CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist's Guideline

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

As required under section 547(1)(b) of the *Mental Health Act 2014*

December 2025

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Version Control

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Acknowledgements

We acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of our State and its waters. We pay our respects to Elders who were, who are and who will be, and extend this to all Aboriginal and Torres Strait Islander peoples seeing this message.

We recognise the individual and collective expertise of those with a living or lived experience of mental health, alcohol and other drug issues. We recognise their vital contribution at all levels, and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

We are committed to embracing diversity and eliminating all forms of discrimination in the provision of health and mental health services.

This document would not have been possible without the invaluable contribution from the Chief Psychiatrist's Standards and Guidelines Working Group, and the broader agencies and individuals involved in feedback.

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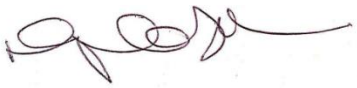
Message from the Chief Psychiatrist

The *Mental Health Act 2014* (MHA) makes the Chief Psychiatrist responsible for overseeing the treatment and care of a range of users of mental health services. As Chief Psychiatrist, I am required to discharge that responsibility by publishing guidelines identified in the MHA s 547.

These guidelines were originally developed prior to the implementation of the MHA, by a working group consisting of consumers, carers, families, mental health professionals, and relevant peak bodies, the Chief Psychiatrist's Standards and Guidelines Working Group (CPSGWG). Some amendments have been made over time as clinical interpretation of the MHA has evolved. They complement and must be read in conjunction with the Chief Psychiatrist's Standards and other relevant documents.

These guidelines are not intended to provide a full description of best practice approaches to mental health care. However, the person in charge of the mental health service must ensure that regard is had to these guidelines in the treatment and care of persons who have a mental illness (MHA s 191).

As Chief Psychiatrist, I value the skill and commitment of mental health service staff. They, together with the central role of consumers and carers in shared decision making, represent the greatest assets available to mental health services.



Dr Nathan Gibson
CHIEF PSYCHIATRIST

17 December 2025

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

Having decided to complete a Form 1A Referral Order the referring practitioner must now decide where the patient is to be examined by a psychiatrist. The MHA s 26(3)(a) states that for a person referred for examination under the MHA, the practitioner:

> *May refer the person for an examination to be conducted by a psychiatrist at a place that is not an authorised hospital if, in the practitioner's opinion, it is an appropriate place to conduct the examination having regard to the guidelines published under section 547(1)(b) for that purpose.*

This gives the referring practitioner 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.

It should be noted that:

- The Form 1A Referral Order must be written within 48 hours of the assessment having been completed
- If a psychiatrist conducted the assessment and wrote the Form 1A they cannot complete the subsequent examination (s 78).

Factors to consider when deciding where to refer a patient for examination

The choice of destination, which can also be where the person is being assessed by the medical practitioner or AMHP, reflects several variables and options. These variables include the following.

Access to an authorised hospital

There are several authorised hospitals, which are mental health units that are often co-located within a general hospital in Western Australia. However currently there are only four 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 another place may be a preferred option.

Availability of a psychiatrist to conduct the examination

While all authorised hospitals must have access to a psychiatrist, even out of hours, 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.

It is the responsibility of the referrer to ensure that they have made the necessary arrangements to ensure that a psychiatrist is available to conduct the examination in person (or by AV if required, in WA Country Health Service areas) within 24-hours of the referred person having arrived at the place of examination. If it is clear that no psychiatrist will be available within the 24 hours from the time of receival, then alternatives should be considered such as referral to an authorised hospital or another place where a psychiatrist is available.

Physical condition of the referred person

If it is clear to the referrer that the referred person has physical health problems 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 prior written approval of the Chief Psychiatrist. The same requirement to make arrangements regarding the availability of a psychiatrist to conduct the examination still apply.

Acuity of the referred person

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 acuity, where the person is best treated and where the person should be referred to are important safety issues for the patient and staff.

While at times temporary management can occur in an ED while the patient is awaiting transport to an authorised hospital, the environment is often unsuitable and untherapeutic for mental health patients, and there are limitations to the interventions that can lawfully occur in that setting. Effective care for high risk mentally unwell patients generally requires the skills of mental health clinicians in an authorised hospital.

However, it is important to note that some authorised hospitals in non-metropolitan areas may at times 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.

Dislocation from community or 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, referred persons in non-metropolitan areas, referred Aboriginal persons, or persons who come from a CALD community, especially if they 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 criterion 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.

Referral to a place that is not an authorised hospital

There are a number of places that are not an authorised hospital to which a person could be referred, and include:

a) An emergency department (which is part of a general or private hospital)

b) A general hospital (which includes the emergency department)

c) A non-authorised mental health hospital

d) A community mental health or general health clinic

e) A nursing post particularly in remote areas of the state

f) In appropriate circumstances, a place of residence such as a residential home or care facility, hostel or where a person is living.

Intentionally, the variety of places to which a person can be referred 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 is required and should be documented.

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.

For example, the community mental health clinic may be seen as a very convenient place as it is staffed by mental health clinicians including perhaps 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.

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.

The psychiatrist examining a person in their home has the option of placing the patient on a CTO, referring them to an authorised hospital or making no order (see Chef Psychiatrist's Guideline (a):

Making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order).

Terminology

Aboriginal

Within Western Australia, the term 'Aboriginal' is used in preference to 'Aboriginal and Torres Strait Islander', in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to Torres Strait Islander colleagues and community.

Children

The MHA refers to anyone under the age of 18 as a child, so the term 'child' or 'children' has been used in preference to terms such as young person, when referring to anyone under 18.

Consumer/patient

We have used the term "consumer" to refer to groups of people who have used or may use a mental health services, and the term "patient" to refer to a person receiving treatment, and when quoting from the MHA, as this is the term used in the MHA.

Support person

We have used the overarching term 'support person' to refer to a family member, carer or personal support person for a mental health consumer.