious damage to the patient's health
- prevent the patient from suffering or continuing to suffer significant pain or distress

Q 20. Where a young person, under 18 years, has COVID-19 or suspected COVID-19 can they be accommodated in the same mental health assessment or treatment area as adult patients?

Yes, they can, however section 303 of the MHA 2014 still applies under these circumstances.

Under section 303 of the MHA 2014, if a child who has a mental illness is to be admitted to any mental health unit in WA other than Perth Children's Hospital, then the person in charge of the mental health service must be satisfied that safe, appropriate treatment, care and support can be provided in a way that ensures they are separated from adult patients, as appropriate to their age and maturity.

The person in charge of the mental health service must provide the child's parent or guardian with a written report setting out the measures that will be put in place to ensure that the child is protected, and that their individual needs in relation to treatment and care are met.

Copies must also be kept in the patient file and provided to the Chief Psychiatrist.