CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist's Guideline

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

As required under section 547(1)(a) 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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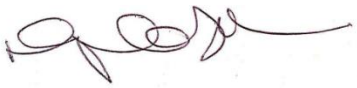
Message from the Chief Psychiatrist

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 about whether or not a person is in need of an inpatient treatment order or a community treatment order (s 547(1)(a))

MHA section 25(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)

This Chief Psychiatrist guideline is made in accordance with MHA s 547(1)(a) and in relation to making decisions about whether or not a person is in need of an inpatient treatment order (ITO) or a community treatment order (CTO).

A person can only be made an involuntary patient if, following examination by a psychiatrist, they meet the criteria laid out in the MHA s 25.

While the criteria for ITOs and CTOs are slightly different reflecting the different purpose of each, in the major elements they are similar.

Examination

A person who is referred for examination by a psychiatrist must be received on arrival at the authorised hospital or other place (e.g. a general hospital (emergency department or general ward), community clinic, remote nursing post) identified on the Form 1A Referral Order. They can be detained at that venue for up to 24 hours (which can be extended outside the metropolitan area) for the examination to be conducted (see Chief Psychiatrist's 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).

On completion of the examination, the psychiatrist must make one of the following orders.

If the examination is conducted at an authorised hospital

- Form 3E – which is an order that the person can no longer be detained because they do not meet one or more of the s 25 criteria for being an involuntary patient.
- Form 5A Community Treatment Order - providing the psychiatrist has determined that the person meets all five criteria for being made an involuntary patient under s 25(2).
- Form 6A - Inpatient Treatment Order in an Authorised Hospital - an inpatient treatment order authorising the person's detention at the authorised hospital specified in the order for up to 21 days (adult) or 14 days (child) from the day on which the order is made, providing that the

psychiatrist has determined that the person meets all five criteria for being made an involuntary inpatient under s 25(1).

- Form 3C – authorising continuation of detention of the person for examination by a psychiatrist for a further 48 hours (providing they are not detained for more than 72 hours in total in the authorised hospital) where there is uncertainty about whether or not the person meets the criteria for any of the other orders above.

If the examination is conducted at a place other than an authorised hospital

- Form 3E – which is an order that the person can no longer be detained because they do not meet all of the criteria in s 25(1) or 25(2) for being an involuntary patient.
- Form 3D - authorising the person's reception and detention at an authorised hospital, to enable a further examination to be conducted there
- Form 5A Community Treatment Order - providing the psychiatrist has determined that the person meets all five criteria for being made an involuntary patient under s 25(2).
- Form 6B - but only with the Chief Psychiatrist's prior written consent and where the person meets all five criteria for being an involuntary patient but detention in an authorised hospital poses significant risk to the person's physical health. A Form 6B authorises detention at a general hospital for up to 21 days (adult) or 14 days (child) from the day on which the order was made (Form 6B) and weekly reports must be made to the Chief Psychiatrist (Form 6B Report to Chief Psychiatrist) until the person become medically stable, at which point they must be transferred to an authorised hospital as soon as is possible.

Criteria for involuntary treatment order (s 25)

A person can only be made an involuntary patient if all s 25 criteria are met. These are the criteria discussed in this section. If even one criterion is not fully met, then the person cannot be made an involuntary patient.

The Mental Health Tribunal when conducting a review will consider whether all the criteria are met and are obliged to revoke an order if any criteria are not fully met.

A person needs an inpatient treatment order only if all these criteria are satisfied:

Criterion 1: Mental illness

> *(1) That the person has a **mental illness** for which the person is in need of **treatment.***

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 judgment or behaviour.*

This definition is similar to that found in other Mental Health Acts and defines mental illness on the basis of identified behaviours rather than on a specific diagnosis.

However, in addition, 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.*

The implication of this requirement is that the condition observed can be ascribed to particular mental illnesses described in 'internationally accepted standards'.

The standards prescribed by the *Mental Health Regulations 2015* are the mental and behavioural disorders sections of the International Classification of Diseases (ICD), published by the World Health Organisation; and the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association

Section 6(1)(b) notes that just having a condition characterised by disturbance of *thought, mood, volition, perception, orientation or memory* 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 judgment or behaviour.

The clinician therefore needs to explore whether changes have occurred which significantly impact on aspects of the person's day to day activities. This may require information from the person, others such as family members, the views of other health professionals and review of the person's medical record.

The MHA s 6(2) lists behaviours which, on their own, cannot be considered evidence of mental illness. These are that:

> *(a) the person holds, or refuses or fails to hold, a particular religious, cultural, political or philosophical belief or opinion;*
>
> *(b) the person engages in, or refuses or fails to engage in, a particular religious, cultural or political activity;*
>
> *(c) the person is, or is not, a member of a particular religious, cultural or racial group;*
>
> *(d) the person has, or does not have, a particular political, economic or social status;*
>
> *(e) the person has a particular sexual preference or orientation;*

(f) the person is sexually promiscuous; or

(g) the person engages in indecent, immoral or illegal conduct;

(h) the person has an intellectual disability;

While an intellectual disability cannot, on its own, be considered to meet the MHA criteria for mental illness, comorbid mental illness may be experienced by a person with intellectual disability, which may meet the MHA criteria; it is important to understand that this clause does not preclude the use of the MHA in such circumstances.

(i) the person uses alcohol or other drugs;

This clause means that the use of alcohol or other drugs cannot, on its own, be considered evidence of mental illness. It is important to understand that it does not prevent physiological or psychological symptoms arising from the use of alcohol or other drugs from being regarded as a mental illness. For example, where a person has a drug induced psychosis, the symptoms of the psychosis may meet the definition of mental illness, regardless of causation. The use of alcohol or other drugs in relation to a mental illness may also form part of the assessment of risk for the purposes of the MHA (see Criteria 2)

(j) the person is involved in, or has been involved in, personal or professional conflict;

(k) the person engages in anti-social behaviour;

(i) 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 an 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.

Having a mental illness, however, is not on its own sufficient to meet the criteria for involuntary treatment. The person must, because of the mental illness, be **in need of treatment**.

Section 4 of the MHA provides a definition of treatment:

> *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.*

This is a relatively broad definition but requires the proposed intervention to be directly related to the mental illness. For example, the use of nutritional therapy when required to alleviate the harmful

effects of starvation occurring as a consequence of the eating disorder is generally accepted to fulfil the MHA definition of treatment. However medical and surgical interventions that the person might be recommended to have, which are not a direct consequence of their mental illness would be unlikely to meet this definition.

Any treatment proposed should be informed by prevailing standards, evidence and clinical judgement.

Criterion 2: Risk

> 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.*

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's own health or safety, or the safety of another person, is at significant risk; or there is a 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 criteria are met.

Whether the level of a risk is 'significant', and whether harm is 'serious' are important to explore and weigh up when making this determination. A significant risk of harm occurring would not be sufficient, if the impact of the harm would be minor or trivial to the person or another person. The harm must be 'serious'.

A high degree of risk does not preclude a person being provided with treatment and care as a voluntary patient, if they are able to demonstrate decision making capacity and provide informed consent.

Risks may include:

a) Suicide.

b) Self-harm or self-injury which presents a risk of serious harm.

c) Significant self-neglect.

d) Absconding and wandering where there is a risk that serious harm may come to the person as a result.

e) Harmful use of substances that is directly related to the mental illness.

f) Lack of recognition and treatment for serious physical health conditions such as eating disorders or medical conditions such as diabetes mellitus, delirium, organic brain injury, epilepsy.

g) Financial harm or damage to employment, access to housing or social relationships, if the potential harm caused has serious consequences such as homelessness.

h) Violence and aggression.

i) Sexual safety risks.

k) Harassment, stalking or predatory behaviour.

l) Serious property damage including arson.

m) Driving while intoxicated or without a licence.

n) Other offending behaviours.

This list is not exhaustive, and, in all cases, the risk must be due to the mental illness and must meet the significant criterion.

Appropriate contemporary methodologies should be used to assess risk. Full risk assessment usually needs multiple sources of information, and may include:

- The interview with the patient, including their account of events, description of their feelings and experiences, and a mental state examination.
- Information from significant others.
- Risk history from the medical record and other sources.
- Information re charges from the police or courts where relevant.
- Clinical knowledge.
- Structured/ standardised risk assessment tools where practicable or relevant.

Risk assessment and management is a dynamic collaboration with the patient and their significant others. The thoroughness of an assessment of risk is dependent on time available, access to relevant records, availability of family members to provide information, location (e.g. ED vs home setting) the patient's cognitive and mental state, intoxication, communication (e.g. need for interpreter) and the clinician's level of engagement with the patient.

However, in the context of an assessment under the MHA, the clinician needs to be confident that they have enough information to form a reasonable suspicion that there is a significant risk. In the context of an examination, the psychiatrist needs to have enough information to be satisfied of the level of risk. This will vary between patients, according to the circumstances.

Criterion 3: Capacity

> 25(1)(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.*

In the context of a decision about the need for an involuntary treatment order, the requirement is specifically that the person does not demonstrate the capacity to make a treatment decision **about treatment proposed for their mental illness**. Therefore, the assessment of capacity needs to be focused specifically on of the decisions required in relation to the proposed treatment.

Section 19 and 20 of the MHA outline the requirements for providing a person with a clear explanation of the proposed treatment.

The criteria for capacity used by the MHA are based on the person's ability to:

a) Understand the explanation and information that has been provided about the treatment, any alternative treatments, and any risks involved.

b) Understand the matters involved in making a treatment decision.

c) Understand the effect of the treatment decision.

d) Weigh up the different factors in the treatment decision.

e) Communicate the decision in some way.

An adult must always be assumed to have capacity unless they are shown, through examination against the above criteria, to lack capacity. In children (the MHA defines anyone under 18 as a child), the assumption is that they lack capacity unless able to demonstrate that they have capacity (this is the concept of the 'mature minor' sometimes also known as Gillick competence.)

Capacity and the term 'insight', often used in a mental state examination, are different concepts, and a person who lacks insight may demonstrate capacity to make the decisions at hand. A person may have the capacity to make a decision about treatment but decline treatment, regardless of whether the clinician supports their decision or believes it to be in their best interest.

All available supports must be provided to help a person understand the relevant matters and communicate their decision, before making an assessment that they lack capacity. Supports might include provision of information in accessible formats, interpreters, sufficient time to consult with support persons, and access to supports such as advocacy services, peer workers, Aboriginal mental health workers, Elders or nominated persons.

If a person lacks capacity but does not meet any of the other criteria for involuntary status, they cannot be made an involuntary patient.

The Guardianship and Administration Act 1990 also provides a framework for matters relating to capacity and substitute decision making. Advance Health Directives, guardianship, substitute decision making, and other related matters are beyond the scope of this guideline. The Chief Psychiatrist's Guidelines for the use of ECT in Western Australia provide further discussion on the topic in section 3.5.

Criterion 4: Community treatment cannot reasonably be provided

> 25(1)(d) *that treatment in the community cannot reasonably be provided to the person.*

This criterion only applies to a situation where a patient could be made an involuntary inpatient. If it is possible to provide the treatment as an involuntary patient in a community setting, then the CTO option should be used rather than an ITO. The reasons why a person may not be able to be provided with treatment in the community include:

a) The acuity of the illness may be so severe that only inpatient care can ensure the health and safety of the patient.

b) The patient may be so physically unwell, for example because of an organic disorder, that inpatient care is required.

c) The degree of supervision the patient needs may not be available without 24-hour inpatient care.

d) The risk posed to other members of the household or other people prevents safe treatment in the community.

For the person to meet this criterion the examining psychiatrist needs to consider the impact of the mental illness on the person as well as the meaningful consideration of community resources available in discussion with the community service which is expected to manage the person if the completion of a CTO is being considered.

Criterion 5: Less restrictive treatment cannot adequately be provided

> 25(1)(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.*

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 receive adequate treatment in a less restrictive setting such as the community or in an open ward as a voluntary patient, then this criterion may not be met.

Freedom of movement and choice of treatment is a fundamental human right. Removing these rights should only be done when it is clear that there is no less restrictive way of providing necessary treatment and it is clear that the person meets all the criteria for being made an involuntary patient.

Criteria for community treatment order

The criteria for making a CTO are similar to making an ITO 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*

The significant risk of deterioration criterion emphasises the essential difference between ITOs and CTOs. While the same criteria apply, the threshold for the risk issues regarding a CTO is slightly different and recognises that the risks, while significant, may be slightly less immediate and in abeyance when the person is in receipt of treatment, only leading to serious deterioration if treatment stops. It also

recognises that CTOs should be kept for those patients with a more long-lasting illness where there is evidence that treatment is required for lengthy periods of time.

Patients should only be put on a CTO if treatment in the community can reasonably be provided. If because of geography, unknown whereabouts or the person actively and consistently avoiding services, it is not possible to provide treatment in the community, then this criterion is not met. In some situations where all other criteria are met, if there is absolutely no cooperation between the patient and the treating team then there may be no purpose in using a CTO.

In determining whether treatment in the community on a CTO can reasonably be provided, there is a requirement for meaningful discussion to be held between the psychiatrist considering writing a CTO and the community service where it is intended that the treatment is to be managed.

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 service, 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.