Mental Health Act 2014
Frequently Asked Questions

Clinical Helpdesk

In the first instance, staff members are encouraged to use the Clinicians' Practice Guide and/or their local mental health clinical lead. Following this, there is a Clinicians' Helpdesk operated by the Office of the Chief Psychiatrist 24 hours a day, 7 days a week, available until 30 May 2016. The number is (08) 9222 4217.

Seclusion and bodily restraint – a note from the Chief Psychiatrist

It is acknowledged that there has been an increase in complexity and quantum of recording and reporting around seclusion and bodily restraint. The tracking of this data to better shape practice remains important, and it is a statutory function. Staff undertaking seclusion and bodily restraint are reminded:

- to please complete the forms, and ensure accurate information is documented;
- to seek to reduce prone restraint, and document reasons if this is longer than three minutes;
- to ensure timely seclusion observations;
- that seclusion may only be extended after two hours with assessment and written authorisation by a medical practitioner; and
- that post-seclusion/post-bodily restraint medical review must be undertaken within six hours of release from seclusion/bodily restraint.

FAQs released 23 December 2015:

How do I send forms to the Chief Psychiatrist?

Forms that need to be provided to the Chief Psychiatrist can be emailed to monitoring@ocp.wa.gov.au

Can I redact my name from forms given to patients?

The Act requires that every form that has to be given to a patient include the name, qualifications and signature of the staff member completing the form. Usually a staff member cannot redact their name from the copy of the form before providing it to the patient. However, the Mental Health Commission is currently seeking legal advice as to whether or not a staff member can have their name redacted from the form where there is good reason for the staff member to be concerned that there is a significant

risk to their own safety. The outcome will be conveyed to all services; however, in the meantime, staff members should follow the following process:

- if the staff member is a mental health practitioner, discuss their concerns with the person in charge of the ward;
- in consultation with the person in charge of the ward (if applicable), decide whether there is a significant risk to their own safety if the copy of the form provided to the patient includes their name;
- file a copy of the completed form, including the staff member's name, on the patient's medical record;
- provide a copy of the form, with the staff member's name redacted, to the patient, but retain the staff member's qualifications and signature;
- document the decision to redact the staff member's name, and reasons for this decision.

Can a referred person who is on an order for continuation of detention for further examination at the authorised hospital be transferred to another authorised hospital for the examination?

Form 3C can be used to continue detention of a referred person who has been examined at an authorised hospital, to enable a further examination at the authorised hospital. The Act only provides for the examination at that same authorised hospital. If the person needs to be transferred to another authorised hospital for the examination, there needs to be a new assessment and referral. The person can then be placed on a transport order (if required) and received and detained at the other authorised hospital for examination.

Can the place specified on an order for reception and detention of a referred person in an authorised hospital for further examination be amended?

Form 3D can be used to authorise reception and detention of a referred person in an authorised hospital for further examination by a psychiatrist at the authorised hospital. Form 3D requires the person completing the form to state the place where the person is to be received for further examination. However, this can be changed at any time before the person is taken to an authorised hospital, by amending the form itself or by preparing a new form. If a new form is used it will need to be signed by the same psychiatrist. The amended or new form needs to be given to the person who is being detained.

What information needs to be included in the terms of a community treatment order?

When you complete Form 5A Community treatment order (CTO), it is important that you also complete the Attachment, which sets out the terms of the CTO. It is important that you also specify the details of the relevant mental health service (hospital or clinic). If known at the time, include the details of when the involuntary community patient will need to attend the service. A Form 5B Continuation of CTO and a Form 5C Variation of terms of CTO should also include this information.

What is the meaning of 'Aboriginal or Torres Strait Islander mental health worker' or a 'significant member of the community'?

Aboriginal and Torres Strait Islander (ATSI) mental health workers have two key roles under the Act. Where a person is being assessed or examined via audiovisual communication, they must be accompanied by a health professional and, in the case of an ATSI person, the meaning of health professional includes an ATSI mental health worker.

Further, where an ATSI person is being assessed, examined, or provided with treatment, the Act encourages services to involve an ATSI mental health worker and significant members of the person's community. Significant members of the person's community may include elders, traditional healers, an Aboriginal Health Worker, or an Aboriginal Liaison Officer. The person may also invite family or another support person to attend. The service should always recognise and be sensitive to the person's individual and cultural needs and any concerns the person has regarding involvement of other people.

In short, a significant member of a patient's ATSI community is ultimately determined by the patient. It is not appropriate to question the cultural validity of the patient's chosen support.

What needs to be reported to the Mental Health Advocacy Service when an involuntary treatment order is made?

The Mental Health Advocacy Service (MHAS) must be given a copy of the involuntary treatment order (including the Attachment to 5A – Terms of the Community Treatment Order), and the name and contact details of any personal support person that the service has informed of the making of the involuntary treatment order. If no personal support person has been notified, the MHAS must be notified of this fact and the reasons for this.

Which form do I used to make a treatment, support and discharge plan?

A treatment, support and discharge plan (TSD Plan) may be made in any form, so long as it includes the treatment, care and support that will be provided to the involuntary patient and upon discharge from the involuntary treatment order. A copy must be given to the patient and to their personal support persons. The TSD plan does not need to be a daily plan, but the Act requires that it be reviewed in consultation with the patient and their personal support persons from time to time and as required.

What is the difference between a nominated person and other personal support persons?

Close family members, carers, and nominated persons are all personal support persons under the Act and their rights are similar. A person does not need to nominate their close family member or carer as their nominated person in order for them to be a personal support person, but they can. It would be more applicable to nominate another person, such as a friend. If a person does choose to nominate a close family member or carer as their nominated person, the difference will be that that other person (the nominated person) will be informed and involved regardless of whether the person is a voluntary or involuntary patient, and regardless of whether the person has decision making capacity. You should provide patients with a copy of the brochure at:
www.mhc.wa.gov.au/Libraries/pdf_docs/Nominated_persons_2.sflb.ashx

Who can witness the nomination of a nominated person?

Form 12A states that the nomination of a nominated person can only be witnessed by a person authorised by law to take declarations. A list can be found at www.courts.dotag.wa.gov.au/_files/Professions_witness_statutory_declarations.pdf
The listed professions include doctors, registered nurses and psychologists.

How long does an apprehension and return order last?

An apprehension and return order (ARO) always lasts 14 days, even if a detention period or other relevant order would otherwise have ended within the 14 days. For instance, if a referred person on a Form 3A Detention order leaves a place shortly before the detention period would expire, or an involuntary inpatient is absent without leave shortly before the inpatient treatment order ends, they can be brought back to the place (or another place specified in the ARO) within 14 days.

When do I need to complete the search and seizure forms?

If the person agrees to be searched as part of any admission or routine search policy, then the search can take place in accordance with hospital policies and practices. If the person does not agree to a search, and staff reasonably suspect that the person has a dangerous item or another item that is able to be seized, then it needs to be in accordance with the Act, and you need to complete Form 8A Record of search and seizure. You will also need to complete Form 8B Record of dealing with seized article, if anything is seized.

When does the provision of non-psychiatric treatment need to be reported to the Chief Psychiatrist?

Non-psychiatric treatment (in the form of medical treatment) that is a consequence of mental illness (such as deliberate self-harm or an eating disorder) may be provided to an involuntary patient or mentally impaired accused without a requirement for informed consent, and this does not need to be reported to the Chief Psychiatrist.

Non-urgent non-psychiatric treatment can be provided with the informed consent of the patient or their substitute decision maker (such as a guardian) and does not need to be reported to the Chief Psychiatrist.

The law in relation to provision of urgent non-psychiatric treatment is similar to the way it was under the *Mental Health Act 1996*. This kind of treatment can be provided under the *Guardianship and Administration Act 1990*. The only change is that, if the person is an involuntary inpatient in an authorised hospital or a mentally impaired accused in an authorised hospital, it needs to be reported to the Chief Psychiatrist, and at least one personal support person needs to be notified.

Forms 4C and 4D provide for interstate transfer. Can these forms be used?

Not yet. Western Australia does not currently have any agreements in place with other jurisdictions for interstate transfer. Therefore, Forms 4C and 4D cannot be used at this time and access to these forms will be removed until interstate agreements are put in place.

FAQs released 10 December 2015:

Who can receive a referred person into a hospital?

A person is received into a hospital at the point at which they are attended to by a health professional such as a doctor or nurse. This will generally be at the point of triage. The health professional should record the time of receival using the Form 1A, 'Receival at place of examination'.

When can a practitioner make a detention order?

A Form 3A detention order can only be made where all of the following requirements are met:

- the person is on a Form 1A referral for examination by a psychiatrist;
- the referred person is at the place where the person was assessed and the referral was made; and
- a medical practitioner or an authorised mental health practitioner is satisfied that the referred person needs to be detained in order for them to be taken to the place of examination.

A detention order can only be made to keep the referred person at the place where they were assessed and the referral was made. A detention order cannot be completed after the person has been taken to the place of examination (or apprehended under a transport order), nor where the person has absconded.

A referred person who absconds can only be placed on an apprehension and return order where they were also on a detention order. If the person is not able to be placed on an apprehension and return order, it is still important to follow up by contacting family, other mental health services, and the police, and take any other action required in the circumstances.

How do I revoke an involuntary treatment order?

If you are revoking an involuntary treatment order, you can use the same form as was used to make the order, or a copy of that form – Form 5A, 6A or 6B. If the involuntary treatment order was made under the *Mental Health Act 1996*, use the revocation section of the new form (Form 5A or Form 6A).

If you are placing an involuntary community patient on an inpatient treatment order, you need to complete Form 6A or 6B. This automatically revokes the community treatment order and you will not need to complete the revocation section of Form 5A. If you are placing an involuntary inpatient on a community treatment order, you need

to complete Form 5A. This automatically revokes the inpatient treatment order and you will not need to complete the revocation section of Form 6A or 6B.

What constitutes 'leave of absence'?

The Act allows a psychiatrist to grant leave following consultation with the involuntary inpatient and all personal support persons, and documentation of leave approval and arrangements using Form 7A. A Form 7A only applies to overnight leave of one night or a series of consecutive nights. Any new period of overnight leave (i.e. not consecutive nights) will require a new Form 7A.

Although these legal requirements do not apply in the case of day leave, good practice requires proper communication with the involuntary inpatient; risk assessment; a record of arrangements; and, where appropriate in the circumstances, notification of personal support persons. The extent to which these requirements apply may vary depending on the person's risk of harm, vulnerability, or failure to return to hospital; the proposed duration of leave; whether it is ground leave or otherwise; and whether it is escorted or unescorted leave.

Who can provide emergency psychiatric treatment, and who needs to complete Form 9A?

If there is no medical practitioner available to administer emergency psychiatric treatment (EPT), it can be provided by another clinician who is authorised to administer psychiatric treatment, but only with prior authorisation by a medical practitioner shortly before EPT is provided (oral authorisation is sufficient).

The medical practitioner that provided the authorisation must then complete the Form 9A as soon as practicable, and include the name/s of the clinician/s who administered EPT.

Which forms need to be filled out where force is used to place a person into seclusion?

A staff member of an authorised hospital can use reasonable force to place a person into seclusion. Therefore, you need to use the seclusion forms but you will usually not need to complete the bodily restraint forms.

The following instances should be recorded as use of bodily restraint:

- use of reasonable force which extends beyond the period expected to place a person into seclusion;

- restraint that occurs after the person has been established in seclusion; for example, for the purposes of provision of parenteral medication against the person's wishes while they are in seclusion.

Which forms need to be filled out where a person is subject to seclusion or bodily restraint for a short period of time?

Where a person is secluded under an oral authorisation for less than two hours, the following forms always need to be completed – Form 11A, 11C, 11D and 11G.

Where bodily restraint is used under an oral authorisation for less than 30 minutes, the following forms always need to be completed – Form 10A, 10C, 10D, 10I.

What do I need to notify the Mental Health Tribunal of?

The Act requires services to notify the Tribunal of the making, expiry or revocation of an involuntary treatment order (including names of personal support persons). To help the Tribunal schedule hearings, it would also be appropriate to notify the Tribunal of any of the following events:

- transfer of an involuntary inpatient between hospitals (Form 4C);
- continuation of a community treatment order (Form 5B);
- variation of a community treatment order (Form 5C);
- continuation of an inpatient treatment order (Form 6C); or
- confirmation of an inpatient treatment order (Form 6D).

These notifications can only be made with the consent of the patient. You can use the Department of Health's form – 'Patient consent to send additional notifications to the Mental Health Tribunal', which then needs to be filed on the patient's medical record.

What is the procedure for the making of an application to the Mental Health Tribunal for provision of electroconvulsive therapy?

Pending any formal advice guides to staff, please note that sections 410 and 414 of the *Mental Health Act 2014* provide specific guidance to psychiatrists and other medical practitioners regarding information the Mental Health Tribunal requires in applications. The Clinicians' Practice Guide section 9.8 also provides advice for clinicians on application to the Tribunal for ECT.

FAQs released 2 December 2015:

Which edition of the Clinicians' Practice Guide should I be using?

Please use the Clinicians' Practice Guide Edition 3, current as of 25 November 2015. Do not use historical versions, as some of the information provided may not be correct.

Are there any special provisions regarding the transition to the new Act?

Please be reminded that there is an information sheet for clinicians regarding the transition of referred persons or patients from the *Mental Health Act 1996* to the *Mental Health Act 2014*.

When do I need to use the Chief Psychiatrist's approved forms, and where should they be filed?

The Chief Psychiatrist's approved forms are legal documents. They must be kept in patient records, regardless of whether they have a Department of Health barcode or medical record number on the individual forms.

Can force be used to detain a referred person?

During training on the new Act, clinicians have asked whether or not reasonable force can be used to detain a referred person. The *Mental Health Act 2014* does not specifically authorise staff to use force to detain a referred person. However, reasonable force may be used where there is imminent risk to the person or others and there is no option but to use force to detain the person (such as the use of emergency psychiatric treatment). If force is used, it is essential that the circumstances, and reasons for use of reasonable force, be documented in the person's medical record, in accordance with existing good practice.