CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist's Guideline

The preparation, review and revision of treatment, support and discharge plans

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

December 2025

Copyright

Disclaimer

The Chief Psychiatrist of Western Australia does not accept responsibility for the quality or accuracy of material on websites linked in this document and does not sponsor, approve or endorse materials on such links.

Version Control

Purpose	Statutory Requirement under the *Mental Health Act 2014 s. 547*		
Relevant To	All mental health services		
Approval Authority	Dr Nathan Gibson, Chief Psychiatrist		
Version	2.0		
Effective Date	December 2025	**Review Date:**	December 2027
Enquiries Contact	Reception, Office of the Chief Psychiatrist Tel: 08 6553 0000		
Source Documents	*Mental Health Act 2014*		

Version	Date From	Date To	OCP Ref
2.0	December 2025	Current	OCP55596
1.0	December 2015	December 2025	OCP840

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.

Table of contents

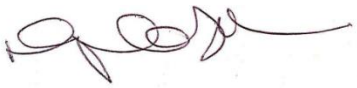
Message from the Chief Psychiatrist

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

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:

- Aboriginal Practice Standard
- Care Planning Standard
- Consumer and Carer Involvement in Individual Care Standard
- Physical Health Care of Mental Health Consumers Standard
- Transfer of Care Standard

Also refer to the Charter of Mental Health Care Principles (MHA Schedule 1).

Introduction and purpose

Treatment, support and discharge plans (TSDP) are a type of care plan mandated under the MHA for people subject to involuntary treatment orders.

Every person receiving treatment on an involuntary or voluntary basis has the right to dignity, respect and participation in decisions made about their treatment or care.

Involuntary treatment can be a confronting and distressing experience, and many people have histories of trauma which may shape their experience of distress, relationships and health care provision. A trauma informed TSDP explicitly seeks to avoid re-traumatisation by focusing on safety, trust, collaboration, empowerment and cultural understanding.

People's family, carer and support networks are central to their lives and recovery journeys. Good care planning includes significant others in the development and review of the plan.

All care planning should be anchored in a recovery framework which recognizes the person's individuality, strengths, values and goals, and is not solely focused on managing symptoms or risk, important as those elements may be. TSDPs should articulate what recovery means for the individual person, and outline how the service will help foster autonomy and self-determination to the extent possible at the time.

Good care planning also recognises the importance of continuity of care and structured bidirectional handover at transition points as central to safety and engagement. Inpatient and community teams should work together in the care planning process to ensure shared understanding of clinical

responsibility, crisis planning, follow up arrangements, social and support needs, and medicines reconciliation.

Statutory requirements

The MHA s 186 states that the treatment, care and support provided to an involuntary patient, supervised person admitted to an authorised hospital, or person under a community treatment order (CTO) must be governed by a care plan, known in the MHA as a *treatment, support and discharge plan* (TSDP).

The plan outlines the treatment and support that will be provided to the patient while they are subject to the treatment order, and the treatment and support that will be offered once they are no longer on the order.

MHA s 187 makes the preparation and review of the TSDP the responsibility of the psychiatrist overseeing the order.

The requirement is that the TSDP is developed as soon as practicable after the person has been admitted as an involuntary inpatient, or after the CTO has been made. It then needs to be reviewed regularly and revised as required.

The MHA does not specify a particular format for the TSDP, but it has to be in written form, as a copy has to be provided to the patient, their parent/ guardian if a child, their carer, close family member or nominated person, and any other appropriate person. A copy must also be filed in the medical record. This provision of copies is, again, the responsibility of the psychiatrist (s 187).

Involvement in preparation and review of the TSDP

The psychiatrist must also ensure that the following people are involved in the preparation of the TSDP:

- The patient* - who must always be involved, whether or not they have the capacity to consent to the contents of the TSDP. 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.
- 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 the parent*, guardian*, or legally authorised decision maker* must also be involved in the development of the TSDP.
- The patient's support persons (carer* or close family member* or nominated person*) should be involved (unless it is not appropriate to supply this information due to risks or concerns under sections 269(1), 288(2), 292(1)). The psychiatrist must take reasonable steps

to ensure that the support persons are included – and these steps must be filed in the clinical notes if the contact attempts are not successful.

- If the patient is Aboriginal, significant members of the patient's community* (including Elders and traditional healers) and Aboriginal mental health workers* must be included wherever possible. (s 189)
- If the patient is from a culturally or linguistically diverse population, every effort must be made to identify how best to support the person to participate fully in the development of a culturally informed and appropriate TSDP. This may involve including interpreters or members from the patient's community to assist with the development of the TSDP.
- Where a person has a community case manager or care coordinator, they should be involved in the development of the TSDP, as a crucial part of safe handover and continuity of care.
- Where a person is being discharged from an inpatient unit on a CTO to a community team, the supervising psychiatrist and treating practitioner who will be continuing the treatment in the community should be involved.
- Wherever practicable, any other relevant people suggested by the patient or central to their life should be involved, to the extent that it is appropriate to do so, for example GPs, support workers, accommodation providers.

*Statutory requirement

A record of the TSDP, 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).

Contents of the TSDP

A high quality TSDP should address at minimum the following domains:

- Personal recovery goals and what matters most to the person.
- Trauma and safety including triggers, coping strategies, safety plans and crisis supports.
- Social and environmental factors including housing, finances, employment, education and meaningful activity.
- Mental health needs including follow up/monitoring arrangements and treatment strategies (biological, psychological and psychosocial).
- Medication monitoring, side effects identification/management, and coordination with primary care. If the medication includes clozapine, lithium, or another medication requiring a specific monitoring regime, details of how this will be carried out.

- Physical health including metabolic monitoring and cardiovascular health, access to primary care, access to screening programs, reproductive health, general health, nutrition, exercise and wellbeing. Any known physical conditions should be included and addressed.
- Interventions and monitoring of use of alcohol or substances where relevant, smoking cessation
- Support person involvement- roles and consent for sharing information
- Communication and handover arrangements including names and contact details of key clinicians and review dates and locations

Review of TSDPs

TSDPs should be reviewed regularly, and on an ad hoc basis if urgent issues arise. The ideal frequency for an individual will vary, but services should set a policy expectation around the frequency of review. Review should be a meaningful process, involving the same people as the initial creation of the plan. If this is not reasonable or possible, then the reason must be explained clearly in the clinical notes.

Copies of the revised treatment, support and discharge plan are to be given to patient and their support persons.

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 2014 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 2014, 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.