



Government of **Western Australia**  
Department of **Health**

Office of the Chief Psychiatrist  
**Clinicians' Guide to the**  
***Mental Health Act 1996***

(Fifth Edition – 2011)



Delivering a **Healthy WA**

## Disclaimer of Liability

This Clinicians' Guide has been prepared in good faith. The information it contains is intended to assist all who provide psychiatric services, both hospital and community-based, as well as police officers, lawyers, emergency services and other health and community staff, in understanding the operations of the *Mental Health Act 1996* (MHA).

The MHA does not specifically address minors but applies to everyone, regardless of age. Whenever possible and where appropriate, legal guardians should be involved in the decision-making process when a minor is referred under the MHA.

While this Clinicians' Guide has been prepared with every care, neither the Western Australian Government nor the authors accept any responsibility for the results of specific action taken on the basis of the information it contains, nor for any errors or omissions within it. The guide will be updated from time to time, and any perceived error or omission should be brought to the attention of the Manager, Office of the Chief Psychiatrist, Department of Health.

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## Preamble

This Clinicians' Guide is an explanatory text to the *Mental Health Act 1996* and refers to specific sections of the MHA. For clarification or further detail, refer directly to the MHA and Regulations. If there are questions refer them to the manager of your health service. The Manager or the Clinical Consultant within the Office of the Chief Psychiatrist may also be contacted.

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## Foreword

The Mental Health Act was passed by Parliament in 1996 and became operational in November 1997.

The *Mental Health Act 1996* (MHA) is informed by the United Nations' *Principles for the Protection of Persons with a Mental Illness* and for the *Improvement of Mental Health Care* (1991) and the *National Mental Health Statement of Rights and Responsibilities* (1991).

It represents a sharing of responsibility across the whole community for the care and protection of people who have a mental illness. It provides for a balance between the civil rights of individuals and the need for appropriate treatment. It paves the way for enhanced partnerships between consumers of services and those who provide them. Such partnerships will reduce the potentially devastating effects of mental illness on individuals, their families and the community.

The Protocol between the Western Australian Police Service and the Mental Health Division in the DoH is one such partnership. The protocol is concerned with the relationship between the police service and health professionals with the main focus being the care of people with mental illness in the community.

This edition of the *Clinicians' Guide to the Mental Health Act 1996* follows a review of the fourth edition of the guide. It clarifies issues arising from publication of the previous editions, provides expanded information on Community Treatment Orders and articulates developments within clinical practice.

A handwritten signature in black ink, reading 'R Davidson', with a stylized 'R' and 'D'.

**Dr Rowan Davidson**  
**Chief Psychiatrist**  
**Department of Health**

March 2011

## Glossary

Defined below are some of the terms used in the *Mental Health Act 1996* (MHA) and this guide. For more complete definitions, refer to appropriate sections in the MHA.

### **Authorised Hospital (s. 3)**

A public hospital, or part of a public hospital such as a unit or ward, authorised by the Governor of the State of Western Australia to receive and admit people as involuntary patients. Private hospitals can also be authorised if their license is endorsed under s.26DA of the *Hospital and Health Services Act 1927*. The Office of the Chief Psychiatrist maintains a Register of Authorised Hospitals within WA.


### **Authorised Medical Practitioner (s.18)**

Every medical practitioner, not being a body corporate, who is registered under the Register of Medical Practitioners under the Australian Health Practitioner Regulation Agency (Health Practitioner Regulation National Law (WA) Act 2010), is designated as an authorised medical practitioner under the MHA.

### **Authorised Mental Health Practitioner (AMHP) (s.20)**

Any mental health practitioner who, in the opinion of the Chief Psychiatrist, has the qualifications, training and experience appropriate to the role may be designated as an AMHP by the Chief Psychiatrist. The designation is published in the *Gazette*.

An AMHP has a number of responsibilities and powers which include the power of referral to a psychiatrist for examination (s.29) and the responsibility to examine a defendant referred by a judicial officer for the purpose of deciding whether a referral under the MHA should be made (part 2, *Mental Health (Consequential Provisions) Act 1996* and the *Bail Act 1992*).



Should the condition of the person referred be such that assistance is required to transport the person to hospital or other place where the person can be examined by a psychiatrist, an AMHP may authorise the police to apprehend and transport the person referred (s.34). If the police, using their powers under s.195, have apprehended a person they suspect has a mental illness, either a medical practitioner or an AMHP must examine that person, who may then be referred for examination under s.29. AMHPs may also offer advice to the treating psychiatrist on patients on leave for more than 28 consecutive days.

The Chief Psychiatrist maintains a register of AMHPs. In relation to the two types of persons who can refer, medical practitioners or AMHPs, the MHA does not dictate a hierarchy and the decision is made on availability and experience. Mental health practitioners are nominated by the service they work for to undertake the AMHP role. All such nominations should be forwarded to the Office of the Chief Psychiatrist. Before accepting the responsibilities of an AMHP, mental health practitioners must undergo appropriate training.

### **Chief Psychiatrist (s.8-13)**

The Chief Psychiatrist has responsibility for the medical care and welfare of all involuntary patients, and the monitoring of standards of psychiatric care throughout the State (s. 9).

Other duties of the Chief Psychiatrist include assisting the Director General of Health in strategic planning, maintaining a register of authorised hospitals and AMHPs, providing information to medical practitioners and reporting to the Mental Health Review Board (s.10).

The Chief Psychiatrist has the power to review any decision of a psychiatrist in relation to the treatment of involuntary patients and to maintain, vary or rescind a decision about treatment (s.12).



The Chief Psychiatrist may inspect any authorised hospital and any relevant premises if there are reasonable grounds to suspect that proper standards of care or treatment are not being maintained (s.13(1)).

As part of the remit for safety and quality in mental health services, the Chief Psychiatrist conducts clinical governance reviews of mental health services on a regular basis. The aim of these reviews is to ensure good standards of care and enable mental health services to consider improvements to their service delivery in line with the principles of best practice.

### **Community Treatment Orders (CTOs) (part 3, division 3)**

In line with the principle of the least restrictive alternative, CTOs allow involuntary patients to be treated in the community for up to three months, with the option of extension for a further three months, after which a new order is required.

The option of a CTO must be considered by the examining psychiatrist before an order for admission of a person to an authorised hospital as a detained involuntary patient is made.

### **Council of Official Visitors (Part 9)**

Appointed by the Minister for Mental Health from the general population, Official Visitors ensure that patients are informed of their rights, hear, enquire and seek to resolve complaints, inspect premises and assist with making and presenting applications for appeals to the Mental Health Review Board.

### **Involuntary Patient (Part 3)**

A person subject to an order for detention in an authorised hospital under s.43, 49, 50 or 70, or subject to a CTO is an involuntary patient.

### **Mental Illness (s.4)**

A person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgement or behaviour to a significant extent.

However, a person does not have a mental illness by reason only of one or more of the following, that is, that the person:

- holds or refuses to hold, a particular religious, philosophical or political belief or opinion;
- is sexually promiscuous, or has a particular sexual preference;
- engages in immoral or indecent conduct;
- has an intellectual disability;
- takes drugs or alcohol;
- demonstrates antisocial behaviour.

Having a mental illness is but one criterion for a person being made an involuntary patient. Other criteria, as detailed in s.26 of the MHA, must be met.

### **Mentally Impaired Accused (s.3 & Part 5 *Criminal Law (Mentally Impaired Accused) Act 1996*) (CLMIAA)**

A mentally impaired accused is a person in respect of whom a custody order has been made and who is to be detained in an authorised hospital, a declared place, a detention centre or a prison. The Governor of WA may release a mentally impaired accused into the community with or without conditions.

### **Mental Health Practitioner (s.19)**

A mental health practitioner may be either a psychologist, a nurse in Division 1 of the Register held by the Nursing and Midwifery Board of Australia (Health Practitioner Regulation National Law (WA) Act 2010), an occupational therapist, or a person with another recognised qualification such as a social worker, who has at least three years experience in the management of persons who have a mental illness.

Mental health practitioners have responsibilities in relation to CTOs, when they are referred to as 'responsible practitioners' (s.66 and 68), in returning patients to the hospital who are absent without leave (s.58 and Regulations), in observing patients who are in seclusion (s.120 (b)) and being in physical attendance with the patient when the patient is subject to a mechanical bodily restraint (Regulation 16).


Mental health practitioners may be nominated by their service for the role of AMHPs.

### **Mental Health Review Board (MHRB) (Part 6)**

The MHRB conducts independent reviews as to whether or not a person should be maintained as an involuntary patient. Their responsibilities and powers are detailed in the relevant section of this guide. The MHRB is collocated with the State Administrative Tribunal.

### **Psychiatrist (s.3)**

Means a person whose name is contained in the register of specialist psychiatrists kept by the Medical Board of Australia under the *Health Practitioner Regulation National Law (Western Australia)* section 223.



Psychiatrists in authorised hospitals are responsible for examining persons referred to them (s.29 and 30). They have the power to make such persons involuntary patients (s.43), either detained in an authorised hospital or on a CTO, or to extend the detention of the person for a period of up to 72-hours to decide whether to make an order. If the psychiatric examination occurs in another place external to an authorised hospital, a psychiatrist has the power to refer a person to an authorised hospital and involve police officers in the transport of that person.

A psychiatrist also has the power to approve leave, discharge a patient or vary a CTO. The treating psychiatrist is the psychiatrist in charge of a patient's treatment. Supervising psychiatrists are responsible for supervising a CTOs. A treating psychiatrist may also be a supervising psychiatrist.

**Responsible Practitioner (s.68 (1)(c))**

Is a medical or mental health practitioner who is responsible for ensuring that the treatment plan for a patient on a CTO is carried out. The responsible practitioner is also referred to as the “treating practitioner”. The supervising psychiatrist may also be the responsible practitioner. The supervising psychiatrist may transfer the responsibilities of the responsible practitioner to another medical or mental health practitioner and notify the patient in writing.

**Senior Mental Health Practitioner (SMHP) (s.3)**

Is a mental health practitioner with at least five years experience in the treatment of persons with a mental illness.

There is no requirement for a Register of SMHPs to be maintained, however mental health services as part of good practice may maintain a register of SMHPs.

The powers and responsibilities of SMHPs relate mainly to involuntary inpatients. They have a holding power [Form 2] of six hours with respect to voluntary patients they believe should be detained in the authorised hospital (s.30) and may authorise in an emergency, seclusion (s.118) and mechanical bodily restraint (s.122).

### **Treatment (Part 5)**

In psychiatry, the term 'treatment' covers a number of interventions by doctors, nurses, psychologists, occupational therapists and social workers; for example, medication, electroconvulsive therapy, rehabilitation, counselling, individual and group psychotherapy, cognitive behaviour therapy, occupational therapy and psychological programs.

Part 5 of the MHA includes a provision that prohibits certain treatments (s.99) and regulates others, such as psychosurgery (Division 4) and emergency psychiatric treatment (Division 7). Involuntary patients can be given psychiatric treatment without their consent (s.109) and involuntary detained patients who do not have the capacity to provide informed consent may also receive medical treatment with the approval of the Chief Psychiatrist or their guardian (s.110). The powers of the Chief Psychiatrist in relation to (s.110) have been delegated to the heads of services. (Delegations March 2010)

## **Voluntary Patient**

The term 'voluntary patient' is not defined in the MHA. However, by virtue of the principle of the least restrictive alternative, a person can be admitted as a voluntary patient on a psychiatrist's recommendation and is entitled to all the rights and freedoms of any patient admitted to a general hospital. There is no obligation for a voluntary patient to give notice of intent to leave, although for clinical and administrative reasons it may be appropriate to do so. In relation to voluntary patients who seek to discharge themselves an SMHP may hold such a person for up to six hours for examination by a psychiatrist (s.30). Section 107 also applies to voluntary patients, in that such patients must give their informed consent to Electroconvulsive Therapy. Voluntary patients in authorised hospitals are subject to Division 2 of Part 7 of the MHA which provides for further rights of inpatients.

## *Mental Health Act 1996*

### Key Features

The objects of the MHA, as stated in s.5, are as follows:

- to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity
- to ensure the proper protection of patients as well as the public
- to minimise the adverse effects of mental illness on family life.

With these objects the MHA, informed by the documents *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (United Nations Commission on Human Rights, November 1991) and the *National Mental Health Standards of Rights and Responsibilities* (March 1991), reflects the following four core principles.

#### **1. Protection of Patients' Rights**

Patients' rights have been specifically articulated and, apart from those mentioned in Part 7 of the MHA, the MHRB and the COV have specific responsibilities and powers in relation to reviews of involuntary status and advocacy. Furthermore, there are consequences such as fines and imprisonment should rights be denied or ignored.

## **2. Least Restrictive Alternative**

The introduction of CTOs and the requirement to always consider a CTO before making a referred person an involuntary detained patient is an example of applying the least restrictive alternative. It is also a requirement that patients are discharged from involuntary status if they do not meet the criteria under s.26.

## **3. Mental Illness Alone is not Sufficient to Warrant Involuntary Status**

Section 26 of the MHA makes it clear that having a mental illness is but one of a number of criteria to be fulfilled before a person can be made an involuntary patient.

## **4. Balance of Rights and Responsibilities**

In respecting the rights of patients, the MHA also recognises that health professionals have a duty of care to persons with mental illness and the community at large. The MHA also defines the responsibilities of the police in dealing with people who are suspected of having a mental illness. This balancing of rights and responsibilities promotes the principle that while all patients should be treated with dignity and respect the MHA is also concerned with the care of the patient who is mentally ill and the protection of the community.

It is important to understand that the MHA informs but does not dictate clinical practice. Nor does it remove the responsibility of clinicians to exercise skill and knowledge when making decisions about patient care. A comprehensive understanding of the MHA and how it impacts on decision-making should enhance good clinical practice, not inhibit appropriate intervention and treatment options.



The MHA requires that communication between mental health, other health professionals and the police, be open, allowing information and cooperation to flow freely. Inevitably, lack of communication will make the implementation of certain options under the MHA, such as CTOs and referrals for psychiatric examination in a community setting, difficult. The success of the legislation depends not only on a comprehensive knowledge of the details of the MHA but willingness on the part of health professionals to cooperate and communicate with each other.

It should be noted the MHA is concerned with minimal requirements and does not define best practice.

# Chapter 1 Patients' Rights

## 1.1 Explanation of Rights

A person admitted to an authorised hospital voluntarily or involuntarily, is to be given an explanation, verbally and in writing, regarding his or her rights and entitlements (s.156). The explanation must be in the language usually spoken by the person. Explanatory pamphlets in English and fifteen other community languages are available at mental health facilities. Practitioners should also know how to access language and sign language interpreters.

Responsibility for providing the explanation, ensuring that the patient receives written information and recording in the medical record that an explanation has been given lies with a psychiatrist for inpatients, the supervising psychiatrist for a person subject to a CTO, and the person in charge of any location in which a mentally impaired accused is being detained (s.158). This responsibility may be delegated to another member of the mental health team.

Explanatory pamphlets, including *Your Rights under the Mental Health Act 1996*, should be distributed as appropriate to patients and carers.

The Rights pamphlet, however, is not a substitute for informing people verbally of their rights.

The psychiatrist or person responsible under that section of the MHA must give a copy of an order (s.159) to:

- the detained person if the detention continues for further assessment [Form 4] (s.37(1)(b));

- the detained person if they are examined in a place other than an authorised hospital and ordered to be received into and detained at an authorised hospital [Form 5] (s.39);
- the detained person if they are made an involuntary detained patient [Form 6] (s.43(2) (a)) and if the order is extended for further periods of detention [Form 9] (s.49 and 50);
- a person made subject to a CTO, and also if the CTO is extended, varied or revoked or there is a breach or an order to attend [Forms 10, 11, 12, 13, 14] (s.43 (2)(b), 70, 76, 79, 80, 82);
- a person made the subject of a Transport Order authorising police assistance [Form 3] (s.34, 41, 84);
- a voluntary patient detained in an authorised hospital by a SMHP [Form 2], (s.30).
- the patient when an involuntary detention order is revoked and the person made no longer involuntary [Form 8];
- the patient when a period of involuntary status as either an involuntary detained patient in an authorised hospital or under a CTO, lapses [Form 8]. Although not specifically required by the MHA, such a Form should be provided as good practice; or
- the patient when a CTO is revoked because the patient no longer is required to be an involuntary patient [Form 8 or Form 11].

Information pamphlets should also to be given to a relative/guardian/friend or other person, as nominated by the patient. When no person is nominated, or the nominated person cannot be found, the pamphlets are to be given to whoever has responsibility for the care of the patient. Copies of the forms may also be given to a nominated person to ensure that carers are fully informed regarding a patient's status (s.157).

## **1.2 Right to Make a Complaint**

A person has the right to complain if they are not satisfied with the care received, or feel unfairly or improperly treated. They may complain to staff members, the hospital management or external agencies, such as the Health and Disability Services Complaints Office (HaDSCO) formerly Office of Health Review.

A patient or any other person may complain to the MHRB regarding any failure to recognise rights given by the MHA (s.146). Complaints may also be made to the COV (s.188) or the Chief Psychiatrist (s.9).

## **1.3 Personal Records**

A person who is or has been an involuntary patient, including a mentally impaired accused detained in an authorised hospital, has the right to inspect and receive copies of any document pertaining to themselves. This right does not apply if the person having possession or control of a relevant document is of the opinion that disclosure of the information it contains will have an adverse effect on the health or safety of the patient or any other person, reveal personal information of a confidential nature about another (without the prior permission of that person) or reveal information obtained in confidence (s.160). In circumstances such as these, the patient may nominate a suitably qualified person to exercise his or her right (s.161). Since the MHA does not define the term 'suitably qualified person', the Chief Psychiatrist recognises a consultant psychiatrist as such a person.

If a patient's legal representative requests access to a patient's medical record where the service has deemed that section 161 of the MHA applies preventing the patient access, the service will allow the patient's legal representative to have access to the patient's medical

record, provided the legal representative signs an undertaking stating that he or she will not provide to the patient any of the restricted information to which he or she is being allowed to access.

Essentially, if the legal representative is willing not to divulge information to a patient identified by the mental health service as falling under the provisions of section 161 of the MHA and is willing to sign a document to that effect, he or she will be provided with access to the entire medical record. If despite this undertaking, the patient's legal representative does reveal information to the patient which should not be revealed a complaint may be laid with the Complaints Committee of the Legal Practice Board under Part 13 of the Legal Profession Act 2008.

A copy of the undertaking can be downloaded from the Chief Psychiatrist's website.

Sections 160 and 161 do not apply to certain records under the Prisons Act 1981.

### **1.4 Right Not to be Ill-treated**

Any person with responsibility for the patient who ill-treats or willfully neglects the patient has committed an offence, the penalty for which is a fine of \$4000 or one year's imprisonment. Any claim of a breach of this right must be progressed through Legal and Legislative Services at the DoH.

## 1.5 Right to a Another Opinion

In addition to the right to an interview with a psychiatrist at the hospital, a voluntary or involuntary detained patient also has the right to an interview with and to be examined by another psychiatrist. The request can be made verbally or in writing to the treating psychiatrist. The second opinion to be given as soon as is practicable and the examination may be conducted by audiovisual means if unable to be done face-to-face (s. 164).

If an involuntary patient or a mentally impaired accused in an authorised hospital being given psychiatric treatment (s 109) is dissatisfied with the treatment he or she may request from the treating psychiatrist that an opinion as to whether the treatment should be given be obtained from a psychiatrist who has not previously considered the matter. Alternatively they may request that the Chief Psychiatrist arrange for that opinion. The Chief Psychiatrist has delegated this process to the Head of Service in the mental health facility.

If, having been informed that the second psychiatrist recommends that the treatment be modified or discontinued, the patient remains dissatisfied, then the matter may be referred to the Chief Psychiatrist. The Chief Psychiatrist may give directions as to treatment (s 12), or refer the matter to the MHRB, or transfer the responsibility for treatment of the patient to another psychiatrist (s112). For further information see Office of the Chief Psychiatrist Operational Circular OP 0250/09 available on the Chief Psychiatrist's website.

Note that the views of the second psychiatrist if different from the treating psychiatrist do not prevail over the views of the treating psychiatrist, though treatment can be informed by those views. If the patient is dissatisfied that not sufficient attention is being paid to the opinions of a second psychiatrist, the patient should request a review

of their status from the MHRB and the second opinion presented as part of that evidence before the MHRB.

### **1.6 Right to Personal Possessions**

Inpatients will, as far as is practicable, be given the ability to use and store articles of personal use, unless the psychiatrist feels certain articles are inappropriate for use or storage at the hospital (s.165). Specific attention needs to be given to articles such as spectacles, hearing aids and walking frames which may be deemed essential to the needs of the patient. If a patient's articles are still at the hospital six months after he or she has left they may be sold, provided the patient has been given at least one month's notice of the intention of sale and fails to claim the articles (s.165(3)).

### **1.7 The Right to Send and Receive Mail**

Inpatients have the right to send and receive mail without interference or restriction on the part of any hospital employee. Mail given to staff to post or pass on to the patient is not to be opened or delayed by an employee without 'reasonable excuse'. While the MHA contains no definition of the term 'reasonable excuse', patients can apply to the MHRB if there is any denial or restriction of their mail. Should a staff member be found to have acted illegally, he or she faces a possible \$500 fine. See 1.10 for restrictions to this right (s.166 and 170).

### **1.8 Right to Receive and Make Telephone Calls**

An inpatient must have the opportunity to make and receive telephone calls in reasonable privacy. Hospital policy governs the use of mobile phones which may be restricted for use only in bedrooms or certain parts of the ward or may be kept in storage for safe keeping. All patients have a right to confidentiality and the use of the

camera on mobile phones is restricted (OCP Operational Directive 0253/09). See 1.10 for restrictions to this right.

## **1.9 Right to be Visited**

An inpatient must have the opportunity to receive visitors of their own choice in reasonable privacy. See 1.10 for restrictions to this right.

## **1.10 Restrictions or Denial of Entitlement**

A psychiatrist may restrict any of the above the rights in 1.7, 1.8 and 1.9 if it is considered to be in the best interest of the patient to do so. If such a right is restricted, a psychiatrist, not necessarily the treating psychiatrist, must review the order daily. A review need not include a face-to-face examination but should consider the reasons for the restriction and whether those reasons still apply. If not reviewed, the restriction order lapses at the end of the day. A record of the order and review is to be included in the patient's medical records (s.169).

Patients or interested others may apply to the MHRB for a review. The MHRB has the right to confirm, cancel or vary the restriction order (s.170). Any restriction or denial of a right not considered by the MHRB under s.170 is to be reported to the MHRB at the next review of the patient's status (s.171). Additionally in relation to visits, the patient may, when visiting is denied or restricted, request the involvement of the Chief Psychiatrist who may overturn the restriction or denial (s. 15).

The Chief Psychiatrist advises that none of these restrictions should apply when a patient's legal representative is involved. In other words a patient should not be restricted from phoning or writing to their legal representative or being visited by the legal representative. Restrictions should only apply at the request of the legal representative.



## **1.11 The Right to Vote**

It is obligatory for everyone on the electoral roll to vote. However, if a person is an involuntary patient, a psychiatrist should determine whether or not that person is capable of voting. If not and in relation to state elections, the psychiatrist must give notice of this in writing to the Chief Psychiatrist, who then reports to the Electoral Commissioner. The patient's right to vote is subsequently suspended (s.201 and 202). The psychiatrist may cancel the order at any time, again by writing to the Chief Psychiatrist. The patient or any other person the MHRB considers as having a proper interest in the matter can appeal to the MHRB against the decision to rescind a patient's right to vote. The MHRB may then confirm or cancel the determination. For Federal elections there is an alternative process which requires completion of an 'Objection to Electoral Enrolment Medical Certificate' by the psychiatrist which must be lodged with the Electoral Commissioner. Patients denied the right to vote may appeal to the Electoral Commissioner.

## **1.12 Right to Consent to or Refuse Certain Treatments (Part 5, Division 2)**

A voluntary patient has the same legal rights as any other patient in a hospital. He or she may refuse or consent to any treatment. Involuntary patients should also be involved in matters of consent, in line with good clinical practice.

Consent involves:

- the patient being given a clear explanation of the proposed treatment, along with sufficient information to enable him or her to make a balanced judgement;
- that the explanation should include a warning of any risks inherent in the treatment;

- the information being given in a language the patient understands, with the use of interpreters as necessary and the person giving the information must take into account his or her knowledge of the patient, both medical and social;
- the patient having sufficient time to consider the information, which may involve seeking advice from other sources such as voluntary groups; and
- recognition that a patient's failure to offer resistance to treatment does not of itself constitute that person's consent to treatment.

Good clinical practice dictates that, where possible, the patient be fully involved in treatment options and the obtaining of consent. However, an involuntary patient, whether detained in an authorised hospital or on a CTO, or a mentally impaired accused in an authorised hospital, may be given psychiatric treatment, apart from psychosurgery, without his or her consent (s.109).

### **1.13 Right of Appeal to the Mental Health Review Board (s.142, 103, 106)**

Involuntary patients, Official Visitors and any other person the MHRB is satisfied has a genuine concern for the patient may apply to the MHRB for;

- a review of the patient's involuntary status, whether the patient is detained in an authorised hospital or subject to a CTO;
- a transfer to another authorised hospital;
- a transfer of supervision to another psychiatrist while on a CTO; or
- a review of restrictions under ss.170 and 203.

### **1.14 Application for Review by the State Administrative Tribunal (s. 148A, B, C, D, E)**

If a person remains dissatisfied following a decision by the MHRB they may, without payment of any fee, apply to the State Administrative Tribunal for a review of the decision (See Chapter 5).

### **1.15 Right of Appeal to the Supreme Court (s.149-155)**

A patient or any other person who, in the opinion of the Supreme Court, has sufficient interest in the matter may appeal to the Supreme Court against a decision or order of the MHRB.

### **1.16 Procuring apprehension or detention of a person not suffering from a mental illness or impairment**

The production of a false certificate or document to have a non-mentally-ill person apprehended or detained under the MHA is a criminal offence, the penalty for which is imprisonment for three years (Criminal Code, s.336).

## Chapter 2 Involuntary Detention

### 2.1 A person should be a detained involuntarily patient (s.26) only if:

1. the person has a mental illness, as described by the MHA, requiring treatment, **and**
2. the treatment can be provided through detention in an authorised hospital and is necessary in order to –
  - protect the health or safety of that person or any other person;
  - protect the person from self-inflicted harm, which includes serious financial harm, lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships and serious damage to the reputation of the person; or
  - prevent that person doing serious damage to property, **and**
3. the person has refused or due to the nature of their mental illness is unable to give consent to treatment; **and**
4. the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.

## **2.2 Referral for Examination (s.29)**


A medical practitioner or AMHP, or a Senior Mental Health Practitioner (SMHP) in specific circumstances, can refer a person for examination by a psychiatrist if he or she suspects on reasonable grounds that that person should be made an involuntary patient. This can be done whether the person is in the community or a voluntary patient in an authorised or non-authorised hospital. A person released or discharged under the mental health legislation of another State or Territory (s.90) may also be referred under s.29.

## **2.3 Process of Referral**

The referrer must have personally examined the person being referred before making his or her decision and the referral must be made within 48 hours of this examination (s.32). The implication is that this examination needs to be face-to-face or as close to that as possible. A telephone or other type of audio-visual examination would not be sufficient.

The referral must be in writing [Form 1] and specify the date and time at which the referral was made, as well as the date and time the examination occurred. The referrer should state the basis on which the referral is being made and distinguish personal observation from information received from another person such as a family member (s.33).

Facts communicated to the referrer from another person, cannot be the only grounds for a referral, however they may be part of the information which the referrer uses in forming his or her suspicion that the person should be referred (s.31).



The referrer should also state where the examination by the psychiatrist is to take place, either at an authorised hospital or some other place, such as a clinic, an Emergency Department (ED) or community mental health centre, as determined by the referrer (s.33). Although it is not necessary for the referrer to provide the person examined with a copy of the Form 1, particularly where that form contains information from confidential sources, good practice indicates that a copy of the form be provided where possible.

### **2.3.1 Referral to Authorised Hospital**

When referring a person to an authorised hospital, the referrer should contact the hospital to notify them that a person is being referred. If the hospital is unable to accept the patient because a bed is unavailable it is the responsibility of the hospital to arrange receipt into another authorised hospital though this does not preclude the referrer contacting other authorised hospitals regarding bed availability.

If no bed is available within the mental health system it is the duty of the catchment area hospital to receive the patient and manage the receipt. In these circumstances where there are bed management problems it is contrary to good practice for the patient to be kept for long periods in ambulances, other forms of transport, in EDs or in the community. Essentially the responsibility lies with the service to receive a person referred. For further information see the *Assertive Patient Flow and Bed Demand Management for Adult Mental Health Services: Policy and Practice Guideline*.

The referrer must indicate on the Form 1 the destination where the examination will occur. If there is a change of destination for example due to bed availability in another authorised hospital the referrer may alter or authorise the alteration of the Form 1 to the new destination. If the referrer cannot be contacted then it may be necessary for a

new Form 1 to be completed by a different referrer. That part of the Form should not be left blank when written or enacted.

### **2.3.2 Referral to 'some other place'**

When referring a person to a place other than an authorised hospital ('some other place'- s.29 (2)(b)) the referrer should be aware that staff at the other place do not have the power under the MHA to detain the person referred. If that person wishes to leave he or she may do so. If the person needs to be detained because they are posing an imminent risk to themselves or others, staff may take action such as detaining the person under a duty of care. A duty of care exists under common law where the doctrine of necessity to protect the person or others overrides the rights of the person to leave.


Subsequently or alternatively a medical practitioner or AMHP may complete another Form 1 to refer that person to an authorised hospital. Good practice indicates that communication with the authorised hospital commences during this process. Further, the person's original referrer should be informed of the decision.

### **2.3.3 Persons of no fixed abode**

Persons of no fixed abode who have been known to a particular service in the previous three months should be referred to that service. Persons of no fixed abode who are not known to any service in the previous three months should be referred to the service covering the area they are in currently.

## **2.4 Detaining a Referred Person**

The MHA does not make provision for a person referred under s.29 to be detained prior to the person being received in the authorised hospital or other place. The issuing of the Form 1 referral does not in itself grant a power to detain or transport the person.



In most cases, the transportation of the person to an authorised hospital or other place is conducted on a basis agreed by the referrer and person referred or their carer.

There may be occasions when agreement is not possible and the alternative of issuing a transport order and the involvement of the police is necessary. In those circumstances a Form 3 needs to be completed (see 2.5).

There is no provision in the MHA enabling anyone other than a police officer to apprehend and detain a person referred for examination under section 29 of the MHA. However, a person other than a police officer may detain a referred person if there is an over-riding necessity for the protection of the referred person and/or others. A person cannot be detained merely because it is believed to be for the 'benefit' of that person. The detention must be for the urgent protection of the person detained or for others' urgent protection. Further, the force used must be commensurate with the circumstances.

Where a Form 1 and a Form 3 have been issued, but the person has not yet been apprehended for transfer; or a Form 1 has been issued, but a Form 3 is not needed, for example a person with dementia who wanders, the referred person may be detained pending the arrival of the police, or transfer to the authorised hospital, only if there is an over-riding necessity to do so for the urgent protection of the person or others.

In circumstances where a Form 1 has been issued, but there is no 'emergency' situation which will allow for the person to be detained, although it may appear to be in the 'best interests' of the person to be detained, staff must make a decision how best to take all reasonable steps to eliminate the risks of harm to that person or others, without breaching his or her rights, to leave.



Circumstances in which there may be an over-riding necessity for the urgent protection of the referred person and others would include threats or actual attempts to physically harm him or herself or others. Behaviour such as spending money in a manic state, approaching strangers, or being sexually permissive may not be urgent enough behaviour to justify detention but may be relevant to an overall assessment of the risks to the referred person or others. For detention to be justified there must be clear evidence of a real, significant and urgent risk to the person or to others unless the person is restrained and detained. It is essential to document the reasons for detaining a person.

Where a referred person's care is being transferred from one clinician to another all the risk factors should be made known to the second clinician. This information will assist the clinician in making decisions relevant to the discharge of his or her duty of care to the person.

### **2.5 Conveyance to an Authorised Hospital (ss.34 and 35)**

To convey the referred person to an authorised hospital for examination, the referrer must make a clinical judgement as to whether the condition of the person is such that assistance with transport is required. The clinician should bear in mind the welfare, safety and dignity of the person concerned. Involving the police in the transport of a referred person should not be a practice of first choice.

The person may be conveyed to hospital in a DoH vehicle, an ambulance, a police car, a police divisional van or, if appropriate, a private vehicle.

If transport is by way of a DoH vehicle, which may or may not be done under a Transport Order, observing the following guidelines is advisable:

- a DoH vehicle is the preferred means of transport for patients not overtly aggressive or physically compromised;
- the patient is to sit behind the front passenger seat, with the accompanying staff member or police officer in the adjacent rear seat;
- where appropriate, the patient is to sit between the two escorting staff/police officers in the rear seat;
- on occasions where the staff member is alone, the patient may sit in the front passenger seat if this is considered a safe clinical decision;
- patients are to wear a safety belt and refrain from smoking at all times.


If the condition of the person is such that police assistance is required to take the person to the examination, and where no suitable alternative is available, the referrer can make a written Transport Order [Form 3]. This authorises a police officer to apprehend the person, if that person is not already in custody, and take him or her to the place of examination.

Police should not be provided with a copy of the Form 1 as there may be confidential information on that Form which does not relate to the police transport. If there is specific information which it is important for the police to know, such as previous aggression or possession of firearms, that information can be put in the Form 3 in the box entitled '*Special factors or other important details*'.

If a Transport Order is necessary, it must specify the date and time at which it was made. Apprehension and transportation of the referred person by the police must be completed within 72 hours of the person being referred to an authorised hospital, or 24 hours if he or she was referred to another place (ss.34 and 35).

A Transport Order places a responsibility on the police to apprehend and transport the person concerned to either an authorised hospital or other place specified by the referrer as soon as is practicable, and within the above time frames. However, the police can seek the advice and guidance of mental health staff, who may assist them in transporting the referred person. Where appropriate, it would be good practice for mental health staff to accompany the referred person and the police. The police are responsible for the person during the transport procedure and they decide as to the form of transport. However, that does not preclude discussions between police and clinicians about the condition of the person and the most appropriate form of transport.

If the person is being transported from a rural or remote area and needs to remain in a local hospital awaiting the Royal Flying Doctor Service (RFDS) or if it is necessary for the person, because of the need for a physical assessment, to attend at an Emergency Department (ED) the police remain responsible for the person. This does not preclude cooperative arrangements with health services, whereby given the condition of the patient, immediate attendance by the police at all times is not required. If the situation is safe for the police to leave temporarily, the patient's immediate care may be managed by health professionals. When the patient requires transportation the police may then resume their duties.



A Transport Order lapses when the person concerned is received into an authorised hospital (s.36), within the time limits detailed above, or within the seven-day time period following completion of the Form 1 if that is sooner.

Although police have the responsibility for transporting the person, it may be done using a DoH vehicle, ambulance or police car. Conveyance in a police divisional van is potentially distressing for patients and should be avoided where possible. Where it is deemed necessary the police may search the referred person before transportation.

Conveyance by ambulance is necessary when the person concerned is in a debilitated state, has been sedated or has compromised his or her health through an act of self-harm. In appropriate cases it may be possible to transport the person in a private vehicle.

In some circumstances and/or in some areas of WA the police may request a Transport Risk Assessment Form to determine prioritization.

Should the Police Operations Centre indicate they will not provide an escort or there will be a long delay which the referrer perceives as exacerbating the risk issues significantly, mental health staff should request a further review of that decision at that time by speaking with the Inspector at the Police Operations Centre who is the Duty Patrol Commander at the time. The direct Phone number is 9374 4025. The issue can be discussed at that level and the decision reconsidered and any problems resolved.

If matters are still not resolved the matter should be referred to the Consultant Psychiatrist on call who can discuss the issues with more senior police officers.

For the purpose of ensuring the highest firearm safety, it is WA Police policy that Officers will have their accoutrements including firearms, tasers and OC sprays on their persons at all times including when transporting referred persons or involuntary patients or attending DoH services including hospitals.

Police officers may be asked and agree to remove their accoutrements but are not obliged to remove them or place them in locked cabinets or in the care of other officers to conduct any business with mental health services or staff. The only exception is police escorts involving Royal Flying Doctor Service aircraft.

See the Protocol between the Police Service and the Mental Health Division and the General Procedures (Police Standing Orders) for further information.

### **2.6 Responsibility of Authorised Hospitals**

If a person is referred to an authorised hospital, it is the responsibility of that hospital to receive the person referred. If the person in charge of the authorised hospital decides that the facility is unable to accommodate the person referred due to a shortage of beds, then the authorised hospital must arrange the referred person's transfer to another authorised facility. In these circumstances it is recommended that the referred person be examined by a psychiatrist and a decision made regarding legal status before the person is transferred. (See – *Assertive Patient Flow and Bed Demand Management for Adult Mental Health Services: Policy and Practice Guideline*.)

## **2.7 Not Acting on a Form 1**

Although the MHA does not specify the option of not acting on a Form 1, the potential for such an occurrence in clinical practice indicates the need for this practice guideline. If during the period between the completion of a Form 1 and a person's receipt at an authorised hospital, or other place, there is a change in that person's mental state, and if assessment by a medical or mental health practitioner indicates that, under the principle of the least restrictive alternative, a referral is no longer required, then there is the option of the Form 1 not being acted on.

This should only be done after discussion with and the agreement of the referrer. If the referrer cannot be contacted then the medical or mental health practitioner may make a decision in line with good practice and make a note of that in the medical record. On these occasions the Chief Psychiatrist should also be informed. If the referrer believes that the referral should continue despite what the other health practitioner feels then it is up to the referrer to manage the process of transportation to the authorised hospital. The form which is not acted on should remain in the patient's medical record and the process documented in the patient's medical record.

## **2.8 Referral from an Authorised Hospital (s. 30)**

If a voluntary patient in an authorised hospital seeks to leave but a SMHP suspects on reasonable grounds that that patient should be made an involuntary patient, the practitioner can make a written order [Form 2], that the patient be detained at the hospital for up to six hours, to be examined by a psychiatrist who is not at the time of referral the person's treating psychiatrist. The examining psychiatrist may then make the person an involuntary detained patient [Form 6], or make the person subject to a CTO [Form 10] or extend the assessment period for up to 72 hours from the time the person was detained [Form 4] or not make any order.

If the person concerned is not seen by a psychiatrist within the 6-hour time frame the order lapses.

Alternatively a medical practitioner or AMHP may refer a voluntary patient, without reference to s.30, on a Form 1 for examination by a psychiatrist (s 29). As the person is in an authorised hospital the Form 1 is valid immediately. In these circumstances the person may be detained for up to 24 hours for a psychiatrist to examine the person.


## **2.9 Referral from a Judicial Officer (Mental Health (Consequential Provisions) Act 1996, Part 2 – Bail Act 1982)**

A judicial officer who is of the opinion that an accused's mental state ought to be examined can grant bail on the condition that the person be examined by a medical practitioner or AMHP for the purpose of deciding whether a referral should be made under s.29.

The medical practitioner or AMHP may then refer the person for examination by a psychiatrist. The judicial officer may impose any condition, which the officer considers desirable, including that the accused be admitted to an authorised hospital and that the accused be examined by a psychiatrist (Consequential Provisions - s.3(2)).

## **2.10 Detention for Examination in an Authorised Hospital (s.36 and 37)**

A person referred to an authorised hospital for examination by a psychiatrist may be detained for up to 24 hours from the time of receipt, in order for that examination to occur. If no examination of the person occurs during that time, the person may leave.



Being received for the purpose of examination does not mean the person is admitted to the hospital. Technically, that person is not a patient and therefore cannot be held under the 6-hour holding power once the 24-hour period has expired.

The purpose of the examination is to make decisions about the care of the patient and the psychiatrist has four options. He or she can:

- make an order under s.43 whereby the person becomes an involuntary detained patient [Form 6];
- make an order under s.43 making the person subject to a CTO [Form 10];
- postpone making a decision to enable a further assessment, which must take place within 72 hours of the person being received into the hospital [Form 4]; or
- not make any order, in which case the person may leave or choose, with the psychiatrist's agreement, to become a voluntary patient.

## **2.11 Choices Upon Examination in a Place other than an Authorised Hospital (s.38-40)**

A psychiatrist examining a referred person in a place other than an authorised hospital may make an order that the person be received into and detained in, an authorised hospital for assessment [Form 5]. A psychiatrist cannot make a person an involuntary detained patient external to an authorised hospital. If the condition of the referred person is such that police assistance is required, the police may be authorised to transport the person [Form 3] to an authorised hospital as soon as is practicable. The Transport Order lapses 72 hours after being made.



Once the person has been received into the authorised hospital, a psychiatrist must examine the patient within 72 hours and decide whether or not to make the person an involuntary patient. If no order is made, the person is entitled to leave or, with the psychiatrist's permission, become a voluntary patient. The person is not admitted as a patient during this period and the 6-hour holding power does not apply (ss.40, 41 and 42).

Without the requirement of a referral a psychiatrist examining a person may make that person an involuntary patient on a CTO [Form 10] (s.67). In these circumstances the order must be confirmed by another psychiatrist or, if none is available, a medical practitioner within 72 hours (see Chapter 4).

## **2.12 Detention in an Authorised Hospital**

Involuntary patients may be admitted to the hospital in which they were examined and that hospital has the authority to detain them. At any time, the psychiatrist may order that such patients be transferred to another authorised hospital once appropriate arrangements have been made with the other authorised hospital [Form 7] (s.45-47).

Initially, involuntary detained patients can be detained for up to 28 days (s.48). During that period, the treating psychiatrist must ensure that the involuntary patient is examined again, and must then consider one of three options. He or she can:

- authorise at any time that the person no longer be detained as an involuntary patient [Form 8];
- order that the patient be subject to a CTO [Form 10]; or
- order an extension of the period of detention for up to six months [Form 9] (s.49).

## 2.13 Further Periods of Detention (s.50 and 51)

Before the continuation order [Form 9] lapses the treating psychiatrist must ensure that the patient is examined, after which, that psychiatrist considers the options described above. This must occur before any further period of detention [Form 9].

## 2.14 Leave (s.59-63)

A psychiatrist may authorise leave of absence for an involuntary detained patient if it is likely to benefit the health of the patient, or the patient requires any surgical or medical treatment (s.59).

Any decision to allow a patient leave should be consistent with the reason for which the person was admitted, which is that treatment can be provided by way of detention and is necessary to protect that person or any other persons (s.26 (1)(b)).

When considering leave, the psychiatrist should consider whether making the patient no longer an involuntary detained patient or making a CTO is more appropriate (s.59).

Although the patient is on leave he or she continues to be a detained involuntary patient and the psychiatrist can impose certain conditions considered appropriate, as well as extend the period of leave (s.59). Whenever a detained patient is given leave of absence, that person must be provided with information on his or her rights and entitlements. (The pamphlet *Involuntary Patients* contains information about leave and absence without leave) (s.156 (1)(c)).

There is an obligation on the psychiatrist to review a person's involuntary status if the leave of absence is longer than 28 consecutive days. The psychiatrist must consider whether the patient should be discharged from involuntary status or made the subject of a CTO (s.62).

If a medical practitioner or AMHP writes to the psychiatrist advising that the patient should not continue to be detained as an involuntary patient then the treating psychiatrist on the basis of the opinion may order that the person no longer be an involuntary patient [Form 8], or make the person subject to a CTO [Form 10] (s.63), or maintain the detained involuntary status.

### **2.15 Cancellation of Leave (s.60)**

If the psychiatrist believes on reasonable grounds that a patient's leave of absence should be cancelled, he or she must give written notice to the patient. The notice is to be served personally, such as by letter, on the patient by or on behalf of the psychiatrist.

### **2.16 Absence without Leave (s.57 and 58)**

An involuntary patient is considered to be absent without leave if he or she leaves an authorised hospital without being granted leave or fails to return from leave that has expired or been cancelled (s.57).

The patient may be apprehended and returned to the authorised hospital by either a mental health practitioner employed at the hospital, or if not employed at the hospital, authorised by the hospital to perform that duty, or a police officer, and this should be done as soon as is practicable (s.58). There is no specific form which authorises this action.

In performing this duty, the mental health practitioner or police can enter any premises where they suspect the person to be, without the requirement of a warrant. They can then remove that person, returning him or her to the authorised hospital and seize anything that could be used by that person to prejudice the health and safety of any of the parties or cause damage to property. Such objects could include dangerous items like knives or guns but also

potentially dangerous items such as medication. Clearly, the decision must be based on all the information available and seizure should not occur as a matter of course (s.58).

Any person who rescues or willfully permits the escape of a detained patient, or conceals such a person while he or she is absent without leave, commits an offence and is liable to imprisonment for three years (Criminal Code s.149).

## **2.17 Release of a Detained Patient**

Patients can be discharged from involuntary status by a psychiatrist (s.49) [Form 8] or by the MHRB (s.145). If a psychiatrist believes the patient should no longer be an involuntary patient, he or she can discharge the order and the patient may leave the hospital or, with the psychiatrist's permission, become a voluntary patient (s.52).

Alternatively, if the psychiatrist believes that the person requires treatment as an involuntary patient but that this treatment can be provided adequately in a less restrictive environment, then he or she can make a CTO [Form 10] (s.52). The patient or another person the MHRB is satisfied has a genuine concern for the patient can apply to the MHRB for a review of the patient's involuntary status.

When a patient is discharged from an authorised hospital but under a law of the State or Commonwealth there is a requirement that he or she be kept in custody, then that person may only leave the hospital when delivered into that custody (s.55). When a patient, but not an involuntary patient, in an authorised hospital is also a prisoner under the Prisons Act 1981 and about to be discharged from lawful custody, then that person, before being released from the hospital, must be examined by a psychiatrist to determine whether he or she should be detained as an involuntary patient (s.56).

## Chapter 3 Treatment Issues

The term 'treatment' covers a number of interventions by doctors, nurses, psychologists, occupational therapists and social workers, and includes medication, electroconvulsive therapy, counselling, rehabilitation, individual and group psychotherapy, occupational therapy and psychological programs. The term 'psychiatric treatment' means treatment for a mental illness and the MHA specifically covers ECT, psychosurgery, medical treatment and emergency psychiatric treatment. Involuntary patients can be given psychiatric treatment without their consent, though good practice should include where possible informed consent even from involuntary patients. There is no specific mention of medication in the MHA but it is included as a 'psychiatric treatment' under ss.108 and 109.

### 3.1 Prohibited Treatments (s.99)

Certain treatments are prohibited and it is a criminal offence to administer them, punishable by imprisonment for up to five years. They are deep sleep therapy, insulin coma or sub-coma therapy.

### 3.2 Psychosurgery

This treatment is rarely used, and then only as a treatment of last resort. Nevertheless, it was considered important to have safeguards in place should the treatment be considered. Psychosurgery requires the informed consent of the patient and the approval of a special five member Mental Health Review Board, which includes a neurosurgeon (Part 5, Division 4).

### 3.3 Electroconvulsive Therapy (ECT)

An involuntary patient may not be given ECT unless it has been recommended by the treating psychiatrist and approved by a second psychiatrist, unless the therapy is given as emergency psychiatric treatment (ss.104 and 113).

Before a psychiatrist approves a recommendation for the treatment, the psychiatrist must be satisfied that the proposed treatment has clinical merit and is appropriate in the circumstances. He or she must also decide whether the patient has the capacity to give informed consent and whether that consent has been given (s.105). An ECT Consent Form can be downloaded from the Chief Psychiatrist's website. If the person is an involuntary patient or mentally impaired accused the box on page 2 of the form needs to be completed relating to a second opinion for ECT under section 105. If a patient is able to provide consent the Consent for Anaesthesia form downloadable from the Chief Psychiatrist's website also needs to be completed.

If the second psychiatrist does not approve the treatment the treatment cannot be given. It is not appropriate to seek a third opinion to justify the giving of the treatment. The treating psychiatrist is to refer the matter in writing to the MHRB who cannot authorise the treatment, however if the second psychiatrist continues to withhold approval of the recommendation, the MHRB may recommend that the treating psychiatrist use an alternative treatment or that care of the patient be transferred to another psychiatrist, or order that the involuntary patient no longer be an involuntary patient (s.106).

As with any treatment, patients should be as fully involved and informed as possible. Thus, involuntary patients too should be fully informed regarding ECT and may consent to the treatment, although

that does not negate the requirement that the recommendation be approved by another psychiatrist. If an involuntary patient is unable to give consent or refuses to do so, he or she may still be obliged to have the treatment. However, this does not negate the responsibility of staff to fully inform the patient and seek his or her consent. One aspect of the role of the second psychiatrist is to ascertain whether the person has the capacity to give informed consent to the proposed therapy (s.105).

A voluntary patient may receive ECT only if that person has given his or her informed consent, including consent for the anaesthesia (s.107), unless the treatment is given as emergency psychiatric treatment (s.113). Guardians and carers are not able to consent to ECT on the patient's behalf.

### **3.4 Consent not Required for Psychiatric Treatment**

An involuntary patient or mentally impaired accused remanded or on bail to an authorised hospital may be given psychiatric treatment without his or her consent (ss.93 and 109). For patients' rights in regard to involuntary treatment see '*Right to another opinion*' in 1.5.

### **3.5 Medical Treatment (s.110)**

An involuntary detained patient can consent to medical treatment and then be discharged, granted leave or made subject to a CTO and be referred for medical treatment.

An involuntary detained patient who is unable because of their mental illness to consent to medical treatment may be given that treatment, if it has been approved in writing by the Chief Psychiatrist (s.110). The Chief Psychiatrist has delegated this power to the psychiatrist in charge of the service the patient is detained at. Such medical treatments generally involve surgery requiring a general

anaesthetic. Minor medical treatments may be dealt with by the treating team. Medical treatment may also be approved by a patient's guardian, if one is appointed.

For further information on delegations see the Chief Psychiatrist's Delegations 0273/2010, available on the Chief Psychiatrist's website.

### **3.6 Emergency Psychiatric Treatment (s.113-115)**

Emergency Psychiatric Treatment (EPT) means treatment it is necessary to give to a person to save a person's life or prevent a person from behaving in a way that can be expected to result in serious physical harm to the person or others.

EPT can be given to a person regardless of that person's status under the MHA, and without his or her consent. ECT may be given as an EPT but psychosurgery may not.

The duties of the person administering EPT include ensuring that a record is made of the particulars of the treatment, the names of those involved and the time and place at which the treatment was given. A report must then be sent to the MHRB.

The Office of the Chief Psychiatrist should be informed if ECT is given as EPT.

### **3.7 Seclusion (s.116-120)**

Seclusion means sole confinement in a room that it is not within the control of the person confined to leave (s.116). Seclusion can only be used in an authorised hospital (s.117).

A patient may only be secluded if it is necessary for the protection or well-being of that patient or others whom the patient may come into contact with if not kept in seclusion (s.119). Only a medical



practitioner or, in an emergency, a SMHP can authorise seclusion. The SMHP must then notify a medical practitioner as soon as possible, who can either vary or revoke the authorisation (ss.118 and 119).

Authorisation must be in writing and include particulars of the period for which the authorisation is given and any other details prescribed by the Regulations (s.119). These include:

- the name and qualifications of the SMHP or medical practitioner who gave authorisation;
- date and time authorisation was given;
- reasons for the authorisation;
- particulars of any special observations and any directions issued by a medical or mental health practitioner regarding clinical care while in seclusion;
- where the authorisation was given by a SMHP, details of the emergency.

Records of each authorisation of seclusion must be kept (s.119). The MHA specifies certain duties when a patient is in seclusion. They include:

- that the patient must be observed at regular intervals by a mental health practitioner, which may include entering the seclusion room for close observation to ensure the person is conscious. Regulations specify at regular intervals of not more than 15 minutes following seclusion;
- that the patient is regularly monitored by a psychiatrist or another medical practitioner. Most service policies require medical monitoring at least 2 hourly;
- that the patient's basic needs, such as bedding, appropriate clothing, food, drink and toilet facilities are provided for;

- a report on the patient who has been kept in seclusion is to made as soon as is practicable to the MHRB.

Regulations specify additional particulars, which are to be kept in respect of a patient authorised to be kept in seclusion (Regulations 1997 s.12). These include the requirement that a separate record of any seclusion authorised be kept as part of the patient's case notes (Regulations 1997 s.12 (b)).

The treating psychiatrist is to report the clinical details of every seclusion authorised under s.119 to the psychiatrist in charge of the authorised hospital, which must maintain a register of seclusions.

On the written request of the Chief Psychiatrist, the psychiatrist in charge of the authorised hospital is to provide a copy of the register of seclusion to the Chief Psychiatrist.

### **3.8 Mechanical Bodily Restraint (s.121-124)**

Mechanical bodily restraint means restraint by mechanical means to prevent the patient from moving his or her body or limbs. It excludes the use of medical or surgical appliances for the proper treatment of physical disease or injury or the use of cot-sides or a table in front of a chair preventing a person wandering and falling over (s.121).

A patient may only be mechanically restrained for the protection, safety and well-being of self or others, to prevent that patient from persistently destroying property or for the medical treatment of the patient (s.123). Mechanical bodily restraint can only be used if authorised by a medical practitioner or, in an emergency, by a SMHP. Further, it may only be used within the period for which the authorisation is given. If a SMHP authorises restraint, a medical practitioner is to be notified of this as soon as possible and may vary or revoke the order (s.122 and 123).

Authorisation must be in writing and include particulars of the period for which the authorisation is given (s.123).

Regulations specify that a patient under restraint must be observed continuously by a medical practitioner and a mental health practitioner in physical attendance with the patient for the first 15 minutes of restraint. Thereafter, the patient must be observed continuously by a mental health practitioner in physical attendance with the patient, with the patient reviewed by a medical practitioner every half an hour from the time the restraint is applied. A record must be kept, and the treating psychiatrist is also to send a report of the restraint to the MHRB as soon as is practicable (s.124).

Regulations specify that additional particulars be kept in respect of an authorisation to use mechanical bodily restraint (Regulations 1997, s.14).

Regulations further specify that a separate record of any restraint authorised is to be kept as part of the patient's medical record (Regulations 1997, s.15).

The treating psychiatrist is to report the clinical details of every restraint authorised under s.123 to the psychiatrist in charge of the authorised hospital.

The psychiatrist in charge of the authorised hospital is to maintain a register of those restraints. On the written request of the Chief Psychiatrist, the psychiatrist in charge of an authorised hospital is to provide a copy of the register of restraints to the Chief Psychiatrist.

## Chapter 4 Community Treatment Orders

### 4.1 Background

An involuntary patient may either be a patient detained in an authorised hospital or a patient on a Community Treatment Order (CTO). The CTO permits treatment in the community, where a person with a mental illness refuses or is unable to consent to treatment, and also fulfils the other criteria of s. 26 of the MHA.

CTOs offer a less restrictive, community-based alternative to detention in an authorised hospital. Community based care and treatment is consistent with deinstitutionalisation and a principle that treatment is best offered in a less restrictive environment than a hospital setting.

Although CTOs have a legal basis and clinician's actions are shaped by the legislation, the effectiveness of a CTO will depend on a respectful relationship between the patient on the CTO and the clinicians who are caring for the patient.

CTOs are not just post-discharge 'aftercare' as it is possible for a psychiatrist to place a person on a CTO without the need for the person to have been previously a voluntary or involuntary patient in a hospital.

A CTO may be used as part of a community care plan. However, the MHA places responsibilities on the mental health service and obligations on the patient, which go beyond the usual care provided to patients in the community. As with any community care plan, CTOs require consistency of approach, information sharing, negotiation and the involvement of families, carers and community services.


The primary purpose for making a person subject to a CTO is to ensure they receive treatment, at a time when they are either unable to consent, due to the nature of their mental illness, or refuse to consent to treatment. Accordingly, due consideration must be given to both the potential benefits as well as restrictions consequent to making a person subject to a CTO.

CTOs appear to work best with patients who have a severe and enduring mental illness and a history of non-compliance which places their own or another person's health or safety at risk. CTOs were first initiated as an effective way of working with people with severe and enduring mental illness, attempting to reduce or stop the revolving door of institutionalisation and discharge.

In some jurisdictions, however not in Western Australia, legislation requires that the patient should have previously failed to be maintained without legal imperative in the community. If the patient can be treated on a voluntary basis and this has proved successful in the past, a compulsory order is unlikely to be necessary, except in changed or extraordinary circumstances.

The patient needs to have a degree of competence in order to understand the requirements of a CTO and if they lack this cognitive ability it may be difficult for them to comply. In such a case, alternatives such as guardianship may be more appropriate as a long-term aim of ensuring treatment.

The patient needs to have the capacity to comply with the treatment plan. A degree of cooperation is necessary. If a person is so antagonistic towards the CTO that there are constant difficulties between the patient and the community staff to obtain the patient's compliance with the order, then a CTO may be inappropriate. In some cases the only option is to try and work with a patient on a voluntary basis and, if that proves unsuccessful, to monitor the situation until



the patient requires involuntary detention. However if a decision is made to work with a non-compliant patient then a written plan recognising the problems that will ensue and ways to manage the situation needs to be articulated.

The treatment outlined in the treatment plan under a CTO needs to have demonstrated efficacy when used properly by the patient. If the treatment is not effective it may be thought that the patient is not being compliant, when in fact the problem lies with the treatment.

The treatment plan must be such that the treatment can be delivered by the community care team, is sufficient for the patient's needs and necessary to maintain the patient's ability to live in the community. If the community care system is inadequate, the CTO may fail. Success depends as much on the efficiency of the mental health service as the cooperation of the patient.

If the style of community management is inappropriate or if the coercion used to ensure treatment is excessive, then patients may express their dissatisfaction by not cooperating with the conditions of the CTO. It is important for services to regularly review their practices to note whether some of those practices are alienating patients.

The treatment must be such that it can be monitored by the community team. Treatment plans that cannot be monitored undermine the purposes of the CTO and strain the relationship between the patient and the clinician. Examples of such ordered treatments as '*no alcohol consumption*' or '*no non-prescription medications*' may be impossible to monitor or enforce.

Administering treatment without consent to a patient detained in an authorised hospital can be, from a practical viewpoint, simpler than obtaining compliance from a person in the community. It may be

beneficial for the patient to receive treatment in the community, but the practicalities of administering the treatment may be so complex that a CTO may be inappropriate. For example, a person with a severe and enduring mental illness may require a CTO, as it would ensure treatment and prevent re-hospitalisation, but if the person leads an itinerant lifestyle and therefore finds it impossible to cooperate with the community team, a CTO may be too impractical to be a viable option.

The principle of the least restrictive alternative dictates that a CTO must be considered as an option before an order for involuntary detention is made (s.65), and at other times when decisions on patient care are being made.

CTOs cannot be made in respect of involuntary patients to whom s.25 (3) of the *Criminal Law (Mentally Impaired Accused) Act 1996* applies.

## 4.2 Making a CTO

There is a general power for a psychiatrist to make a person an involuntary patient on a CTO without a referral order [Form 1] being required. In those circumstances the CTO must be confirmed within 72 hours by another psychiatrist or if a psychiatrist is not readily available a medical practitioner.

A CTO can be made if the psychiatrist who examined the person is satisfied that (s.66):

- treatment in the community is achievable and not inconsistent with the objectives set out in s.26(1)(b);
- there is a psychiatrist who is willing and available to supervise the order (s.66(d));

- suitable arrangements can be made for care of the patient in the community including the availability of a suitably qualified medical practitioner or mental health practitioner to ensure that the patient receives the treatment as outlined in the CTO. This person is referred to as the 'responsible practitioner' or 'treating practitioner' (s.66 (b)(c)).

An issue that arises is that the criteria for detained involuntary status and a CTO are similar with the additional requirements of s. 66. Essentially the decision then is a qualitative one. A person meets all the s. 26 criteria, however the psychiatrist believes that treatment for the significant mental illness is amenable to treatment in a community setting. Likewise the possible harm to self or others is of a degree which can be managed in the community and does not require the restrictions of detained status. Furthermore, although the person is not consenting or is unable to consent to treatment there is enough cooperation between the community clinicians and patient to allow either attendance at the clinic or home visits. It further implies that the degree of resistance to treatment is not so great as to prevent treatment being administered in a community setting. However, this does not exclude CTOs being used with patients who are significantly non-compliant, although any management plan would need to reflect this difficulty.


The treating psychiatrist must be satisfied that there is a medical practitioner or mental health practitioner willing and able to ensure that the patient receives the treatment outlined in the order and a psychiatrist willing to supervise the order. This criteria has two consequences. Firstly it is not possible to ensure that there is a suitable medical or mental health practitioner or supervising psychiatrist unless there is communication and discussion between the treating psychiatrist and the community team. A patient should not be placed on a CTO unless such discussion has taken place and arrangements for supervision have been agreed.



Secondly the treatment outlined must be discussed and arranged with the community team, as a community clinic may not be able to deliver a specific treatment program proposed to be included in the CTO. For example, the psychiatrist may outline ECT on the treatment plan, however, most rural services would be unable to provide this treatment. No matter how well known a patient is to a community clinic it is imperative that contact is made and the issues discussed. Failure for those arrangements to be made may result in difficulties for the community team in offering a service and confusion for the patient, which may lead to an unintentional breach of the order. The basic tenet for the success of a CTO is ample discussion prior to the making of the order and agreement as to what is stated in the treatment plan on the Form 10. It should be noted that that the community team can if they wish re-negotiate the treatment plan. In those circumstances, the supervising psychiatrist may issue a variation order [Form 12] when the person commences under the care of the community team.

All patients whether voluntary or involuntary detained require a discharge plan which should include reasons why a CTO is being or not being considered prior to discharge. It is important that the treating team make a decision based on all the essential information such as severity of illness, past history, family or community support, previous treatment compliance and prognosis. Deciding a person should be made subject to a CTO should not be a last minute decision but a considered one based on previous experience, present assessment and future prognosis.

A psychiatrist, when considering whether a person should be made subject to a CTO, should discuss the issue with the patient. This is not only to ensure that the patient has an understanding of his or her obligations while on a CTO but also to elicit the patient's preferences in relation to treatment and follow-up.



Families and carers need to be involved and have a clear understanding not only about the obligations placed on the patient and the responsibilities placed on the community team but also recognition of the limitations of a CTO. Families may have unrealistic expectations about the extent of the supervision and the legal powers of the community team. It is important therefore to engage families and carers in the agreement between the patient and the community team. However, before consulting with families and carers, the treating team must first seek the consent of the patient as required by the MHA (s.206). When seeking the consent of the patient, the treating team should endeavour to ascertain the patient's preference with respect to what information may be or may not be disclosed. Patients have a right to confidentiality. If the patient categorically refuses to give consent for information to be disclosed to families or carers that right must be respected. However it is also important for the clinician to ascertain the reasons for the refusal, as it may be possible to negotiate some disclosure for the benefit of the patient and his or her carers.

There are four occasions when a CTO should be considered, however if a person can be treated on a voluntary basis then a CTO should not be made.

- a) in preference to a psychiatrist referring a person to an authorised hospital for further assessment after an initial examination by a psychiatrist in the community;
- b) in preference to making a person referred to an authorised hospital and examined by a psychiatrist, an involuntary detained patient;
- c) in preference to continued involuntary detention or discharging a person from hospital as a voluntary patient;

- d) in preference to the continued detention of an involuntary patient who is on leave of absence from the hospital, on the advice of a medical practitioner or AMHP (s.63 (2b)).

There are no time limits in the MHA between the psychiatrist examining a person and the making of the order. There is an expectation that as soon as the examination is completed and a decision made that the person will be placed on the CTO.

### **4.3 Terms of a CTO (s.68)**

Each CTO [Form 10] must specify the following:

- a) the name of a psychiatrist who will be responsible for supervising the order (this can be the psychiatrist who made the order);
- b) details of the treatment plan including where and when the treatment is to be given as well as other matters relating to the treatment that it is appropriate to specify. A patient on a CTO must be made aware of when and where treatment is to be administered, with a record of that notification kept in the patient's medical record<sup>1</sup>;
- c) the name of a medical practitioner (this can be the supervising or treating psychiatrist) or mental health practitioner who will be responsible for ensuring that the treatment plan is carried out;
- d) the time when the order will end, which cannot be longer than three months from the time the order was made.

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<sup>1</sup> In the Supreme Court decision in *EO v the MHRB*, Templeman J found that the CTO the subject of the appeal was defective as it did not comply with the provisions of s.68 specifically stating where and when treatment was to be given.

Particular effort should be made to ensure that the patient has an understanding of:

- a) why the CTO is being made;
- b) where the patient will be expected to attend for treatment, including when the first appointment is and the necessary steps that must be taken if it is not possible to attend. This information should be on the Form 10 and also on an appointment card;
- c) what is the treatment, expectations of the treatment, possible side effects, dose and frequency and where to go to for any queries about treatment;
- d) expectations with respect to adherence to treatment, including being available for regular review and monitoring by the community team;
- e) the proposed duration of the CTO, including information that the CTO can be extended;
- f) an explanation of the role of the supervising psychiatrist, including the power to revoke or vary a CTO;
- g) an explanation of the role of the responsible practitioner;
- h) an explanation of possible consequences of non-compliance;
- i) an explanation of possible consequences if the patient requires treatment as a detained involuntary patient;
- j) an explanation of rights such as second opinions, access to Forms, the right to MHRB review and the right to make a complaint to or seek advocacy from the COV.

The information will be in a form and language which will enable the patient to have as full an understanding as possible. The explanation given to the patient must be given orally and in writing (CTO pamphlet) or in any other form which the patient is used to communicating in (s.156). Use may be made of interpreters and the information pamphlets available in 15 community languages.

The responsibility for giving the explanation to the patient rests with the supervising psychiatrist (s.158 (1)(b)), however in most situations it is the treating psychiatrist who makes the detained patient subject to a CTO. It would therefore be appropriate for the treating psychiatrist to initially inform the patient about the CTO and his or her rights. A further explanation should also be given by the supervising psychiatrist once the person is in the community. The supervising (and treating) psychiatrist must make a note in the patient's clinical record that the explanation was given to the patient (s.158)

### 4.4 Treatment Plan

The treatment plan on the Form 10 must outline or give a summary of the treatment that the patient is to receive and where and when the treatment is to be given. The treatment plan could include information such as specific medication, as well as appointments in the clinic or in the patient's home. It should include information the clinician thinks it is important for the patient to know in order that they may understand the purpose of the CTO and be able to comply with treatment. The information given should not be restricted to that written on the Form 10. Other written or verbal information, appointment cards, pamphlets and medication specific information may also be given. A note should be made in the patient's medical record as to who gave the information and what was given.

The treatment plan must include details of where and when treatment is to be given particularly in relation to the first appointment as giving such details will ensure that the patient is fully aware of his or her obligations and cannot attribute non-attendance to the clinician's failure to notify him or her of appointments. CTOs which just state '*attend as required*' or words to that effect are not in keeping with the requirement that details must be provided of when and where the treatment outlined in the treatment plan is to be given.

## 4.5 Residency Condition

Psychiatric treatment is defined as ‘treatment for mental illness’<sup>2</sup>. This may include the provision of supervision and a safe place to live. If as part of his or her treatment it is necessary for the patient to reside in a particular safe environment where there is supervision then, although not specifically addressed, the MHA does not disallow a residency condition.

In particular cases where the issue of where the patient resides is relevant to their treatment or to their ability to function at a level which will continue to allow community living, then the community team could consider adding a residency clause in the treatment plan. If there is a degree of cooperation between the patient and the community team so that the patient can see the wisdom in residing in the place specified then imposing it as part of an order might be sufficient to sway the patient to comply.

However if the patient is adamant that he or she will not comply with the residency clause then the likelihood of the patient breaching the order is high and so the making of a CTO with such a clause should be reconsidered. If a residency clause is included when the patient refuses to comply, this may leave the community team with the only option of taking out breach proceedings. This action may serve no useful purpose and further alienate the patient. It is not practical to keep returning a patient to a particular place if he or she insists on leaving and the CTO does not allow compulsory residence in an alternative community setting.

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<sup>2</sup> Case of *MM v the MHRB* [1999] WASC 1005 (4 March 1999) Justice Scott agreed with the MHRBs findings that the patient was being treated for her mental illness, not only by anti-psychotic medication, but also by the provision of supervision and a safe environment in which to live.

If it is not appropriate to include a residency condition for a CTO then a Guardianship Order under the *Guardianship and Administration Act 1990* could be considered.


### 4.6 Compliance

Deciding how to manage a patient who is not consenting to treatment is a difficult clinical problem. The MHA states that treatment can be given without consent, however, the practicalities are certainly more complex. A patient may acquiesce when confronted with the possibilities of a breach order or re-admission to hospital. Persuasion is one of the many communication strategies a community clinician may use to obtain the patient's compliance with the CTO. However, maintaining a therapeutic relationship with the patient while at the same time attempting to coerce them to take medication may not be possible. Clearly it depends on the strength of the relationship, the stability of the patient and the skills of the community clinician.

Prior to making a decision to enforce compliance it should be noted that some patients may not comply with medication for a long time before it is apparent that there is deterioration arising from non-compliance, which is a requirement for issue of a breach order.

Medication is not the only intervention that keeps patients well and attention to other factors such as work, stable accommodation, counselling and supportive relationships may be effective for a considerable time.

Many non-compliant patients can be maintained in the community for a considerable time despite suffering from a mental illness. The alternative of revocation of the CTO and re-admission of the patient to an authorised hospital may be more damaging to the patient's health than if he or she was functioning at a lower level in the community.



Experienced community clinicians are able to use a variety of strategies, short of coercion, such as inducements to obtain the patient's compliance to the CTO. However, there are limits to these strategies and in the end the community clinic may be faced with the decision as to whether to enforce compliance in a community setting or seek revocation of the order and re-admission. Even this decision depends on a number of factors. Revocation and re-admission may be a relatively simple procedure in the metropolitan area but is more complex in relation to a patient in a rural or remote area of WA.

A comprehensive risk assessment needs to be made before implementing a decision to enforce compliance. The risk factors include safety for the clinicians, possible harm to the patient, the therapeutic relationship, and relatives and carers and the use of the least restrictive option by the mental health service.

A step by step plan which allows exploration of the different options, commits the service to trying a number of ways to entice a patient to comply and a decision as to what should be done if these methods are not successful needs to be considered. One of the positives of enforced treatment is that a delay in providing treatment may result in a greater risk to the patient or others and a more assertive approach in the present may be preferable to minimal intervention as the patient deteriorates.

If the risk assessment indicates that physical restraint will be necessary and it is essential for the patient to receive treatment then the preferred option is to revoke the CTO and if necessary using the police under a Transport Order take the patient to an authorised hospital for treatment. Restraint should only be used in the community in exceptional situations and when absolutely necessary. In these situations the circumstances must be fully documented in the patient's clinical record.



## **4.7 Time Limits**

CTOs can be made for a period of up to three (3) months, however the psychiatrist may state any lesser length of time. A specific date on which the CTO will cease must be stated on the Form 10.

The CTO commences from the time indicated on the Form 10 and lapses at the time also indicated on the Form, which cannot be past midnight on that day (eg the form may last from 10 am on 8 November to midnight on 8 February).


## **4.8 Directions for Reporting**

Directions for Reporting on the Form 10 (s.68(2)) notes that the CTO may include directions to the treating (responsible) practitioner or supervising psychiatrist as to reporting on the patient's progress. The treating psychiatrist who completed the Form 10 may continue to have an interest in the patient's progress and may request by completing this part of the Form to be updated on a regular basis. However the completion of this part of the Form is not obligatory.

## **4.9 Confirming a CTO**

A CTO when done under a general power to make a person subject to a CTO (s. 67) or made on any voluntary patient does not have effect unless within 72 hours the order is confirmed by another psychiatrist or if another psychiatrist is not readily available a medical practitioner.

Confirming a CTO is not required if the person is already a detained involuntary patient or a person referred under s.29 for examination by a psychiatrist. A CTO is confirmed by completing the reverse of Form 10 (s 69).



Confirming means providing validity for the correctness of a decision that a person should be made subject to a CTO. The MHA is silent on what is required and does not state whether a personal examination of the patient is essential. Good practice would indicate that the psychiatrist or medical practitioner confirming a CTO must have an understanding of why a CTO is being made and has discussed the issues with the psychiatrist and the patient. With a patient who is well known to the confirming practitioner the requirements may be less strenuous, however the confirming practitioner needs to understand that he or she is playing an important part in deciding whether a person becomes an involuntary patient.

In many cases the confirming practitioner will be either the General Practitioner or psychiatric registrar in the community and their decision acts like a filter ensuring that the least restrictive option is being used. If a confirming practitioner feels he or she is unable to confirm the CTO then contact must be made with the treating psychiatrist for the matter to be further discussed. Resolution of the situation depends on some agreement being reached between the psychiatrist and confirming practitioner. If agreement is not reached the MHA does not forbid the treating psychiatrist approaching another psychiatrist or medical practitioner to be the confirming practitioner, however this may be seen as a way to circumvent the protections for the patient under the MHA. In situations such as this detailed notes should be maintained in the patient's clinical record as the issue may be raised at a review by the MHRB. It would also be advisable to inform the Chief Psychiatrist.

## 4.10 Review

The supervising psychiatrist must examine the patient at least monthly and review whether the CTO should continue (s.75). If the patient no longer meets the criteria of s.26 of the MHA, the person must be discharged from involuntary status. The supervising psychiatrist must keep a record of each of the examinations in the patient's medical record.

If it is not possible for the supervising psychiatrist to fulfil the requirements of s. 75(1), then he or she may request that a medical practitioner, such as the patient's GP or a Registrar working in the clinic, examine the patient and provide a written report about the patient to the supervising psychiatrist. This request must be in writing and may specify requirements for the carrying out of the examination and the preparation of the report (s.77).

The requirement for monthly review is the minimum expectation under the MHA. Good clinical practice may include more frequent contact between the patient and the psychiatrist such as home visits or appointments in the community clinic. The MHA should not limit what the treating team views as important in the clinical care of the patient.

A failure to review the patient in accordance with the requirements of the MHA does not invalidate the CTO. The MHA is silent on the consequences of failing to conduct a review. However, the failure may be addressed at a review by the MHRB, regardless of whether the failure to review was the result of the patient failing to attend or the service not offering an appointment. The MHRB may decide to make the patient no longer an involuntary patient or maintain the order depending on the circumstances of the case and information from the patient or the service.

#### **4.11 Admission as a voluntary patient while on a CTO**

A patient on a CTO may either require admission or seek admission to a psychiatric hospital because of a relapse of their mental illness or to manage a crisis situation.

If a psychiatrist decides that inpatient status is required, in line with the principle of least restriction, voluntary admission should be offered. A patient subject to a CTO may become a voluntary patient in a psychiatric hospital and remain on the CTO. The psychiatrist cannot use the CTO to detain or give treatment without consent as the patient must be cared for on a voluntary basis. When discharged the patient will continue to be subject to the CTO.

If it appears that admission will be lengthy it would be appropriate for the treating team in discussion with the community clinic to consider revoking the CTO and making the patient no longer an involuntary patient.

If at any time while the patient is a voluntary patient in the hospital it is necessary to make the person an involuntary detained patient, the supervising psychiatrist should revoke the CTO and make the person an involuntary detained patient. If the supervising psychiatrist is not available then the head of service should make the person no longer involuntary (form 8) and a Form 1 completed by a Medical Practitioner or AMHP.

#### **4.12 Lapsing CTO**

A CTO lapses at the time indicated on the Form 10 or if the CTO is extended the Form 12. Although not required by the MHA it would be good practice that when a CTO lapses the patient should be informed that they are no longer an involuntary patient. The simplest way to do this is for the supervising psychiatrist to complete a Form 8 'Patient no longer an involuntary patient' and forward a copy to the patient.

#### **4.13 Extension of a CTO (s.76)**

The Form 10 notes when the CTO expires which cannot be longer than 3 months from the time it commenced. A CTO can then be extended beyond that time for any time up to another three months by completing a Form 12. After that second period the order lapses and if the patient needs to be on a CTO a new Form 10 must be completed which requires confirming.


A specific examination to decide that the CTO should be extended is not required. However, it would be preferable for the patient to be examined more recently than a month prior to extending a CTO. A Form 12 completed many weeks prior to the end of the CTO, although legally valid, is less likely to reflect the mental health status of the patient.

There may be situations, particularly in rural and remote areas where due to infrequent visits by a psychiatrist it may be necessary to complete a Form 12 some time before the Form 10 is due to lapse, but these situations should be rare and the reasons documented in the patient's medical record.

Any extension order completed after the Form 10 has lapsed is not valid. In those circumstances and if the patient needs to be on a CTO then it as though the patient is not subject to any order and all the requirements to make a new CTO as stated above apply.

Having received a copy of the extension [Form 12] the patient may, at any time during the remainder of the order, request in writing that the supervising psychiatrist obtain a second opinion from another psychiatrist as to whether the order should have been extended.

Having received the request it is the duty of the supervising psychiatrist to arrange for another psychiatrist to give an opinion. Although not specifically required by the MHA, it would be



expected that the second psychiatrist examine the patient in order to give a second opinion. In rural areas where a personal examination by another psychiatrist is not achievable within the timeframe, consideration should be given to an assessment by videoconferencing.

The second psychiatrist must provide his/her opinion within 14 days and confirm to the supervising psychiatrist and the patient that the CTO will continue. If the second psychiatrist does not confirm the extension of the order, or fails to provide his/her opinion within 14 days, the CTO lapses. If the patient fails to keep any appointment arranged with the psychiatrist providing the second opinion, then the extension is maintained.

The supervising psychiatrist must send a copy of the patient's request for a second opinion to the MHRB before the next date on which the MHRB carries out a review of the case. This will alert the MHRB to consider the issues raised by the request and second opinion. A copy of the request and the second opinion should be maintained on the patient's medical record.

#### **4.14 Variation of a CTO (s.79) [Form 12]**

It is possible for the supervising psychiatrist to vary the CTO in a number of ways at any time during the life of the order. Variations include changing the supervising psychiatrist or responsible practitioner or varying the terms of the order as detailed in the treatment plan on the Form 10. To vary the order the supervising psychiatrist must complete a Form 12 and give the patient a copy.

The supervising psychiatrist may transfer his or her responsibility of supervision to another psychiatrist. This may be necessary because the patient has moved to another catchment area or the psychiatrist

is leaving the service or because the psychiatrist is going on leave and during his or her time on leave another psychiatrist will manage the case.


If a supervising psychiatrist is unable to carry out his or her duties, for example because of sudden illness, but has not transferred the case to another psychiatrist the mental health service should contact the Office of the Chief Psychiatrist to arrange for the Chief Psychiatrist, acting in the role of the Supervising Psychiatrist, to transfer care to another supervising psychiatrist. The service should complete a Form 12 and fax it to the Office of the Chief Psychiatrist to enable this process.

There is no specific box on the Form 12 indicating where the name of the new supervising psychiatrist should be noted. However the box 'Transferee responsible practitioner' may be altered to indicate transfer to another supervising psychiatrist. The patient must be notified of any change of supervising psychiatrist by providing the patient a copy of the Form 12.

The supervising psychiatrist may transfer responsibility for ensuring that the treatment plan is carried out from the responsible practitioner to another medical or mental health practitioner willing to become the responsible practitioner and inform the patient of the transfer.

#### **4.15 Varying the treatment plan**

At any time the supervising psychiatrist may decide to vary the treatment plan, for example changing medication or prescribing a psychological intervention. These changes should be noted in the box '*Variation of the treatment plan*' on the Form 12 and a copy given to the patient.



The purpose of the variation order is to keep patients fully informed about their treatment obligations on the CTO and changes in the expectations of the mental health service. Failure to keep patients fully informed may result in the patient refusing treatment, the consequence of which might be a breach of the CTO.

A variation order may be completed under the MHA, however a judgement needs to be made by the clinician as to whether the significance of the change warrants a variation order or not. This depends on a number of factors including the extent of the change, the ways used to inform the patient, the rapport between clinician and patient and whether in the clinician's opinion a more formal process should be used. Certain patients, perhaps antagonistic towards the order may require a more formal process while others may appreciate a less formal method. Certainly changes in supervising staff require a variation order as will significant changes in the treatment plan or changes to the time and place of appointments. However less significant changes may not require a variation order though the patient must be informed and a note made in the patient's medical record.

If a supervising psychiatrist is away from a service for any period of time the CTO should be varied [Form 12] to make another psychiatrist the Supervising Psychiatrist. If this is not done and the CTO needs to be varied or revoked then the service should contact the Office of the Chief Psychiatrist and request that the Chief Psychiatrist sign a Variation Order to make another psychiatrist the Supervising Psychiatrist.



#### **4.16 Person discharged from involuntary status**

If the supervising psychiatrist on examining the patient believes that the patient does not meet s. 26 criteria to be an involuntary patient, then the psychiatrist is to order that the person is no longer an involuntary patient. The psychiatrist should complete a Form 8 (*Patient no longer an involuntary patient*). A copy of the Form must be given to the patient. A copy of the Form must be forwarded to the MHRB.

#### **4.17 Revocation of a CTO**

Revocation means the cancellation of the CTO by the completion of a Form 11 '*Revocation of a CTO*'.

##### **4.17.1 Revocation without making an order for admission**

The supervising psychiatrist may revoke a CTO making the person no longer an involuntary patient because it no longer appears that the requirements of s. 66 are satisfied. In this case the supervising psychiatrist is not stating that the CTO is being revoked because the patient no longer fulfils the criteria of s. 26. It may well be that the patient is still unwell enough to need a CTO, however for other reasons a CTO is no longer considered a valid option.

These situations could include –

- that a supervising psychiatrist or responsible practitioner is no longer able to provide a service as the patient is moving into a non-accessible remote area; or
- the patient has moved interstate or overseas and although still mentally unwell is out of the jurisdiction of the WA MHA; or
- the patient although still requiring treatment in the community is living such an itinerant lifestyle that it is not possible for mental health clinicians to offer an active community service; or

- the patient on a CTO is made subject to a Custody Order under s. 25 of the *Criminal Law (Mentally Impaired Accused) Act 1996* and admitted to an authorised hospital as an involuntary patient.

The supervising psychiatrist completes a Form 11, and ticks box 1 in the section '*Reasons for revocation*' and box 1 in the section '*Revocation of order*'. A copy of the Form must be given to the patient and a copy forwarded to the MHRB.

#### **4.17.2 Revocation with making an order for admission**

The supervising psychiatrist may revoke a CTO and make an order that the person be admitted to and detained in an authorised hospital if the patient becomes so unwell that community care is no longer an option.

The supervising psychiatrist may also revoke the CTO if the patient has failed to do anything required to be done under the CTO. For example if the patient fails to comply with the treatment plan or fails to attend when directed. Although the supervising psychiatrist has this power, good practice would indicate that inappropriate or ill-considered use of this power could lead to damaged relationships and a poor outcome for future community care. Alternatives such as development of a contract with the patient or even use of the breach order should be options considered before ordering a patient back into hospital because they have failed to comply with a condition of the order.

Nevertheless if a patient persistently refuses to comply with the conditions of the order and other alternatives have been explored without success, then despite the fact that the patient might not have relapsed, they may be admitted and detained in an authorised hospital. Given the number of community options and procedure of securing a bed for a patient who perhaps is not unwell enough to

require detained status, this power should be infrequently used and part of a care plan rather than an unconsidered reaction to non-compliance.

The supervising psychiatrist should complete a Form 11 and tick box 2 in the section '*Revocation of order*'. A copy must be given to the patient and the patient should be advised of his or her legal status and rights. There is no time limit for a Revocation to be enacted however good practice would be that action on the order should commence as soon as is practicable.


The period of detention in the authorised hospital is for a period of up to 28 days and the date detention ends must be specified on the Form 11.

The supervising psychiatrist may also revoke a CTO ordering the person to be admitted and detained in an authorised hospital if the patient has failed to attend as directed under an Order to Attend [Form 14].

If it is necessary to involve the police in transportation of the patient, the psychiatrist can complete a Transport Order [Form 3] (s.71). The police, given such an order, should apprehend the patient as soon as is practicable (which must be within 72 hours or the Transport Order lapses) and convey him or her to hospital (s.72).

If the supervising psychiatrist is not available to revoke the order, a psychiatrist in charge of a mental health service may revoke the CTO by completing a Form 8. This orders that the person is no longer is an involuntary patient. A Form 1, referring the person to an authorised hospital, may then be completed by a medical practitioner or AMHP.

Although this process appears protracted, it reduces the possibility of inappropriate re-admission, as it is the medical or authorised mental health practitioner with the patient who makes the decision



to refer the person to an authorised hospital. Furthermore, in relation to patient's human rights, it is preferable that a psychiatrist examine the patient in an authorised hospital and decide whether detention is appropriate rather than relegating that decision to a psychiatrist who may have limited knowledge of the patient and has not conducted an examination.

At times a Form 1 is used to refer a person to an authorised hospital when that person is already an involuntary patient on a CTO. It is only later, when the patient has been admitted to hospital, that it is discovered that he or she is subject to a CTO. In such circumstances it is good practice to contact the supervising psychiatrist and discuss the referral with him or her. In order to facilitate the admission process which may already have been completed, it would be appropriate for the supervising psychiatrist to make retrospectively the person no longer involuntary by completion of a Form 8, to enable the Form 1 or 6 to be valid, and inform the MHRB.

#### **4.18 Breach and Order to Attend (s.80-84)** **[Forms 13 & 14]**

At times patients will not comply with treatment on a CTO, or fail to attend as directed. This may be due to the patient becoming unwell again or for social and personal reasons the patient does not wish to comply. CTOs may be seen as an undue imposition by some patients and a reluctance to cooperate might arise from either the patient feeling that he or she is now well and does not require further treatment or a general negativity towards the treatment and the mental health system. Patients previously treated on a voluntary basis may feel aggrieved at involuntary status. Clinicians sometimes underestimate the stigma attached to the label “mental illness” and that the patient's reluctance to comply may arise from very genuine feelings of disillusionment and disempowerment rather than recalcitrance.


It is likely that commencing the breach process, even if successful will result in either temporary or permanent damage to the therapeutic relationship. Breach proceedings should only be used when all other options have been exhausted and it is imperative that the patient receives treatment or the consequences will be detained status in an authorised hospital.

The breach process is one way to persuade compliance without having to re-admit the patient. It should not be a first step if a patient is non-compliant. Rather it is a process whereby the community team attempt to cajole or entice a positive outcome, encouraging cooperation from the patient. One view of a breach, particularly from the patient's perspective, is that it is a threat. However if the process is handled with sensitivity a constructive conclusion may result.

There are two outcomes when a patient is breached. The first is that the patient decides to comply, in which case the CTO continues. However, this may be an opportunity to amend the treatment plan or directions for attendance in order to engender a greater degree of cooperation in the future. The second outcome is that the patient continues not to comply, which requires further decisions about the CTO to be made.

The following three components are necessary to constitute a breach and if any of them are not met then breach proceedings should not be progressed. The reasons for breach proceedings must be documented in the patient's medical record (s.81).

**Component 1:** The patient does not comply with the order in some respect. Either the patient does not comply with the treatment plan or fails to attend for appointments. The clinician must be certain that the patient's non-compliance is on purpose rather than just misunderstandings or miscommunication. The patient may have valid reasons for non-compliance such as distress from side-effects or



being unclear about the expectations placed on them while on a CTO. These reasons need to be fully explored before embarking on the breach process.

**Component 2:** The supervising psychiatrist believes that all reasonable steps have been taken to obtain compliance without success. What is reasonable is not defined and depends on policy and practice in the clinic, the relationship between the clinician and the patient and the history of the patient. Clinics should have procedural guidelines in how non-compliance should be dealt with. A graded system of letters and visits, being very specific with regard to appointments and yet giving the patient the opportunity to comply should be part of any guidelines.


If non-compliance or non-attendance is the result of a deteriorating relationship between the clinician and the patient then that relationship should be managed as part of any breach process. The history of the patient will also indicate future behaviour and just as the original treatment plan is structured on previous experience, breach procedures should also be shaped by the clinic's previous experience in working with the patient.

**Component 3:** The supervising psychiatrist believes there is a significant risk of the condition of the person deteriorating arising from the non-compliance. Knowledge of the patient's treatment history is important as well as information regarding personal and social problems that may be significant. Certainly clinicians would be justified in acting earlier if the patient's history indicated violence to self or others when becoming unwell. However a balance should be sought between the potential for harm to self or others when unwell with allowing the patient to function in the community even at a lower capacity.

If a patient breaches a CTO, the supervising psychiatrist has the capacity to immediately revoke that CTO [Form 11] (s.70). Alternatively, the breach provisions, as outlined below, may be followed.

If a breach of the order occurs, the supervising psychiatrist must make a written record of the breach [Form 13], stating exactly why the patient is believed to have breached the order. Unless it is impracticable to do so, he or she must also give the patient notice of the breach by providing them a copy of the form (s.81). The MHA does not detail the manner of giving the patient the notice of the breach, however using Australia Post, hand delivery, or through relatives or carers are all methods which may be used. Even a phone call indicating that breach proceedings have commenced will make the patient aware of the situation, though any phone call should be followed up by giving the patient a copy of the Form. Every effort must be made to inform the patient, as he or she may be unaware of the legal process being used which may result in them being re-admitted to hospital. The purpose of the Breach Order is to give the patient an opportunity to comply with the order, and the patient be given sufficient time to comply.

Most clinicians are aware of the best way to manage a patient and a decision about the method used to inform the patient needs to be made in light of what is known about the patient, particularly as to whether he or she may use the issue of the notice as a way of challenging the authority of the legislation. Informing the patient may be impractical if the patient has left his or her place of residence without informing any person of a forwarding address. Because patients have freedom of movement in the community it may require repeated attempts by clinic staff before a patient receives the copy of the Form.



The breach order informs the patient that continued non-compliance with the order may result in the patient having to attend at a specific place to receive treatment. The details of the warning are spelled out clearly on the reverse of the Form. When giving the patient a copy of the Form 13 it would be good practice to emphasise the warning on the back and inform the patient how they could avoid the consequences of ignoring a breach. If the issue is non-compliance then an arrangement should be offered so that the patient receives their treatment. If the issue is non-attendance, a further appointment should be arranged in order for the CTO to be reviewed.

However, if the supervising psychiatrist is not satisfied that the patient has complied with the order, he or she can make an Order to Attend [Form 14] at a time and place specified, so the patient may receive treatment (s.81). This notice must be in writing, must be given to the patient and must include the warning that failure to attend may result in the police being involved to ensure attendance. This process enables the psychiatrist to inform the patient of his or her non-compliance and gives the patient an opportunity to comply before any decision is made about treatment. If the patient fails to comply with the Order to Attend the supervising psychiatrist has a number of options.

The supervising psychiatrist may choose to take no immediate action, continue to monitor the situation and see if the patient re-establishes contact voluntarily. As part of continuous monitoring, incentives such as a change of medication may be attempted in order to induce the patient to return to treatment. However the supervising psychiatrist does have a responsibility in ensuring the safety of the patient and others and taking no immediate action may lead to further problems for the patient, the family or the community.



Alternatively the supervising psychiatrist may decide to revoke the CTO and make the patient no longer an involuntary patient on the basis that it is not possible to meet the requirements under s. 66. The implication here is that suitable arrangements cannot be made for the continued care of the patient in the community but the patient does not require admission to an authorised hospital. For example there maybe a patient who does not pose a severe threat to self or others in the community yet would benefit from a CTO and is therefore made subject to one. However the difficulties for the community clinic posed by the lifestyle of the patient make it extremely difficult to offer an appropriate level of community care. In these circumstances the supervising psychiatrist may issue a breach order and an order to attend but not feel it is appropriate to take the matter further. As mentioned previously there are limits to what a CTO can achieve and in some cases it may be sensible for the patient and the community clinic for the patient not to be on an order even though a clinical assessment could indicate that it could be a valid option.

The supervising psychiatrist may decide to make the patient comply with the *Order to Attend* and using community staff and/or the police get the patient to the specified place for treatment. A Transport Order (Form 3) authorises the police to apprehend the patient and take him or her for treatment as specified in the *Order to Attend*. The psychiatrist should complete the box 'Special factors or other important details' in the Transport Order indicating where and when the police should take the patient for his or her treatment.

It is expected that community staff will work together with the police in this operation and that police are there to assist rather than be expected to act on their own initiative. However, the police are responsible for the apprehension and transport of the patient. The patient must be given a copy of the Form 3. The patient is to be taken to the place specified for treatment as close as is practicable to a

time when the treatment can be given. The patient may be detained by the police at the place under the order until treatment is given.

This process results in the patient receiving treatment without revoking the order. After the treatment is given the patient is allowed to go home and continues on the CTO.

The MHA does not prevent an *Order to Attend* from specifying the patient's home as the place at which the patient must attend to receive treatment. However clinicians should be aware of the physical risks to the clinician, the patient and others such as relatives posed in enforcing treatment in a patient's home. There may be occasions, such as in rural areas, where treatment in the patient's home may be appropriate, but overall it is advisable to use a treatment venue away from the patient's home such as a clinic or hospital. A copy of the order must be forwarded to the MHRB.

Alternatively the supervising psychiatrist may decide to revoke the CTO and order that the patient be detained in an authorised hospital as an involuntary patient as detailed above.

#### **4.19 Patient's Rights**

Although patients on CTOs are involuntary, they are living in the community and should be involved in their treatment plans. Clinicians should be aware when making appointments and times for reviews that patients may be working or occupied in other ways during the day. Although there is an expectation that patients will comply there is also an obligation on services to work together with patients so that arrangements are made which suit both parties. Clinicians should be aware of the costs in terms of finance and time for patients when advocating for a treatment programme of daily attendance. Unreasonable demands by services may inevitably lead to non-compliance and the ultimate aim of CTOs should be borne


in mind, which is that patients are maintained in reasonable mental health while living in the community.

Patients on a CTO have the right for an explanation of how the CTO will affect them, their obligations and the services responsibilities. Clinicians must give an explanation, verbally and in writing which must be in the language spoken by the person. Any explanation must be recorded in the patient's medical record (s.156). This extends to relatives and carers.

Patients on CTOs can request a review of their status from the MHRB or they will be reviewed on a mandatory basis before eight weeks of being made an involuntary patient and then every six months. If a new CTO is made after the period of extension then the time period for the next review will be within eight weeks unless the new CTO is made within seven (7) days of the old CTO lapsing, in which case the review will be six (6) months from the last review.

MHRB reviews of CTOs usually occur either at the community clinic, or by teleconferencing for patients who live in the rural areas. Patients have a right to be represented and a representation service is offered by the Mental Health Law Centre. Patients may also seek assistance with the making and presentation of an application to the MHRB from the COV.

The supervising psychiatrist is expected to prepare and forward to the MHRB a report, indicating why he or she believes that the involuntary status should be maintained. A report from the responsible practitioner as to the patient's progress on the CTO is also informative. It is expected and the MHRB's preference for the supervising psychiatrist to be present at the review. If that is not possible a representative from the community mental health service should attend to answer questions from the MHRB and the patient. The patient is also expected to attend, particularly if the review has



been requested by the patient, however the patient may choose not to attend and the review will still continue.

The MHRB may at any time carry out a review if it considers it appropriate to do so. For example, they may while continuing the involuntary status, request further information or a report and schedule a further review.

Patients on CTOs may seek advocacy services from an Official Visitor. The role of the COV is to provide individual advocacy and attempt to resolve any complaints. Community staff may be approached by an Official Visitor on behalf of a patient to discuss any complaint and community staff are expected to cooperate with the COV in resolving the complaint. In investigating any complaint the COV have the right to make inquiries relating to the care and treatment of the patient and, unless the patient objects, inspect any medical records or other documents in relation to the patient. An Official Visitor should ensure that the patient has been informed of his or her right to object to the inspection of his or her medical records.

The COV have a duty to inspect premises such as licensed psychiatric hostels where patients on CTOs may be living and report to the Chief Psychiatrist or the Minister for Mental Health. A patient on a CTO living in a licensed psychiatric hostel has the right to request a visit by an Official Visitor which should be organised by the person in charge of the premises.

#### **4.20 Death of a patient while on a CTO**

The death of any involuntary patient, including a patient on a CTO, must be reported to the WA State Coroner. It is also policy to report to the Chief Psychiatrist, who has a responsibility for the medical care and welfare of all involuntary patients, the death of any patient on a CTO.


#### **4.21 CTO Patients Leaving Western Australia**

A patient on a CTO is able to leave Western Australia as the order cannot detain a person in this State. If the supervising psychiatrist suspects that a patient is thinking about leaving the State, he or she may make a condition as part of the treatment plan that the mental health service is informed so that suitable arrangements for treatment can be made in another State or overseas. However it is not possible for a supervising psychiatrist to make a direction that a patient is not allowed to leave the state if he or she so wishes. This would be viewed as a curtailment on a person's freedom and human rights.

Should a patient travel interstate or overseas, the supervising psychiatrist should review the options available. If it is known that the patient is likely to return during the term of the CTO and would need to continue to be on an order then it may be appropriate to continue with the CTO. However, the patient's medical record should reflect this decision, as it is likely that expectations of review will not be met. Alternatively, if it is unlikely that the patient will return or that treatment can be continued in the State, the supervising psychiatrist may revoke the order and the patient is no longer an involuntary patient (ss 66 and 70).

#### **4.22 Guardianship and Administration**

At times a person on a CTO might also have an appointed Guardian. Clinicians may at times consider the alternative of Guardianship when considering a CTO and the decision whether to apply for a CTO or Guardianship can at times be problematic. The following is basic information about Guardianship and the Office of the Public Advocate. For further information contact the Guardianship Board or the Office of the Public Advocate directly.



The Guardianship system is established through the *Guardianship and Administration Act 1990* (GAA) to protect the best interests of adults who are unable to or incapable of making reasonable judgments in respect of matters relating to them. The decision-making disability may occur because of dementia, mental illness, intellectual disability or acquired brain injury.

The GAA allows for the appointment of a substitute decision-maker in relation to day to day and long term care, welfare and development of the person, including the person's living arrangements, nature of work and provision of consent to treatment and health care decisions (called a Guardian) or financial decisions (called an Administrator) on behalf of the person.

The Public Advocate is an independent statutory officer appointed under the GAA to provide assistance to any person in respect of whom an application or order has been made. The Public Advocate's role is also to provide information and advice to a proposed guardian or administrator, to investigate allegations and complaints about the need for or the appropriateness of a guardianship or administration order and to arrange legal representation for a person under an order or in respect of whom an application for an order has been made. The Public Advocate takes on the role of Guardian for a person under a guardianship or administration order when the Guardianship and Administration Board finds no one else is suitable or willing to act as Guardian.

The GAA contains six principles that must be taken into account before making any order to appoint a substitute decision-maker. These principles include the presumption of competence, the best interest of the person, the least restrictive alternative, whether a limited or plenary order is required, the current wishes of the person and any previous actions.

Guardians can be given plenary or limited powers. These may include one or more of the following:

- a) where the represented person is to live, whether permanently or temporarily;
- b) with whom the represented person is to live;
- c) with whom the represented person is to associate;
- d) consent to any treatment or health care;
- e) whether the represented person should work, the nature or type of work, who the person should work for and other matters related to work, education and training;
- f) matters relating to legal proceedings, acting as a guardian ad litem or legal next friend.

Guardianship may also include the following:

- a) in the case of medical treatment s119 (3) of the GAA describes a hierarchy of persons, who must have a close personal relationship with the person, who can consent to medical treatment in specified circumstances without need for a Guardianship order to be made;
- b) if the person is an involuntary detained patient in an authorised hospital s110 of the *Mental Health Act 1996* can apply to non-psychiatric medical treatment.

## Chapter 5 Mental Health Review Board

Principle 17 of the UN document *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* requires that involuntary detention be reviewed at reasonable intervals by a body that is judicial or otherwise independent, assisted by independent specialist medical practitioners. The principle also requires that the review body's procedures be simple and expeditious and that there be a right of appeal to a higher court against a decision. With the establishment of the Mental Health Review Board (MHRB), the MHA meets this principle.

### 5.1 Establishment and Membership

The Governor of Western Australia, on the recommendation of the Minister for Mental Health, appoints members of the MHRB (s.125). The MHRB at a hearing comprise a three-person panel. Each panel consists of a psychiatrist, a legal practitioner and a person who is neither a medical nor a legal practitioner and referred to as a community member (s.126). Membership of the MHRB is for a period of up to three years, with members eligible for re-appointment. The Governor of Western Australia may from time to time add or remove persons from the panel. Non-public-service MHRB members receive remuneration for their work.

### 5.2 Duties of the MHRB (s.22-25)

The Registrar to the MHRB keeps particulars of every involuntary patient, organises the reviews and keeps a record of all review outcomes. The MHRB may delegate to the Registrar any function under the MHA that the Regulations provide may be delegated.



### 5.3 Periodic Review

All involuntary patients, whether detained or subject to a CTO, must be reviewed by the MHRB within eight weeks of them becoming an involuntary patient, unless a review has already been requested by or on behalf of the patient (ss.138 and 142).

If a person is made an involuntary patient again within seven days of the discharge of an involuntary order, his or her status with regard to reviews is considered that of continuous involuntary status (s.140). The time between periodic reviews must not be longer than six months (s.139). The MHRB may conduct a review at any time (s.144).

### 5.4 Request for Review

A request for review may be made in writing by a patient, an Official Visitor or another person whom the MHRB is satisfied has a genuine concern for the patient (s.142). Once the MHRB commences its review it has the power to suspend the operation of an order or prevent any further action being taken until the application has been determined or the review concluded (s.143). The MHRB information pamphlet includes an application form for a requested review. Official Visitors may assist an involuntary patient with their application for a review.

### 5.5 Powers of the MHRB

The MHRB may:

- determine any matter coming before it for consideration and make any order in respect of a matter that it considers appropriate (s.145);
- order that a person is no longer an involuntary patient, either detained in an authorised hospital or on a CTO;

- order that a CTO be made in respect of an involuntary detained patient, giving such directions as it thinks fit, or, if the patient is already subject to a CTO, vary the order and give such directions as it feels fit (s.142);
- order that a involuntary patient detained in an authorised hospital be transferred to another authorised hospital;
- order that the care of a patient on a CTO, such as supervision and treatment, be transferred to another supervising psychiatrist;
- order that, where ECT is recommended for an involuntary patient and the second psychiatrist does not concur with that recommendation, resulting in a referral to the MHRB, the MHRB may recommend alternative treatment, transfer or discharge from the order;
- inquire into complaints in relation to any failure to recognise the rights of involuntary patients or other administrative matters (alternative avenues of complaint, such as the COV or the Chief Psychiatrist, may be accessed for other matters (s.9 and 146));
- review the case of any involuntary patient based on any report or complaint the MHRB may have received (s.144); and
- be ordered by the Minister for Health to make any inquiry and report back to the Minister (s.147 and 148).

In making its determinations the MHRB is expected to consider the psychiatric condition of the person concerned, as well as any medical or psychiatric history and social circumstances deemed relevant (s.137).


## 5.6 Procedures

All three MHRB panel members must be present at a review in order to constitute a quorum and, in the absence of the President, the legal representative presides (s.132). When decisions are made, at least two of the three members of the review panel must be in agreement. Telephone and/or audiovisual link-up are permissible, provided all participants in the proceedings can communicate with each other instantaneously at all times (s.133).

Patients will be given notice of a review, including details of the time and place (schedule 2.1(1)). If a patient fails to attend, the MHRB may conduct the proceedings in his or her absence (schedule 2.1(2)). There is a right to be heard and the MHRB will give all parties an opportunity to call evidence, cross-examine witnesses and make submissions (schedule 2.2). The MHRB has the power to compel attendance by any person, or the production of documents (schedule 2.4). Further, it may retain and photocopy any documents (schedule 2.4 (1)(b)).

The MHRB can require that a person swear (or affirm) to be truthful and also that any person answer when questioned. While there is no privilege against self-incrimination, any answer given or document produced is inadmissible as evidence against any person in any civil or criminal proceedings, other than in cases of perjury. Therefore, there should be no barrier to answering any questions (schedule 2.5). The MHRB may consider evidence from other proceedings and make decisions on the basis of that evidence (schedule 2.6).

The MHRB is not bound by the rules of evidence and it is expected that sessions will be informal. However, the MHRB is expected to act according to equity and good conscience, and be more concerned with the merits of a case than any legal technicalities (schedule 2.7 and 2.8). The MHRB has the power to dismiss proceedings instituted



for frivolous or vexatious reasons and can impose fines by way of compensation to any wronged parties (schedule 2.9). Subject to the MHA, the MHRB is to determine its own procedures (s.132 (2)).

## **5.7 Representation**

A patient may appear in person before the MHRB unless the MHRB considers it detrimental to the health of that patient, in which case it can order representation. Patients can be represented by legal counsel or, with the MHRB's permission, anyone else. With the patient's permission the MHRB can arrange representation. If the person who represents the patient is not a certified legal practitioner, he or she is not entitled to a fee. Demanding a fee in such circumstances is an offence punishable by a fine of \$1000 (schedule 2.3). Costs incurred by the parties are their own responsibility (schedule 2.10). The Mental Health Law Centre is funded to assist involuntary patients at review (see contacts list). Legal representatives who are willing to sign an Undertaking form, agreeing not to disclose information subject to section 161 of the MHA, can be provided with the patient's entire medical record without restriction.

## **5.8 Proceedings**

All MHRB proceedings are closed to all, apart from those with an interest, such as the patient, his or her representative and representatives of the treating team, unless otherwise ordered by the MHRB. The MHRB may allow certain people such as relatives or carers to be present, and can allow part opening of the proceedings.

It is an offence not to attend upon a summons without reasonable excuse, fail to supply requested documents, fail to answer any questions, give false or misleading information, misbehave or willfully insult a MHRB member or interrupt the proceedings (schedule 2.11).

A recording of all proceedings is made (schedule 2.14). Any person taking part in the proceedings can request in writing within 14 days of the MHRB's decision the reasons for its decision. The reasons are to be expressed in a manner and language that enable all participants to understand the decision (schedule 2.15).

Decisions must be in writing and signed by each MHRB member (s.134). Anyone failing to act on a decision of the MHRB is liable to a fine of \$2000 or six months imprisonment (schedule 2.16).

## **5.9 Clinician's Responsibilities**

The treating or supervising psychiatrist is informed of a review at the same time as the patient. It is expected that a report will be provided which should include why the patient needs to remain an involuntary patient. At times when there are frequent reviews an update report may be sufficient to inform the MHRB. The report should be written in such a way that it can be provided to the patient and his or her legal representative. It would be preferable for the report to be made available prior to the review.

The psychiatrist in charge of the care of the patient, or if the psychiatrist is not available a member of the treating team should be present at the review to answer questions and update the panel. The patient's medical record should be made available for the panel at review.

Clinicians should be aware that some patients have high expectations of being made no longer involuntary at review and when this does not occur can be distressed and at times angry. It would be good practice to prepare for this occurrence in order to reduce any potential behavioral disturbance.

## 5.10 Appeals

If dissatisfied with the MHRB's decision, patients or other interested parties have the right to appeal to the State Administrative Tribunal (SAT) (s. 148A) and if they remain dissatisfied to the Supreme Court (s.149). A person who remains dissatisfied after a MHRB decision may apply to the SAT without payment of any fee. This right is extended to any other person who in the opinion of the SAT has sufficient interest in the matter.

A person who remains dissatisfied following an appeal to SAT may apply to the Supreme Court. Grounds for appeal are that the SAT made an error in law and/or in fact or acted outside or in excess of its jurisdiction, or that there are other sufficient reasons (s.150).

An appeal must be brought within one month of the SAT's decision, unless the SAT or the court is satisfied that it is just and reasonable to extend this period (s.151). The patient must be represented by a legal practitioner at an appeal (s.152). While the appeal is pending, the court may suspend any decision of the MHRB and revoke any suspension (s.153). The Appeal Court can confirm, vary or quash any MHRB decision, make another decision or remit the matter back to the MHRB for further review (s.154).

The MHRB has published a *Handbook*, which gives details of its operations. For copies of the handbook, contact the MHRB (see contacts details).

Information on the MHRB can also be obtained at the MHRB website on [www.mhrbwa.org](http://www.mhrbwa.org). The MHRB is collocated with the SAT.

## Chapter 6 Council of Official Visitors (COV)

Members of the COV are known as Official Visitors, and are concerned with 'affected persons'. These people include involuntary patients, mentally impaired accused in authorised hospitals and those who are socially dependent and reside in private licensed psychiatric hostels. The work of Official Visitors includes patient advocacy, listening to and resolving complaints and assisting in the preparation and presentation of the patient's position at a MHRB review. They also visit and inspect authorised hospitals and private licensed psychiatric hostels.

### 6.1 Establishment, Membership and Administration

The Minister for Mental Health (the 'Minister') appoints from the general community a number of Official Visitors who are not required to have any specific experience and qualifications, though they will be expected to have some experience or qualifications relevant to their appointment. The COV has a Head and an Executive Officer (s.177).

People who have an interest or association with a particular mental health organisation or service may be Official Visitors even though they may have a disqualifying interest. When an Official Visitor has a disqualifying interest such as a financial interest in an organisation or has a close association with the affected person then they are unable to act as an Official Visitor in regard to those specific organisations or services (s.178 & schedule 3). Appointments as Official Visitors are for a period of up to three years and are eligible for re-appointment (s.179).

An Official Visitor may resign at any time or they may be dismissed by the Minister if they are incapable of performing their duties due to mental or physical problems, or if they neglect their duties, or for misconduct (s.179). Official Visitors who are not employed in the public sector are entitled to remuneration, which has been determined by the Minister (s.180).

An Executive Officer and other staff administer the duties of the COV.

## **6.2 Functions of the Council of Official Visitors (s.175)**

The duties of Official Visitors include visiting authorised hospitals at least once a month, visiting other places such as hostels or group homes as directed by the Minister, reporting to the Minister as required, and visiting an affected person as soon as practicable after a request is received. The request for a visit by an Official Visitor can be made through the person in charge of the hospital, hostel or group home or made directly to the Executive Officer of the COV (s.186-189). Either an Official Visitor or a 'panel' may perform the above duties. A panel is at least two people appointed by the COV, at least one being an Official Visitor (s.187).

Functions of the Official Visitor include:

- ensuring that affected persons have been informed of their rights;
- ensuring that the rights of affected persons are observed;
- ensuring that places where affected persons are detained or cared for are inspected to ascertain that they are suitable and safe;
- hearing complaints from affected persons, their guardians or relatives;
- enquiring into and resolving complaints;
- referring matters to another person such as the Chief Psychiatrist or other body such as the MHRB as necessary;



- assisting with the making and presentation of applications or appeals to the MHRB, or where authorised by the MHA, make any such application.

### **6.3 Powers of an Official Visitor (s.190)**

The powers listed below do not apply to mentally impaired persons detained in prison. The powers of an Official Visitor are as follows:

- to visit even if no notice is given;
- the visit can be at any time and for any length of time;
- during the visit inspect any part of the establishment;
- during the visit see any affected person who has not declined to be seen (an affected person does have the right to decline to be seen);
- during the visit make enquires regarding admissions, detention, care, treatment and control;
- inspect any medical or other records, though the affected person has the right to deny an Official Visitor access to their personal medical records Refer: Operational Directive 0249 09 COV access to personal records.

### **6.4 Expectations of Staff**

Staff are expected to assist the Official Visitor in exercising any of their powers and answer any queries that they may have.

### **6.5 Offences (s.191)**

Any person who fails to answer an inquiry without a reasonable excuse, makes false or misleading statements, fails to assist an Official Visitor, willfully insults an Official Visitor or panel member or obstructs the carrying out of Official Visitors' functions is liable to a fine of \$2000.

## **6.6 Reports (s.192)**

An Official Visitor or person on a panel may report any matter to the Minister or Chief Psychiatrist for consideration. The Minister may request a report from an Official Visitor or member of a panel. The Head of the COV prepares for the Minister an annual report, which is laid before Parliament.

The pamphlet giving further information about the COV is obtainable from the Executive Director of the COV (see contact list).

## Chapter 7 Police Powers


In the community, it is often the police who have initial contact with people suffering from a mental illness and whose behaviour is putting themselves or others at risk. The MHA recognises the necessity of enabling the police to take action where appropriate and to divert such people through the health rather than the judicial system.

### 7.1 Taking a Person into Protective Custody

The police may take into protective custody anyone they suspect has a mental illness and needs to be apprehended to protect the health and safety of that person or others, or to prevent serious damage to property (s.195).

In apprehending a person they can enter any premises where the person is suspected on reasonable grounds to be. They can search the person and seize anything in his or her possession that is likely to prejudice the health and safety of any parties or cause damage to any property (s.197). Police officers are also entitled to seize anything they believe is likely to assist in determining questions that may arise from the apprehension of the person such as a weapon or medication which may be used to inflict harm to self or others (s.198). Anything seized may be held for as long as is necessary, depending on why it was seized and later returned or dealt with according to the law (s.199).

Once the person has been apprehended, the police must arrange as soon as is practicable for that person to be examined by a medical practitioner or AMHP, who may refer the person for examination by a psychiatrist. In these circumstances the person has not been arrested but only apprehended.



The assessment by the medical practitioner or AMHP can be conducted in the place the person was apprehended, for example in the person's home, though usually it is an Emergency Department. It should not be an automatic practice for the police to take the person to an authorised hospital for assessment. Alternatively they may take the person to a place in the community such as a Community Mental Health Centre, a doctors' surgery, or a police station.

## **7.2 Dealing with an Arrested Person – Option 1**

Having arrested a person and suspecting on reasonable grounds that he or she has a mental illness requiring immediate treatment, the police must, as soon as is practicable, arrange for that person to be examined by a medical practitioner or AMHP. The medical practitioner or AMHP may then refer the person for examination by a psychiatrist (s.29) or decide not to refer him or her, whereupon the person remains the responsibility of the police (s.196).

If a referral is made that results in the person being detained as an involuntary patient in an authorised hospital, the arrest is suspended until that person is released from detention. At that time he or she must be released into the custody of the police (s.55).

## **7.3 Dealing with an Arrested Person – Option 2**

Having arrested a person the police may take that person before a judicial officer, who has the power, if he or she suspects on reasonable grounds that the person has a mental illness requiring treatment, to make a 'hospital order' (s.5 of the *Criminal Law (Mentally Impaired Accused) Act 1996*) or grant bail (Bail Act 1982), with a condition that the accused be examined by a medical practitioner or AMHP for the purpose of deciding whether to make a referral under s.29. The Judicial Officer may also, when granting bail impose a condition that the accused be admitted as a voluntary patient to an authorised hospital for examination by a psychiatrist.

## 7.4 Use of Reasonable Force

A police officer may use such force as is necessary in apprehending the person (s.200). Under s.243 of the Criminal Code it is lawful for any person to use such force as is necessary to prevent a person from doing violence to any other person or property. What constitutes reasonable force is debatable. In ss.249 and 250 of the Criminal Code, terms such as '*like degree of force*' and '*preservation from death or grievous bodily harm*' are used to justify the action taken when a person is subjected to an assault by another.


## 7.5 Forced Entry

When police enforce entry to a person's property at the request of mental health staff or as a result of the completion of a Form 3 then the DoH remains responsible for any costs of repair and have a duty to ensure that the property is made safe. If the entry is under section 195 or 196 and where there has been no mental health involvement, then the police remain responsible for any repair required.

## 7.6 Forced Entry to Department of Housing Premises

State Government agencies work together in relation to safety and welfare of the community, and there are likely resource and budget implications when passing on cost of repair to subsequent agencies. When the welfare of a tenant has been the purpose of the forced entry, the Department of Housing has absorbed costs where WA Police have forced entry. The policy now is as follows-

*'Where WA Police have initiated a forced entry, or force entry at the request of the Department of Housing... or Mental Health Services, any associated damage will be charged to (the) maintenance, insurance non recoverable accidental (policy). The forced entry must be due to concern for welfare of the tenant'*.



Charges will not to be passed onto the Mental Health Services. Other aspects of the forced entry policy are under review and will be updated in conjunction with other Maintenance Policy changes to be advised to all staff in the near future. Where the DoH makes a forced entry, to apprehend a tenant or visitor, any damage will be charged to tenant liability. Where property damage occurs due to willful damage or arson, the DoH will take legal action through the courts against the tenant or other persons proven to have been responsible for the damage.

## **7.7 Transport Orders**

In prioritising their workload Police may request the completion of a Prioritisation Form which gives guidance as to the urgency of the request. Only the police are given the statutory power to apprehend and transport. This power does not extend to any other person or group. If at times it is necessary to detain and restrain a patient it is done under a duty of care.

### **7.7.1 Referral from a Medical Practitioner or AMHP**

Where a person not in custody is referred for a psychiatric examination at an authorised hospital or other place by a medical practitioner or AMHP and the condition of the person is such that police assistance is required to apprehend and/or transport the person, then the referrer may make a written order [Form 3] authorising a police officer to apprehend the person and take him or her to the examination (s.34). Such an order cannot be made if more than seven days have elapsed since the date of the Form 1 referral. Transport Orders must specify the date and time at which they were made. The Form 3 authorises a police officer to apprehend and transport but does not place an obligation on the police to act.

Once apprehended, the person must be taken as soon as is practicable but not more than 72 hours later to an authorised hospital or within 24 hours to the other place mentioned on the Form 3, as the order lapses at that time. A person may be detained until the order lapses or he or she is received into an authorised hospital or examined by a psychiatrist in another place.

While Forms 1 last 7 days, Form 3s only last either 72 or 24 hours. At times the Form 3 may lapse because the Form 1 has lapsed as the person has not been transported within the 7 days. More frequently the Form 3 lapses while the Form 1 is still in force and the referrer may need to do a further Form 3 or if the referrer is not available a Medical Practitioner or AMHP may do both a Form 1 and Form 3 after completing a further assessment. While a copy of the referral [Form 1] under s.29 may, but need not, be given to a patient, a copy of the Transport Order (s.34) must be given to the patient (s.159). For further information see Office of the Chief Psychiatrist Operational Circular OP 0241/09.

### **7.7.2 Referral from a Psychiatrist**

A psychiatrist who examines a person on a Form 1 in a place other than an authorised hospital and decides that the person should be received into an authorised hospital [Form 5], may make a written order [Form 3] authorising the police to apprehend and transport the person to the authorised hospital (s.41). A transport order is not to be made unless the condition of the person is such that police assistance is required.

The person apprehended under this order must be taken as soon as is practicable to the authorised hospital and given a copy of the Transport Order (s.159). A person may be detained under the Transport Order until the order lapses, which is 72 hours after it was made.

### **7.7.3 Referral in Regard to Revocation of CTOs**

When revoking a CTO and ordering that the person be admitted to an authorised hospital [Form 11], a supervising psychiatrist may make a written order [Form 3] authorising a police officer to apprehend and transport the patient to the hospital (s.71). A patient must be taken to an authorised hospital as soon as is practicable and may be detained until the order lapses, which is 72 hours from when it was made.

### **7.7.4 Referral in Regard to an Order to Attend**

If a person who is in breach of their CTO fails to comply with an order to attend [Form 14], then the supervising psychiatrist may make a written order [Form 3] authorising a police officer to apprehend that person and transport him or her to the place specified for treatment (s.83).

The person that is apprehended must be given a copy of the Transport Order and taken to the place specified as close as is practicable to the time at which the treatment can be given. The person may be detained there until the treatment is administered.

## **7.8 Not enacting a Form 3**

At the time of completing a Form 1 the referrer may feel that the condition of the person is such that police assistance is required to transport the person and there is no suitable alternative available (s.34). However while waiting for the police the mental state of the person may change so that the police are no longer required and a more suitable manner of transport is available. This may be due to the person receiving medication or due to an improvement in the person's mental state.




The MHA is silent on the issue of not acting on a Form 3 and the Chief Psychiatrist in upholding the objectives of the MHA (s. 5(a)) advises that where police assistance is no longer required, the referrer, or if the referrer is not available, a medical practitioner or mental health practitioner may decide, in line with the objects of the MHA for the least restrictive option and good practice, to request police not to act on the Form 3, in effect withdrawing the Form 3. The Form 3 should not be destroyed, but placed in the person's medical record with a note as to why the decision was made to withdraw the authorisation of police assistance.

The police should be informed of the decision and requested not to attend or if having attended that their services are no longer required. In making this decision the referrer or other practitioner must be aware of the potential risk issues and only withdraw the Form 3 if it is clear that police assistance is no longer required.

## **7.9 Referral for a Patient Absent Without Leave**

An involuntary patient, absent without leave may be apprehended by a police officer at the request of the mental health service. The police officer must ensure that the person is returned to the authorised hospital as soon as is practicable (s.58).

In carrying out this duty, the police officer may enter any premises at which the person is suspected of being and, when apprehending the person, seize anything likely to prejudice the health and safety of that person or others or cause damage to any property. Anything seized may be held for as long as is necessary, according to the purpose for which it was seized, and later returned or dealt with according to the law (s.199).



However, before requesting police assistance to return an involuntary detained patient absent without leave, all steps should be undertaken to consider why the patient has not returned from leave and look at alternatives like extending leave. Police assistance should only be used if it is essential the patient is returned to the hospital and all less restrictive ways are not appropriate.

For further information, refer to the protocol between the Western Australian Police Service and the Mental Health Division of the DoH which remains current though the police have unilaterally withdrawn from the protocol.

## Chapter 8 Records and Information

In general, ownership of medical records lies with the service or private practitioner caring for or treating a patient, rather than the patient.

### 8.1 Forms

Fourteen forms have been developed for use with the MHA. (See List of Approved Forms). Other forms in relation to Emergency Psychiatric Treatment, Seclusion, Mechanical Bodily Restraint, Consent to Treatment, Leave, Absent Without Leave and other requirements under the MHA are provided by mental health services.

Copies of Forms 6 to 14 must be sent or faxed to the MHRB.

A clerical or material error in the description of a person on a form does not render the form invalid. Whoever completed the form may rectify any mistake, but even where that does not occur such a mistake does not render invalid actions taken under the MHA.

### 8.2 Records in an Authorised Hospital (s. 204 & Regulations)

The person in charge of an authorised hospital must ensure that proper records are kept, which should include not only information such as a person's name, address and date of birth but also the nature of his or her illness and details of the treatment provided. Where a person is admitted to an authorised hospital, additional information such as their status under the MHA, the date they were received or admitted, the day discharged and whether it was to a CTO, any leave granted or absence without leave and whether the person was prevented from exercising their right to vote (Mental Health Regulations, no. 19).

### **8.3 Access to Personal Records (ss.160 and 161)**

A person who is or has been an involuntary patient or a mentally impaired accused (except for mentally impaired accused under the Prisons Act 1981) has the right to inspect and be given copies of relevant documentation, a right separate from the Freedom of Information Act. However, if a psychiatrist is of the opinion that patient access will have an adverse effect on the health or safety of the patient or former patient, or if it reveals details about another person or confidential information, then this right is restricted. In such circumstances the patient may nominate a suitably qualified person to exercise his or her right (s.161). (see chapter on Patient's Rights).

### **8.4 Access to Records in Relation to the Mental Health Review Board**

Patients made involuntary under the MHA are entitled to representation at a review scheduled before the MHRB, either by a lawyer or, with the leave of the MHRB, any other person.

In taking instructions for representation, the legal representative may request access to the clinical file of the patient in preparation for the review. Section 160 of the MHA states that an involuntary patient, whether or not detained in an authorised hospital, has the right to inspect and be given an accurate reproduction of any relevant document. This includes the patient's medical record, held by the hospital or the DoH. With the patient's authority this right extends to the patient's legal representative. The legal representative should have access to the patient's entire medical record (past and present), unless s.161 (1) applies.

Section 161(1) states that s.160 does not apply in certain circumstances. These include whether the person who has control of the file is of the opinion that disclosure would have a substantially adverse effect on the health and safety of the patient or any other person; or reveal personal information about another individual or reveal information of a confidential nature obtained in confidence. In order to ascertain whether any of this applies prior to release to a patient or a patient's representative, the medical file requires scrutiny.

If s.161 is relevant, s.160 does not apply. This does not preclude the option of partial access to the file by the patient of those parts of the file to which the exceptions do not apply. Alternatively, information as described in s.161(1), may be deleted from a copy of the medical record prior to access by the patient.

If a patient's legal representative requests access to a patient's medical record where the service has deemed that section 161 of the MHA applies preventing the patient access, the service will allow the patient's legal representative to have access to the patient's medical record, provided the legal representative signs an undertaking stating that he or she will not provide to the patient any of the restricted information to which he or she is being allowed access.

Essentially, if the legal representative is willing not to divulge information to a patient identified by the mental health service as falling under the provisions of section 161 of the MHA and is willing to sign a document to that effect, he or she will be provided with access to the patient's medical record. If despite this undertaking, the patient's legal representative does reveal information to the patient which should not be revealed a complaint may be laid with the Complaints Committee of the Legal Practice Board under Part 13 of the *Legal Profession Act 2008*.

Should s.161 (1) apply then the patient or former patient may nominate a suitably qualified person to exercise the right given by s.160 (see chapter on Patient's Rights).

## 8.5 Confidentiality

A person must not directly or indirectly divulge any personal information obtained by reason of any function that person has, or at any time had, in the administration of the MHA. A breach of confidentiality is punishable by a fine of \$2000 (s.206).

The above does not apply to the divulging of information –

- With the consent of the patient;
- In the course of duty, such as the sharing of information at team meetings or in hand-over reports;
- Under the MHA such as in the course of preparing reports authorised by the MHA or in relation to another law such as the mandatory reporting of child sexual abuse;
- In the course of investigating any suspected offence;
- When only statistical type information that could not reasonably be expected to lead to identification of any of those to whom it relates is divulged.

Not all information known by a health professional about a patient is confidential. General information which is on the public record, or information which is freely given by the patient to any person who asks, is not confidential. Only that information which pertains to private matters relating to the patient's past history and illness and is learned in the course of a therapeutic relationship is confidential. Access to confidential information should be limited to those employees who have a legitimate interest in it. All health service employees are bound by considerations of confidentiality.

Patient information should only be given to non DoH staff such as general practitioners, who play a genuine role in the further treatment of that patient. Students from the various professions involved in the provision of mental health services may be considered as having a genuine interest if they are seen as being part of the treating team.

The duty of confidentiality may be strained when a health professional feels he or she has a duty to warn a third person that a patient poses a risk to them. The MHA does not deal specifically with this situation but, at common law, the duty of confidentiality may be overruled by a duty to warn a person whose physical well being is in immediate danger. In this situation the health professional should adopt a thoughtful approach to the duty of confidentiality and, if in doubt, seek advice regarding its application in a particular situation. For further information see '*Communicating with Carers and Families: Information sharing for better outcomes*', published by the Office of the Chief Psychiatrist and available from the Chief Psychiatrist's website.

### **8.6 Access to certain information about a patient**

Members of the police, and others, may be interested in a patient and seek to access his or her file or interview members of the treating team. As a general rule, the police have no greater right than others in this respect, although they may apply to the Chief Psychiatrist for access to information. If the Chief Psychiatrist believes the inquirer has a proper interest in the matter, some information may be divulged (s.205). This function of the Chief Psychiatrist has been delegated to heads of service (Delegations March 2010).

Alternatively, the police may seek access to information by issuing a warrant. Further, the police or others may issue a subpoena returnable in a court of law.

## Chapter 9 Miscellaneous

### 9.1 Obstruction of Mental Health Staff

It is an offence punishable by a fine of \$2000 (s.211) to obstruct another in the performance of his or her functions under the MHA.

### 9.2 Protection from Liability

Under the MHA, staff are protected from liability for any act taken, or not taken, in good faith and without negligence in the performance of a function. This protection extends to members of the COV and the MHRB. This does not relieve the Crown from any liability (s.213).

### 9.3 Interstate Movements (part 4)

The Minister may, on behalf of the State, from time to time enter into agreements with other States and Territories in relation to patients who are discharged and move interstate. All States and Territories have laws and regulations with regard to the detention, discharge and community care of patients with a mental illness. Any agreements between the States and Territories concerning the taking, reception, care, treatment maintenance, burial or payment of expenses of such patients will be published in the Gazette. Any interstate movements arranged for patients must be in the best interests of those affected (s.88).

If the police apprehend a person, they may in certain circumstances and in accordance with interstate agreements deal with that person under the mental health legislation of another State or Territory (s.89). A person may be referred under s.29, having been released



or discharged under the mental health legislation of another State or Territory (s.90). If under the agreement an involuntary patient needs to be dealt with under the laws of another State or Territory, the Chief Psychiatrist can order that that person no longer be detained as an involuntary patient and arrange for the transfer of said person to the other State (s.91).

To date no interstate agreements have been entered into.

## **9.4 Restrictions on Authority of Practitioners (s.193 and 194)**

No psychiatrist, medical practitioner, AMHP or SMHP is to exercise any of his or her powers, which include referral for examination, the making, varying or revoking of an order and the authorising of transfer or leave, in relation to a relative, guardian, partner, principal or assistant.

No practitioner is to exercise any powers, including detention, treatment release or transfer, for a person from a private hospital in which the practitioner has a financial or management interest (s.194). Nor is a practitioner to exercise any of the above powers in relation to a patient in a public hospital if the practitioner is a member of the board of management of that hospital (s.194).

## **9.5 Matters to be reported to the Chief Psychiatrist**

Mental health services are to report to the Chief Psychiatrist all known occurrences of:

- suicide, even of individuals not known to mental health services;
- deaths of mental health patients, even expected deaths from physical causes;
- deaths of non-mental health patients whose death may have implications for mental health care;
- serious Incidents.

For further information see Office of the Chief Psychiatrist Operational Circular OP 0242/09, or contact the Manager, Office of the Chief Psychiatrist.

## List of Approved Forms and downloads from the Chief Psychiatrist's website

No.	Form	Section
1	Referral for examination by a psychiatrist	29
2	Order for detention when voluntary patient referred	30(3)
3	Transport Order	34(1), 41(1), 71, 84(1)
4	Order to continue detention for further assessment in an authorised hospital	37(1)(b)
5	Order for receipt into, and detention in, authorised hospital for further assessment	39(1)
6	Involuntary patient order	43(2)(a)
7	Transfer of detained person or involuntary patient between authorised hospitals	46
8	Patient no longer an involuntary patient	49(2), 52(a) 62(2)(a) 63(2)(a), 78
9	Continuation of involuntary patient order	49(3), 50(2)
10	Community Treatment Order	49(3)(b), 52(b), 62(2)(b), 63(2)(b), 67
11	Revocation of community treatment order	70
12	Variation or extension of community treatment order	76, 79
13	Notice of breach of community treatment order	81
14	Order to attend for treatment	82

The following can be downloaded from  
[www.chiefpsychiatrist.health.wa.gov.au](http://www.chiefpsychiatrist.health.wa.gov.au)

- Copies of the 14 MHA Forms (requires password from OCP)
- The Clinicians' Guide to the Mental Health Act 1996
- The Supplement to the Clinicians' Guide
- Community Treatment Orders: A Practitioners Guide
- The Mental Health Act 1996
- The Mental Health Regulations 1997
- The Criminal Law (Mentally Impaired Accused) Act 1996
- Medical Practitioners Guide to the Mental Health Act 1996
- Flowchart for Medical Practitioners
- Protocol between the West Australian Police Service and the Mental Health Division
- Guidelines for Authorised Mental Health Practitioners
- The ECT Guide
- The ECT Consent Form
- The Chief Psychiatrist's Guide to the Authorisation of Hospitals
- Carers Guide to Information Sharing with Mental Health Practitioners
- Communicating with Carers and Families
- Rights Card and consumer pamphlets.

## Contact Details

<p><b>Council of Official Visitors</b> Unit 1, 18 Harvest Terrace WEST PERTH WA 6005</p> <p>Tel: 9226 3266 or Free call: 1800 999 057</p>	<p><b>Mental Health Commission</b> 5th Floor, 81 St Georges Tce, PERTH WA 6000</p> <p>Tel: (08) 6272 1200 Fax: (08) 672 1299</p>
<p><b>Guardianship and Administration Board (SAT)</b> Ground Floor, 12 St Georges Terrace PERTH, WA 6000</p> <p>Tel: (08) 9219 3111 or 1300 306 017 (for regional STD callers) Fax: (08) 9325 5099</p>	<p><b>Mental Health Law Centre</b> 38 Brisbane Street Perth, WA 6000 Mail: PO Box 8466 PERTH WA 6849</p> <p>Tel: 9328 8266 Free call: 1800 620 285</p>
<p><b>Health Consumers' Council</b> Unit 13/14 Wellington Square 4 Lord Street EAST PERTH WA 6004</p> <p>Tel: 9221 3422 Free call: 1800 620 780</p>	<p><b>Mental Health Review Board</b> Level 4, 12 St. Georges Terrace PERTH 6000</p> <p>Tel: 9219 3162 Fax: 9219 3163</p>
<p><b>Health and Disability Services Complaints Office (HaDSCO)</b> Level 12, 44 St Georges Terrace PERTH WA 6000 Mail: GPO Box B61 PERTH WA 6838</p> <p>Tel: 9323 0600 Free call: 1800 813 583</p>	<p><b>Office of the Chief Psychiatrist</b> Department of Health 1C, 189 Royal Street EAST PERTH WA 6004</p> <p>Tel: 9222 4462</p>

<b>Office of the Public Advocate</b> Level 1, Hyatt Centre 30 Terrace Road EAST PERTH WA 6004  Tel: 9278 7300 A/H: 9278 7300 Country Free call: 1300 858 455	<b>State Ombudsman</b> St Martin's Tower PO Box Z5386 St George's Terrace PERTH WA 6831  Tel: 9220 7555 Free call: 1800 117 000
<b>Public Trustee</b> Public Trust Office 565 Hay Street, PERTH WA 6000  Tel: (08) 9222 6777 Fax: (08) 9222 6607 Free call: 1800 642 777	<b>Translating and Interpreting Service</b>  Tel: 13 14 50



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