CHIEF PSYCHIATRIST
of Western Australia

Information for Referring Practitioners

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Acknowledgement

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Purpose			
Relevant To	Medical Practitioners, General Practitioners, Psychiatric Registrars and Authorised Mental Health Practitioners		
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Introduction to the Mental Health Act 2014 (MHA 2014)

The MHA 2014 is legislation intended to provide for the treatment, care, support and protection of people who have a mental illness protection of the rights of people who have a mental illness; and recognition of the roles of carers and families in providing care and support to people who have a mental illness

All clinicians must make every effort to comply with the Charter of Mental Health Care Principles when providing treatment, care and support to people experiencing mental illness. The Charter can be found in Schedule 1 of the MHA 2014

The Approved Forms for the MHA 2014, which need to be completed with all the required legal information, are accessible from the Office of the Chief Psychiatrist website.

Referring Practitioners' Role and Responsibility under MHA 2014

1. Who can refer?

1.1. Medical practitioners and Authorised Mental Health Practitioners (AMHPs) can refer a person, for an examination by a psychiatrist at either an authorised hospital or other place.

1.2. Police also have the power to apprehend a person that they suspect has a mental illness and requires assessment and take them to a place where they can be assessed by a medical practitioner or an AMHP.

2. What are the MHA 2014 criteria for a Form 1A Referral Order?

2.1. A medical practitioner or AMHP can only refer a person for examination by a psychiatrist when they form a genuine and reasonable suspicion that:

2.2. the person is in need of an involuntary treatment order, or

2.2.1. if the person is currently on a community treatment order, the person is in need of an inpatient treatment order.

2.3. In forming that reasonable suspicion they must have regard to the MHA 2014 s.25 criteria for an involuntary treatment order which are:

2.3.1. the person has a mental illness requiring treatment, and

2.3.2. because of their mental illness there is a significant risk:

2.3.2.1. to the person's health or safety or to the health or safety of another person, or

2.3.2.2. of harm to the person or another person, and

2.3.2.3. the person does not demonstrate the capacity to make a decision about treatment, and

2.3.2.4. there is no less restrictive way of providing them with treatment

3. What is the MHA 2014 (s.6) definition of mental illness?

3.1. A person has a mental illness if the person has a condition that:

3.1.1. is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and

3.1.2. significantly impairs (temporarily or permanently) the person's judgment or behaviour

3.2. Just because a person uses alcohol or other drugs does not mean they have a mental illness. However, the use of alcohol and drugs does not preclude the reasonable suspicion that a person who is intoxicated has an underlying mental illness and may need to be referred.

4. Conducting the assessment

4.1. An AMHP or medical practitioner cannot refer a person unless the practitioner has assessed the person and the assessment must have been completed within the previous 48 hours.

4.2. The assessment must be conducted in the least restrictive way and in the least restrictive environment available.

4.3. 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 through the door without the use of a communication device such as a phone or laptop.

5. Conducting an assessment using Audio Visual means in non-metropolitan areas only

5.1. A medical practitioner or an AMHP may conduct an assessment using audio-visual (AV) means if:

5.1.1. the person being assessed is in a non-metropolitan area, and

5.1.2. it is not practicable for the practitioner and the person to be in one another's physical presence, and

5.1.3. there is a health professional with the person being assessed.

5.2. A health professional is either a medical practitioner, a nurse, an occupational therapist, a psychologist, a social worker or, in relation to an Aboriginal person, an Aboriginal mental health worker or a health professional.

6. Making a referral for an examination by a psychiatrist

6.1. A referral can only be made by completing a **Form 1A Referral Order** for an examination by a psychiatrist

6.2. **Form 1A** is in force for 72 hours, however in non-metropolitan areas the order can be extended for another 72 hours **Form 1B** (Variation extending referral outside the metropolitan area) (maximum of 144 hours).

6.3. Referrals can be made to an authorised hospital or another place where a psychiatrist will be available to examine a person within 24 hours of arrival at the place, such as an emergency department, a mental health clinic or a general hospital.

6.4. The referred person must be provided with the information on the **Form 1A Referral Order**. This can be done either by verbally informing the person or by giving them a copy of the **Form 1A**.

6.5. If information for the purposes of the **Form 1A** is provided in confidence by a third party this information should be recorded in the **Attachment to Form 1A**. This information must remain confidential and the referred person must not be provided with a copy of the **Form 1A Attachment**.

7. Detention of a Referred Person

7.1. If the referring practitioner or another practitioner is satisfied that the referred person needs to be detained to enable the referred person to be taken to the place of examination, they can be detained for up to 24 hours by completing a **Form 3A Detention Order**.

7.2. It should not be routine to make a detention order at the same time as a referral. This should involve a further assessment to determine whether detention is required.

7.3. Detention can be extended for further periods of 24 hours up to a maximum of 72 hours or until the Referral Order expires if this occurs first. However, the extension of detention orders can only be completed if, immediately before the detention order expires a medical practitioner or AMHP has assessed the person to decide whether the person still needs to be detained. Only then can the practitioner complete a **Form 3B Continuation of Detention Order**.

7.4. The detained person must be given a copy of the **Form 3A** and any subsequent **Form 3B**.

7.5. When a **Form 3A** is completed, a personal support person must be notified as this is a notifiable event.

7.6. During the period of detention, the referred person must be given the opportunity and means to contact a carer, close family member or other personal support person, a health professional who is currently providing the person with treatment and the Chief Mental Health Advocate as soon as practicable and at all reasonable times while the person is being detained.

7.7. A person's detention cannot continue if:

7.7.1. the **Form 1A Referral Order** is revoked;

7.7.2. the **Form 1A Referral Order** expires before the person has been taken to the authorised hospital or other place; or

7.7.3. the detention order expires and has not been, or cannot be, extended and the person has not been taken to the authorised hospital or other place and has not been apprehended under a transport order.

7.8. If the detention order expires or the person is not transported, the person must be released from detention. If the person is released a personal support person must be notified. However, if the **Form 1A** is still in force then the person is still required go to the place of examination.

7.9. If a **Form 1A** has been revoked or it expires a new **Form 1A** cannot be written unless a new assessment is carried out, and the criteria are met as described in point 2.

8. Form 4A Transport Order

8.1. If a medical practitioner or AMHP believes that the person can travel safely with their personal support person, a health professional or community staff member to the place where the examination will take place then that is the preferred method of transport.

8.2. If a medical practitioner or AMHP believes that there is no other safe means reasonably available for taking the person to the place for the examination then the practitioner can complete a **Form 4A Transport Order** authorising either a transport officer or a police officer to apprehend the person and transport them.

8.3. The **Form 4A** must be to the same destination as the **Form 1A**. For example, if the **Form 1A** is made to Graylands Hospital then the **Form 4A** must also be made to Graylands Hospital

8.4. This does not prevent stopping on the way, if necessary, to manage urgent requirements such as medical needs

8.5. A copy of the **Form 4A** is required to be provided to the person enacting the **Form 4A.** However, they must not be given a copy of the **Form 1A Referral Order**.

8.6. Police can only be used if:

8.6.1. there is a significant risk of serious harm to the person being transported or to another person; or

8.6.2. when a transport officer is not available to carry out the **Form 4A** in a reasonable time and any delay is likely to pose a significant risk to the person being transported or to another person.

8.7. A **Form 4A Transport Order** is in force for 72 hours in the metropolitan area, or until the person is transported to the place of examination.

8.8. In WACHS regions, an existing **Form 4B Extension of Transport Order** can be extended for another 72 hours up to a maximum of 144 hours.

8.9. If the Form 1A is either revoked or expires, the Transport Order ceases to be in force.

8.10. It can be revoked if no longer required, for example if a less restrictive means of transporting the person to the place of examination is identified.

8.11. A **Form 4A Transport Order** can be revoked when it is no longer required by completing the revocation section on the **Form 4A** and the transport officer or police officer must be informed.

8.12. A personal support person must be notified when a **Form 4A Transport Order** is made, revoked or expires.

8.13. The person must be given a copy of the **Form 4A Transport Order** and revocation order, if any.

9. Changing the place where the examination is to be conducted (Form 1B variation of referral)

9.1. A patient may be referred to a particular authorised hospital or other place for examination, but it may later be decided that another place is more appropriate.

9.2. When changing the place of examination, the medical practitioner or AMHP must consult with clinicians at the new location and change the place where the examination will take place by completing **Form 1B** – **Variation of Referral**.

9.3. The referred person must be provided with a copy of the **Form 1B**.

9.4. If a Transport Order is still required to transport the person to the new place of examination, any existing **Form 4A Transport Order** must be revoked and a new **Form 4A Transport Order** to the new place of examination completed

9.5. The transport officer or police officer responsible for taking the patient to the place of examination must be informed and provided with a copy of the **Form 4A Revocation Order** and the new **Form 4A**.

10. Revocation of a Form 1A Referral Order

10.1. At any time following a referral being made, a medical practitioner or AMHP may revoke the referral if they are satisfied that the person being referred is no longer in need of an involuntary treatment order.

10.2. An order can be revoked by:

10.2.1. the medical practitioner or AMHP who made the order; or

10.2.2. another medical practitioner or AMHP, so long as they consult with, or makes all reasonable attempt to consult with, the referring practitioner as to why the order should be revoked.

10.3. The revocation section of **Form 1A** needs to be completed.

11. Referred person on a Detention Order leaves the place where they are detained

11.1. If the referred person leaves the place where they are being detained (**Form 3A** or **3B**) every effort should be made to return the person to that place.

11.2. If that is not possible the medical practitioner or person in charge of the hospital or other place can make a **Form 7D Apprehension and Return Order** authorising the police, transport officers or a staff member of a mental health service to apprehend the referred person and return them to the place where they were detained.

11.3. A **Form 7D Apprehension and Return Order** can only be made in relation to a referred person if they were subject to a detention order under **Form 3A** or **3B**.

11.4. The **Form 7D Apprehension and Return Order** is in force for 14 days, even if the underlying legal order has expired. It cannot be extended.

11.5. **Form 7D Apprehension and Return Orders** can be revoked, for example if the person returns without the order being required. The person authorised to apprehend must be informed.

12. Providing psychiatric treatment to referred persons

12.1. Referred persons, like all voluntary patients, must provide informed consent to any treatment.

12.2. Emergency Psychiatric Treatment (EPT) can only be provided to a person, including referred persons and voluntary patients, without informed consent, in order:

12.2.1. to save the person's life; or

12.2.2. to prevent the person from causing serious physical injury to themselves or another person.

12.3. The treatment provided must meet the MHA 2014 definition of treatment, i.e. it must be intended to treat a mental illness, or a condition that is a consequence of a mental illness.

12.4. If EPT is provided, then a **Form 9A** must be completed by the medical practitioner who prescribed the treatment and a copy sent to the Chief Psychiatrist.

12.5. The definition of EPT does not include bodily restraint, seclusion or emergency ECT.

13. Cultural Considerations

13.1. When assessing an Aboriginal person either by AV means or face to face, the practitioner must, to the extent that it is practicable and appropriate, conduct the assessment in collaboration with an Aboriginal mental health worker and significant people from the person's community including elders and traditional healers.

13.2. Any communication with a person must be in a language, form of communication and terms that a person is likely to understand using any means of communication that is practicable and using an interpreter if necessary and practicable.

14. Notifying a Personal Support Person (notifiable events)

14.1. A Personal Support Person is a carer, a close family member, a guardian or enduring guardian, a parent or legal guardian of a child, a nominated person (who could be a friend, neighbour or partner who is not a legal de facto)

14.2. At least one personal support person must be notified when certain events occur (notifiable events). (*See Table 14.6)

14.3. Consent is not needed from the person who has been referred to notify a personal support person of these events, but it would be good practice to seek it.

14.4. Every effort should be made to contact at least one personal support person, until either contact is made, or it can be reasonably assumed the person cannot be contacted.

14.5. A personal support person should not be notified if the referrer believes it is not in the referred person's best interest. The Chief Mental Health Advocate must be informed if this occurs.

14.6. List of notifiable events that apply to referred/detained persons:

Where a MHA14 Approved form prompts the making of notification to a Personal Support Person			Responsibility
1	s. 28(8)	Making Form 3A – Detention order in respect of a referred person (Refer to Form 3A)	The medical practitioner or AMHP who makes the order
2	s. 28(12)	Releasing a person because they cannot continue to be detained under a Form 3A – Detention Order	The medical practitioner or AMHP
3	s. 29(4)	Making a transport order to take a referred person to the place of examination (Refer to Form 4A)	The medical practitioner or AMHP who makes the order
4	s. 31(7)	Releasing a person who was being detained under a Form 3A – Detention order, because the referral was revoked (Refer to Form 3A)	The medical practitioner or AMHP who revokes the referral
5	s. 97(3)	When the person is absent without leave from a place where they were being detained	The person in charge of the hospital or other place (where the person was being detained)

15. Informing a referred person about their rights

15.1. A referred person must be informed of their rights, which include:

15.1.1. having the opportunity and means to contact personal support persons and others

15.1.2. the right to be provided on request with advocacy from the Mental Health Advocacy Service who must make contact with the person if the person is detained within 3 days

15.1.3. the right to be provided with information on the **Form 1A**, excluding the **Form 1A attachment**.

15.1.4. the right to a copy of the forms **1B**, **3A**, **3B**, **3D**, **3E**, **4A** and **4B**.

16. Guidelines and information

16.1. The following sources of information are available for those who would like to find out more about the MHA14. The Chief Psychiatrist encourages all clinicians to access relevant MHA14 information and education tools via the links below:

16.1.1. The Mental Health Act 2014

16.1.2. The Clinician's Practice Guide to the MHA 14

16.1.3. The Clinician's eLearning Package (CELP)

16.1.4. The Referrer's eLearning Package (RELP)

16.1.5. The Chief Psychiatrist's Standards & Guidelines

16.1.6. Information for carers, consumers and the general public is available on the Mental Health Commission website

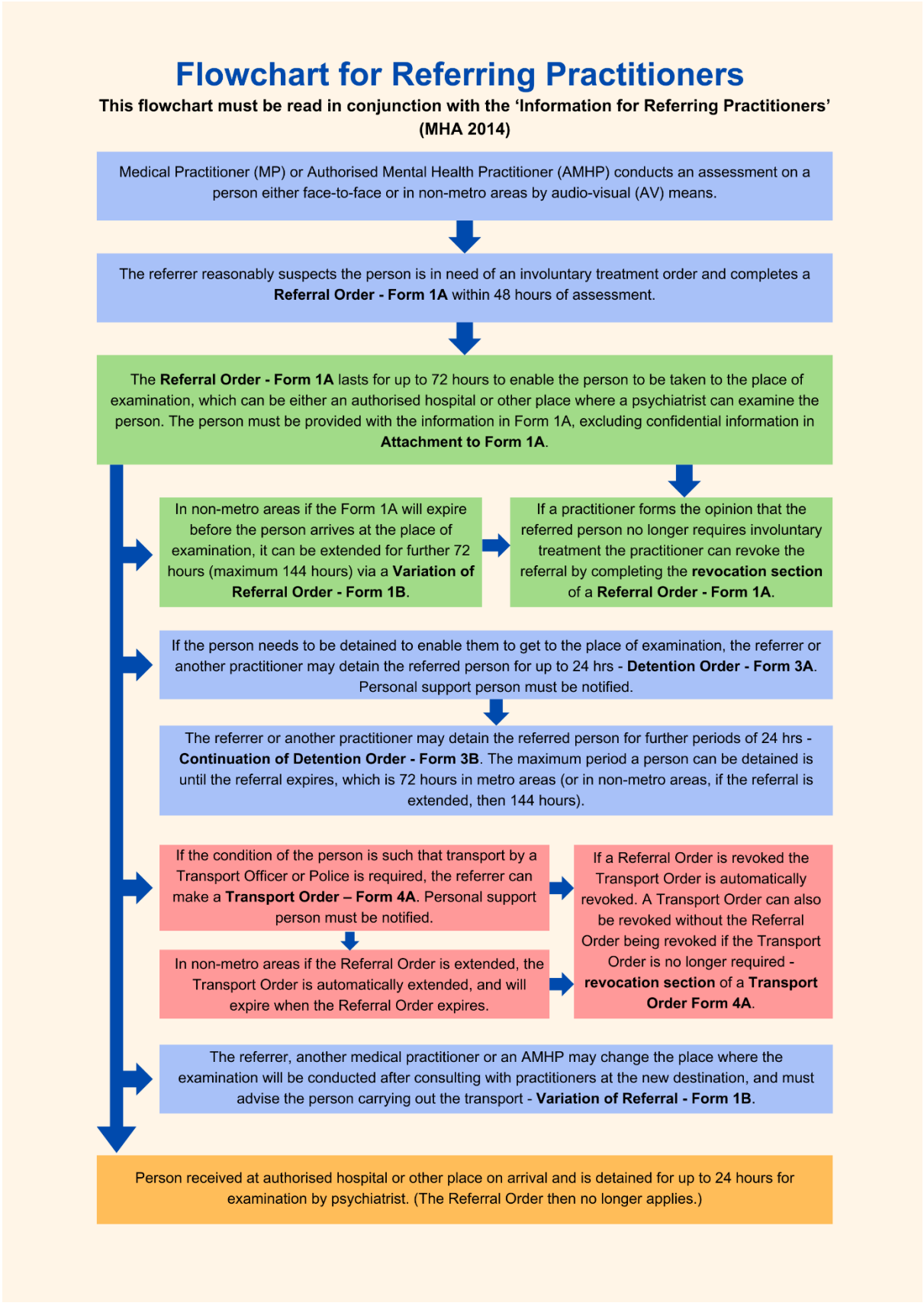
16.1.7. Office of the Chief Psychiatrist Clinical Helpdesk

16.1.7.1. 08 6553 0000

16.1.7.2. clinical.consultant@ocp.wa.gov.au

16.1.7.3. Available Mon – Fri 8.30 – 4.30

Flowchart for Referring Practitioners



Charter of Mental Health Principles

The Charter of Mental Health Care Principles are 15 principles that mental health services aspire to when providing treatment, care and support to consumers, their families and carers.

1. **An organisational culture of dignity, equality, courtesy and compassion**
   A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and meet the standards expected by the community. It must not discriminate or stigmatise them.

2. **Protection of human rights**
   A mental health service protects and upholds the human rights of people experiencing mental illness and acts in accordance with national and international standards including United Nations Principles and Conventions.

3. **Unique care for each individual**
   A mental health service provides care which is unique for each person and recognises the importance of life experiences, needs, preferences, aspirations, values and skills. The service must strive to obtain the best possible outcome for people experiencing mental illness and actively form partnerships with consumers and carers to achieve this. This includes the development of clear goals for treatment, care and support. A mental health service promotes and encourages positive recovery focused attitudes towards mental illness, including knowledge that people can and do recover and live a positive life while making meaningful contributions to the community.

4. **Safe and accessible services**
   A mental health service provides a service when it is needed in order to provide the maximum benefit to those in need. It should be easily accessible and safe. Should the service be unable to provide a specific service, the person is given information, direction, support and assistance to access another appropriate service.

5. **The opportunity for consumers to make their own decisions**
   A mental health service involves people in making their own decisions. The service will support and encourage people with mental illness to be responsible in making their own choices.

6. **Welcoming all from diverse backgrounds**
   A mental health service must be sensitive and respond to diverse individual and family and carer circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices. If required, services will seek advice and refer patients to services where there is more knowledge or familiarity with particular diverse issues.

7. **Care that respects Aboriginal culture and spirituality**
   A mental health service provides treatment and care to people of Aboriginal or Torres Strait Islander descent and must consider their cultural and spiritual beliefs and practices. The service will respect the views of their families and, where possible, the views of members of their community, including elders and traditional healers.

8. **Addressing physical, medical and other co-occurring health issues**
   A mental health service equally addresses physical and medical health needs of people experiencing mental illness including dental health. These physical or health issues may be a consequence of mental illness or side-effects of treatment. Care and treatment also needs to address co-occurring health issues including physical and intellectual disability and alcohol and other drug problems.

9. **Recognition of social factors that influence mental health and wellbeing**
   A mental health service recognises the circumstances which influence mental health and wellbeing of a person with mental illness. Services take a holistic approach to support recovery and to reduce risk of relapse. This includes addressing social and wellbeing problems such as homelessness, unemployment and relationships.

10. **A respect for privacy and confidentiality**
    A mental health service must respect and maintain privacy and confidentiality.

11. **Consideration for personal responsibilities and commitments**
    A mental health service acknowledges the impact of mental illness extends beyond the person. Families including dependents such as children, friends and colleagues of the person are all affected by these issues. The needs of children and other dependents should inform the recovery plan.

12. **Clear information about mental health and treatments**
    A mental health service provides and clearly explains, information about the mental illness and treatment including any risks, side effects and alternatives, to people experiencing mental illness in a way which will help them to understand and to express views or make decisions.

13. **Clear information about legal rights**
    A mental health service provides and clearly explains information about legal rights. These include information regarding representation, advocacy, compliments and complaints procedures, services and access to personal information, in a way which will help people experiencing mental illness to understand, obtain assistance and uphold their rights.

14. **Planning which includes families and carers**
    A mental health service, at all times, respects and facilitates the rights of people experiencing mental illness. This includes the involvement of their family members, carers, and other personal support persons in every aspect of the person's treatment, care and support.

15. **Commitment to continuous improvement with consumers, carers and families**
    A mental health service has a model of treatment and care which considers the wellbeing and quality of life for the person with a mental illness.

The service strives to continually improve the care it delivers and takes a partnership approach to addressing issues and solving problems. This involves everyone, including carers and other support persons, who provide treatment care and support of people experiencing mental illness. For people of Aboriginal and Torres Strait Islander descent, this will include meeting the needs of their culture, spiritual beliefs and practices throughout all phases of care.

The Chief Psychiatrist aims to ensure that

Western Australians receive the highest standard

of mental health treatment and care.

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