

**MEDICAL PRACTITIONERS’
GUIDE
TO THE REFERRAL PROCESS
UNDER THE
MENTAL HEALTH ACT (1996)**



Government of
Western
Australia

DEPARTMENT OF HEALTH

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Preamble

This Guide to the referral process and police powers is a supplement to the Mental Health Act 1996 and refers to specific duties and responsibilities of medical practitioners, authorised mental health practitioners and the police service. For clarification or further detail, refer directly to the Mental Health Act (1996), the Criminal Law (Mentally Impaired Defendants) Act (1996), the Mental Health Act Regulations (1997), the Mental Health (Consequential Provisions) Act (1996) and the Protocol between the Western Australian Police Service and the Mental Health Division of the Health Department of Western Australia (1999). If there are questions refer them to the manager of your health service. The Manager or the Clinical Consultant are the contacts within the Office of the Chief Psychiatrist.

Disclaimer of Liability

This guide has been prepared in good faith. The information it contains is intended to assist all who provide mental health services including medical practitioners, authorised mental health practitioners as well as police officers, lawyers, emergency services and other health and community staff, in understanding the referral process and police powers under the Mental Health Act (1996).

While this Guide has been prepared with every care, neither the Western Australian Government nor the author 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.

Foreword

The Mental Health Act was passed by Parliament in 1996 and became operational in November 1997 and represents the culmination of a number of year's work within the Department of Health.

The Mental Health Act 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. As such, it provides for a balance between the civil rights of individuals and the need for appropriate treatment, and 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 (now the Office of Mental Health) in the Department of Health 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 Guide to the Referral Process and Police Powers is specifically targeted at Medical Practitioners specifically working as General Practitioners or in Emergency Departments and outlines their powers and responsibilities. It also includes information on the role of the police service in that referral process.



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CHIEF PSYCHIATRIST

February 2004

1.0 Role of Medical Practitioner

- 1.1 A "medical practitioner" under the Mental Health Act 1996 (MHA) means
 - (a) a person not being a body corporate who is registered under the Medical Act 1894; or
 - (b) a body corporate which is registered under the Medical Act 1894.
- 1.2 Medical practitioners and specifically General Practitioners and doctors working in Emergency Departments play a significant role in the care and treatment of persons with a mental illness.
- 1.3 All medical practitioners may refer a person with mental health problems to be examined by a psychiatrist on a voluntary basis. This referral may be made to a public mental health service or a private psychiatrist.
- 1.4 Under the MHA Medical Practitioners have a specific role to refer a person they suspect has a mental illness and would meet the criteria under section 26 of the MHA to be examined by a psychiatrist on an involuntary basis.
- 1.5 A medical practitioner is not to exercise this power of referral in respect of a person if the practitioner is a relative, guardian, partner, principal or assistant of the person (s.194).
- 1.6 The production of a false certificate or document to get a non-mentally ill person apprehended or detained under the MHA is a criminal offence and the practitioner who produces such a document is liable to imprisonment for 3 years (Criminal Code, s.336).
- 1.7 Authorised Mental Health Practitioners (AMHPs) may also refer a person they suspect has a mental illness for examination by a psychiatrist under the MHA (s.29).
- 1.8 AMHPs are mental health practitioners (s.19) who have been designated by the Chief Psychiatrist to meet the requirements to be on the Register of AMHPs and whose names have been published in the *Public Service Gazette*.
- 1.9 Either a Medical Practitioner or an AMHP may refer a person under the MHA. The MHA does not dictate a hierarchy as to who should refer, and the use of Medical Practitioners or AMHPs in the referral process is determined by the demands of the situation not by the discipline. For example, the practitioner who knows the person best may feel it is appropriate for them to complete the referral. In other situations a greater knowledge of mental health issues may

indicate who should complete the referral. This is a matter, which requires discussion and negotiation when both Medical Practitioner and AMHPs are available to be involved in the process.

2.0 Referral Criteria

- 2.1 A Medical Practitioner (or AMHP) may refer a person they suspect on reasonable grounds should be made an involuntary patient to a psychiatrist for an examination (s.29). This can be done whether the person is in the community, in a general hospital or a voluntary patient in an 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.
- 2.2 In referring a person under the MHA, the Medical Practitioner must suspect on reasonable grounds that a person should be made an involuntary patient. It is not expected that the Medical Practitioner will be certain that the person has a mental illness. That role of diagnosis of a mental illness is a task for the psychiatrist.
- 2.3 In effect the Medical Practitioner makes a judgement based on the behaviour and speech of the person which indicates that a person may have a mental illness as defined in the MHA as well as information provided from other sources such as relatives, the police or the medical file.
- 2.4 Under the MHA 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 of only 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
- 2.5 It is recognised that at times it is difficult to ascertain, when a person is intoxicated due to the taking of alcohol or drugs yet

is exhibiting behaviour consistent with the definition of mental illness, whether the person should be referred. It should be noted that if the person is referred to an authorised hospital under the MHA while intoxicated the psychiatrist who examines the referred person has the option of extending the referral period for up to 72 hours from the time of receipt before making a decision as to whether the person should be made an involuntary patient. This enables detoxification to occur so that a judgement may be made as to whether the person does have a mental illness or not.

2.6 The other grounds are that the person may meet the criteria under s.26 of the MHA. Section 26 states that:

A person should be detained involuntarily as a patient only if:

- a. the person has a mental illness, as described by the Act, requiring treatment; and
- b. the treatment can be provided through detention in an authorised hospital or through a community treatment order (CTO) 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, (see 2.7, 2.8, 2.9, 2.10 & 2.11)
 - prevent that person doing serious damage to property; and
- c. the person has refused or is unable to give consent to treatment; and
- d. 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.

2.7 Examples of when treatment may be required to “protect the health or safety” of the patient or any other person include suicidal ideation or gestures and expressions of actual or threatened harm to others.

2.8 The term “self-inflicted harm” has a broad definition under s.26(2) of the Act. The term includes:

- serious financial harm;
- lasting or irreparable harm to any important personal relationships 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.

- 2.9 Actual or possible serious financial harm may, for example, be evident in the manic phase of a bipolar illness.
- 2.10 Lasting or irreparable harm to any important personal relationships may be evident in behaviours of the person towards family members, work colleagues or others in the community. The qualification is that harm must be the result of damage to the reputation of the person among these significant others. Clearly for the referrer this may require an inquiry into the life of the person before they became unwell and how those behaviours which are a consequence of their illness are affecting the quality of the relationships they have with these significant others.
- 2.11 With regard to serious damage to the reputation of the person, the referrer must be aware of both the person's present symptoms and the significant changes which indicate that the reputation of this person may be seriously damaged if certain expressed behaviours are not controlled.
- 2.12 The criteria under s.26 also require evidence that the person has refused or is unable to consent to treatment. Therefore, it is important to ascertain from a person his or her compliance to treatment. If a person is so unwell as to make any consent to treatment meaningless, then it should be documented that, due to the person's illness, it was not possible to obtain valid consent.
- 2.13 The last requirement for making a finding that a person should be an involuntary patient under s.26 is whether there is a less restrictive manner in which treatment can be adequately provided. With regard to referral this may be an option between voluntary or involuntary referral.

3.0 Process of Referral

- 3.1 The referrer, either a medical or authorised mental health practitioner, 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).
- 3.2 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 of the person's examination by the referrer.
- 3.3 The referrer should specify the basis on which the referral is being made and distinguish personal observation from information conveyed by another (s.33). Facts

communicated to the referrer, although not of themselves sufficient grounds for suspecting a person should be made an involuntary patient, may be considered by the referrer in forming his or her opinion (s.31).

- 3.4 The referrer should also specify where the examination is to take place, whether at an authorised hospital or some other place, such as a clinic 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 dictates that a copy of the form be provided where possible.
- 3.5 If it is to another place, such as an Emergency Department, non-authorised hospital or a mental health clinic then the referrer must know that there is a psychiatrist available at that other place to carry out the examination. When referring a person to another place 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 threat 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. Subsequent or alternatively a medical practitioner or AMHP may complete another Form 1 to refer that person to an authorised facility. 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.
- 3.6 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 an alternative authorised hospital could be contacted. If no bed is available within the mental health system it is the duty of the catchment area hospital to receive the patient and arrange for a bed either at that hospital or another authorised hospital. 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. 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 Emergency Departments or in the community. Essentially the responsibility lies with the service to receive a person referred not the referrer. That does not preclude the referrer taking some responsibilities in brokering a bed. (For further information see Mental Health Inpatient Bed Management Policy on www.mental.health.wa.gov.au.)

4.0 Detaining a Referred Person

- 4.1 The *Mental Health Act 1996* does not make provision for a person referred under section 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.
- 4.2 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.
- 4.3 There may be occasions when agreement is not possible and the alternative of the making of a transport order and the involvement of the police is necessary. In those circumstances a Form 3 needs to be completed (see 'Conveyance to an Authorised Hospital').
- 4.4 In circumstances where the referred person is unwilling to await the police arrival, the issue may arise whether it is desirable or necessary to detain the person until such time as the police arrive. Where the clinician or person having care or control of the person fall under a duty of care to take reasonable steps to ensure the referred person's welfare, that duty would oblige consideration of the detention options available. The first matter the referrer needs to consider is whether the referred person suffers from a mental incapacity of such a nature or degree as precludes the referred person making reasonable judgements about his or her own welfare. If the person does suffer from such incapacity (a person exhibiting behaviour the result of a florid mental illness typically but not necessarily falls into this category), then the person may be detained in order to ensure that appropriate treatment is provided if that is assessed to be in the best interest of the referred person. No additional factors are

required. Details of the basis on which it is assessed that the person lacks capacity to consent should be recorded.

- 4.5 If a person has the relevant capacity but has indicated an intention not to stay until police arrive, there may exist circumstances that would justify the person being detained against his or her will. Those circumstances are where there is an imminent threat to the health and safety of the person or others if the person is not detained. The mere fact, for example, that detention for the purposes of ensuring a prompt psychiatric assessment in hospital would be, or was indicated to be, to the person's benefit would not be sufficient justification for detention. The detention and manner of detention must not be out of proportion to the peril to be avoided.
- 4.5 To avoid the possibility of legal liability for detaining a person who has the relevant capacity, the clinician must ensure that he or she only detains the person where there is clear evidence of significant risk. It is important to document the reasons for detaining of a person.
- 4.7 Risk factors that may justify detention of a referred person with capacity could include fresh threats made to physically harm him or herself or others and a previous history of such threats or actual harm. A referred person's history of risk-taking behaviour would be an important factor in deciding if a person should be detained. Behaviour such as spending money in a manic state, approaching strangers or being sexually permissive may not in itself be serious enough behaviour to justify detention, but will be relevant to an assessment of the risks of the referred person or others.
- 4.8 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.

5.0 Conveyance to an Authorised Hospital (ss.34, 35)

- 5.1 To convey the person referred 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 common practice.

- 5.2 The person may be conveyed to hospital in a Department of Health vehicle, an ambulance, a police car, a police divisional van or, if appropriate, a private vehicle.
- 5.3 If transport is by way of a Department of Health vehicle, which may or may not be done under a Transport Order, observing the following guidelines is advisable:
- a Department of Health 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.
- 5.4 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. 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, 35).
- 5.5 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, good practice dictates that mental health staff accompany the referred person and the police. The police are responsible for the person during the transport procedure.
- If the person needs to remain in a local hospital awaiting the RFDS or if it is necessary for the person to attend at an

Emergency Department 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 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.

- 5.6 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.
- 5.7 Although police have the responsibility for transporting the person, it may be done using a Department of Health 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.
- 5.8 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.

See Protocol between the Police Service and the Mental Health Division for further information.

6.0 Not Acting on a Form 1

- 6.1 Although the Act does not consider the option of not acting on of a Form 1, the potential for such an occurrence in clinical practice indicates the need for this practice guideline.
- 6.2 If during the period between the completion of a Form 1 and a person's reception 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 least restrictive alternative, a referral is no longer required, then the Form 1 may not be acted on.
- 6.3 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 file.

- 6.4 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 on the patient's file.

7.0 Emergency Psychiatric Treatment (ss.113-115)

- 7.1 Emergency Psychiatric Treatment 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.
- 7.2 Emergency psychiatric treatment 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 Emergency Psychiatric Treatment but psychosurgery may not.
- 7.3 The duties of the person administering emergency psychiatric treatment 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 Mental Health Review Board (MHRB).
- 7.4 With the proposed introduction of the State Administrative Tribunal (SAT) the Emergency Psychiatric Treatment report must be forwarded to the Office of the Chief Psychiatrist. For further information contact the Manager of the Office of the Chief Psychiatrist.

8.0 Confidentiality

- 8.1 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 or six months' imprisonment (s.206).
- 8.2 There are a number of exemptions to the above rule, which allows confidential information to be divulged. These are:
- 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 Child Welfare Act;
 - 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.
- 8.3 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.
- 8.4 Patient information should only be given to non Department of Health 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.
- 8.5 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 is dangerous. 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.

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 Council of Official Visitors and the MHRB. This does not relieve the Crown from any liability (s.213).

For further information and copies of Forms 1 and 3 either contact the Office of the Chief Psychiatrist on 9222 4462 or access the website on

www.chiefpsychiatrist.health.wa.gov.au

Other Agencies that may be of assistance:

Council of Official Visitors	(08) 9226 3266
Health Consumers' Council	(08) 9221 3422
Mental Health Law Centre	(08) 9328 8266
Mental Health Review Board	(08) 9226 3255
Office of Health Review	(08) 9322 0600
Ombudsman's Office	(08) 9220 7555

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