

**OFFICE OF THE CHIEF PSYCHIATRIST**

***CLINICIANS' GUIDE***

***TO THE MENTAL HEALTH ACT 1996***

**(Edition 2004)**



**DEPARTMENT OF HEALTH**

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### **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 (DoH).

## Preamble

**This Clinicians' Guide is a supplement to the *Mental Health Act 1996* and refers to specific sections of the MHA as they are discussed. 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. As such, 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 (now the Office of Mental Health) 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 second edition of the guide. It clarifies issues arising from publication of the previous editions and articulates developments within clinical practice.



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**DEPARTMENT OF HEALTH**

April 2004

## 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)(b))**

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.

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

Every medical practitioner, not being a body corporate, who is registered under the Medical Act 1894, 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. These 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, an AMHP has the power to make a written order authorising the police to apprehend and transport a person referred for examination by a psychiatrist (s.34). If the police, using their powers under s.195, have apprehended a person they suspect has a mental illness, either a medical or an authorised mental health practitioner 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 (MHRB) (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 to 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.

A Practitioners' Guide to the use of CTOs is published by the Office of the Chief Psychiatrist.

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

Appointed by the Minister for 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 Defendant (s.3 & Part 5 of the Criminal Law (Mentally Impaired Defendants) Act 1996) (CLMIDA)**

A mentally impaired defendant 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.

**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 Nurse's Board, 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) and in observing patients who are in seclusion (s.120 (b)).

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.

**Psychiatrist (s.3)**

Means a medical practitioner whose name is contained in a Register of Psychiatrists (s.17, Medical Board).

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 those responsible for supervising the requirements of CTOs. A treating psychiatrist may also be a supervising psychiatrist.

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

Means 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 these practitioners to be maintained, however mental health services as part of good practice may maintain a register of senior mental health practitioners.

The powers and responsibilities of senior mental health practitioners relate mainly to involuntary in-patients. These practitioners have a holding power of six hours with respect to voluntary patients they believe should be detained in the authorised hospital (s.30) and may authorise seclusion (s.118) and mechanical bodily restraints in an emergency (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 (ECT), rehabilitation, counselling, individual and group psychotherapy, occupational therapy and psychological programs.

Part 5 of the MHA deals with treatment. It includes provision that prohibit certain treatments (s.99) and regulate 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 if involuntary detained patients 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. (Operational Circular- OP 164803)

## **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 a senior mental health practitioners 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.

## 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.

#### **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.

#### **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.

#### **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.

#### **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 further defines the responsibilities and details the role of the police in dealing with people who are suspected of having a mental illness. This balancing of rights and responsibilities advocates that patients should be treated with dignity and respect but is also concerned with the care of the ill patient and 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.

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## PATIENTS' RIGHTS

### 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 leaflets in English and 15 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 case notes that an explanation has been given lies with a psychiatrist for in-patients, the supervising psychiatrist for a person subject to a CTO, and the person in charge of any location in which a mentally impaired defendant is being detained (s.158). This responsibility may be delegated to another member of the mental health team.

Explanatory leaflets, along with a card entitled *Your Rights under the Mental Health Act 1996*, should be distributed as appropriate to patients and carers.

The card, 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 person detained in an authorised hospital by a senior mental health practitioner [Form 2], (s.30).

When –

- a period of detention in an authorised hospital comes to an end; or
- a CTO is revoked because the patient no longer is required to be an involuntary patient; or
- a CTO lapses (in line with good practice, not a legal requirement).

The person concerned must be informed that they are no longer an involuntary patient as soon as is practicable and given a copy of the form [Form 8] (s.54).

Copies of the above orders are 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, a copy is to be given to whoever has responsibility for the care of the patient. This section aims to ensure that carers are fully informed regarding a patient's status (s.157).

### **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 other external agencies, such as the Office of Health Review (OHR).

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).

### **Personal Records**

A person who is or has been an involuntary patient, including a mentally impaired defendant 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 has issued information which recognises a consultant psychiatrist as such. Sections 160 and 161 do not apply to certain records under the Prisons Act 1981.

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

Any person with responsibility for the patient who ill-treats or wilfully neglects them has committed an offence, the penalty for which is a fine of \$4000 or one year's imprisonment.

### **Right to a Second Opinion**

In addition to the right to an interview with a psychiatrist at the hospital, an involuntary patient also has the right to a second opinion from 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 (s.111 and 164).

If the patient being given psychiatric treatment (s 109) is dissatisfied with the treatment they may request 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.

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 OP1647/03 available on the Chief Psychiatrist's website.

### **Right to Personal Possessions**

Patients will, as far as is practicable, be given the facilities 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). 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)).

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

Patients 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 below for restrictions to this right (s.166 and 170).

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

A patient must have the opportunity to make and receive telephone calls in reasonable privacy. See below for restrictions to this right.

### **Right to be Visited**

A patient must have the opportunity to receive visitors of their own choice in reasonable privacy. See below for restrictions to this right.

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

A psychiatrist may restrict any of the above three rights if it is considered to be in the best interest of the patient to do so. If such a right is restricted, the psychiatrist must review the order daily. 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 case notes (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 case (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.

## **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 he or she is not, 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.

## **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;
- the explanation including 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 imparting 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, the MHA does stipulate that an involuntary patient, whether detained in an authorised hospital or on a CTO, or a mentally impaired defendant in an authorised hospital, may be given psychiatric treatment, apart from psychosurgery, without his or her consent (s.109).

## **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 s.170 and 203.

**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.

## INVOLUNTARY DETENTION

### **A person should be detained involuntarily as a 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.

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

A medical practitioner or AMHP 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 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.

### **Process of Referral**

The referrer, either a medical or AMHP, 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).

It 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 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).

The referrer should also specify where the examination by the psychiatrist is to take place, either at an authorised hospital or some other place, such as a clinic, an 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 dictates that a copy of the form be provided where possible.

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.

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.

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 EDs or in the community. Essentially the responsibility lies with the service to receive a person referred. (For further information see Mental Health Inpatient Bed Management Policy on [www.mental.health.wa.gov.au](http://www.mental.health.wa.gov.au)).

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 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.

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.

### **Detaining a Referred Person**

The *Mental Health Act 1996* 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 'Conveyance to an Authorised Hospital').

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.

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.

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.

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.

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.

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

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 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.

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 (s.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, 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 Royal Flying Doctor Service (RFDS) or if it is necessary for the person 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 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.

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

### **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 (Policy Directive, Metropolitan Mental Health Service, 2000).<sup>1</sup>

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

Although the MHA does not consider 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 least restrictive alternative, a referral is no longer required, then the Form 1 may not be acted on.

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<sup>1</sup> Advice from the State Solicitor's Office dated 6 April 2004 indicates that s.47 of the MHA is not relevant with regard to referred persons. Accordingly it would not be open to an authorised hospital to decline to receive, for the purpose of examination, a person referred under s.29(2)(a).

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. 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.

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

If a voluntary patient in an authorised hospital seeks to leave but a senior mental health practitioner 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 complete a Form 1, which is immediately valid and allows the person to be detained. Ordinarily a Form 1 allows a person to be detained in an authorised hospital for up to 24 hours, however in these circumstances the person may only be detained for up to the end of the 6 hours from the time the Form 2 was completed. (Crown Solicitor's advice 1999)

A further examination before the end of the six hours needs to be completed for a psychiatrist to make an order of involuntary detention or a CTO, or decide not to 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.

### **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 a defendant'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 defendant be admitted to an authorised hospital and that the defendant be examined by a psychiatrist (Consequential Provisions - s.3(2)).

### **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 three options. He or she can:

- make an order under s.43 whereby the person becomes an involuntary patient, either detained in an authorised hospital or subject to a CTO [Forms 6 & 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 concerned may leave or choose, with the psychiatrist's agreement, to become a voluntary patient.

### **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]. 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 (s.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.

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).

### **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).

#### **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].

#### **Leave (s.59-63)**

A psychiatrist may authorise leave of absence for an involuntary patient who is detained 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 either by way of detention or through a CTO 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 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 or authorised mental health practitioner 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.

#### **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 on the patient by or on behalf of the psychiatrist.

### **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).

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 seizing 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 wilfully 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).

### **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 and under a law of the State or Commonwealth requiring 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).

## TREATMENT ISSUES

The term 'treatment' covers a number of interventions by doctors, nurses, psychologists, occupational therapists and social workers, and includes medication, ECT, 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 treatment. Involuntary patients can be given psychiatric treatment without their consent. There is no specific mention of medication in the MHA but it is included as a 'psychiatric treatment' under ss.108 and 109.

### **Treatments now Prohibited (s.99)**

Certain treatments are now prohibited and it is an offence to administer them. They are deep sleep therapy, insulin coma or sub-coma therapy.

### **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 MHRB review, which requires five members including a neurosurgeon (Part 5, Division 4).

### **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 (s.104, 113).

Before a psychiatrist approves a recommendation 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).

If the second psychiatrist does not approve the treatment the treatment cannot be given and the treating psychiatrist is to refer the matter in writing to the MHRB. 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 (s.107), unless the treatment is given as emergency psychiatric treatment (s.113).

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

An involuntary patient or mentally impaired defendant remanded or on bail to an authorised hospital may be given psychiatric treatment without his or her consent (s.93, 109). For patients' rights in regard to involuntary treatment see '*Right to a second opinion*' on chapter on Patients Rights. For further information see Office of the Chief Psychiatrist Operational Circular OP1647/03 available on the Chief Psychiatrist's website.

### **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 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 attending. 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 see Office of the Chief Psychiatrist Operational Circular OP 1648/03 available of the Chief Psychiatrist's website.

### **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.

With the proposed introduction of the State Administrative Tribunal (SAT) the EPT report must be forwarded to the Office of the Chief Psychiatrist. For further information contact the Manager of the Office of the Chief Psychiatrist.

### **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 at 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 senior mental health practitioner can authorise seclusion. The senior mental health practitioner must then notify a medical practitioner as soon as possible, whereupon the medical practitioner can either vary or revoke the authorisation (s.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 senior mental health practitioner 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 senior mental health practitioner, 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. 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;
- 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 be 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 clinical psychiatric services of the authorised hospital.

The psychiatrist in charge of the clinical services of the authorised hospital is to maintain a register of those seclusions and continually monitor the powers provided for by Division 8 of Part 5 of the MHA.

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

With the proposed introduction of the SAT the Seclusion report must be forwarded to the Office of the Chief Psychiatrist. For further information contact the Manager of the Office of the Chief Psychiatrist.

### **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 (s.121).

A patient may only be 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 senior mental health practitioner. Further, it may only be used within the period for which the authorisation is given. If a senior mental health practitioner 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 case notes (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 clinical psychiatric services of the authorised hospital.

The psychiatrist in charge of the clinical services of the authorised hospital is to maintain a register of those restraints and continually monitor the powers provided for by Division 9 of Part 5 of the MHA. On the written request of the Chief Psychiatrist, the psychiatrist in charge of the clinical services of an authorised hospital is to provide a copy of the register of restraints to the Chief Psychiatrist.

With the proposed introduction of the SAT the Mechanical Bodily Restraint report must be forwarded to the Office of the Chief Psychiatrist. For further information contact the Manager of the Office of the Chief Psychiatrist.

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## COMMUNITY TREATMENT ORDERS

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 Defendants) Act 1996 applies. Only patients at the greatest risk of non-compliance with treatment should be considered for CTOs, as the criteria under s.26(1)(b) applies.

### **Making a CTO**

A CTO can be made if the psychiatrist who examined the person concerned is satisfied that:

- 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);
- 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' (s.68).

Clearly a CTO cannot be made unless there is communication and cooperation between hospital and community staff. Arrangements need to be made before a patient is made subject to a CTO as specific duties need to be fulfilled.

### **Terms of a CTO**

Each CTO [Form 10] must specify the following:

- the name of a psychiatrist who will be responsible for supervising the order (this can be the psychiatrist who made the order);
- details of the treatment plan including details of 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 file<sup>2</sup>;
- 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;
- the time when the order will lapse, which cannot be longer than three months from the time the order was made.

A CTO does not have effect unless within 72 hours the order is confirmed by another psychiatrist, or if another psychiatrist is not available a medical practitioner.

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<sup>2</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.

This does not apply 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).

### **Review**

The supervising psychiatrist must examine the patient at least monthly and review whether the CTO should continue (s.75). The examination may, at the supervising psychiatrist's request, be conducted by a medical practitioner, who should prepare a written report on the patient. This report can be part of the case records the supervising psychiatrist must keep (s.77).

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

A CTO can be extended beyond the initial three-month period for up to another three months. After that second three-month period the order lapses.

If it is felt that the patient should be maintained on a CTO, then a new CTO (Form 10) may be completed and the patient given a copy of the order. In these circumstances a second psychiatrist or medical practitioner must confirm the order within 72 hours.

To extend a CTO for a period of up to 3 months a Form 12 needs to be completed before the CTO lapses and the patient given a copy. Having received a copy of the extension (Form 12) the patient may request in writing that the supervising psychiatrist obtain a second opinion from another psychiatrist as to whether the order should have been extended.

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 provide his/her opinion within 14 days, the CTO lapses. Good practice would dictate that in forming his/her opinion the psychiatrist would examine the patient. If the patient fails to keep any appointment arranged with the psychiatrist providing the second opinion, then the extension is maintained. The supervising psychiatrist is required to 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.

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

The supervising psychiatrist may transfer responsibility for supervision to another psychiatrist and inform the patient of the transfer (s.74(3)).

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.

The supervising psychiatrist may otherwise vary the terms of the order; when, for example, there is a change in the treatment plan or the patient moves to a

different geographical location. The appropriate part of the Form 12 needs to be completed. The patient must be informed of the variation of the order.

### **Breach and Order to Attend (s.80-84) [Form 13]**

A breach of a CTO occurs when the patient:

- does not comply with the order; and
- the supervising psychiatrist believes that all reasonable steps to obtain compliance without sufficient success; and
- a significant risk of the condition of the person deteriorating arises from the non-compliance (s.80).

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 (s.81). This gives the patient an opportunity to comply with the order, and good practice dictates that the patient be given sufficient time to comply.

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 person to whom it is directed 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 with the CTO and gives the patient an opportunity to comply before an order to attend is issued or the police become involved.

Treatment can be given under an Order to Attend whether the patient consents to it or not (s.83). If the patient fails to comply and does not attend as directed, then the supervising psychiatrist should consider other methods of ensuring that the patient attends for treatment. These include the use of community mental health staff.

As a last resort, the supervising psychiatrist can make a written order [Form 3] authorising a police officer to apprehend the patient and take him or her to a specified place for treatment (s.83-84). Whoever takes the patient to the place specified for treatment must give the patient a copy of the order. The patient needs to be conveyed to the place specified for treatment as close as is practicable to the time at which the treatment is to be administered. Further, the patient may be detained under the order until the treatment is given (s.84). After the treatment is administered the CTO remains in force.

### **Revocation of a CTO**

A CTO may be revoked because on examination by the supervising psychiatrist, he or she believes, having regard to s.26 that the person should not continue to be an involuntary patient. The supervising psychiatrist should complete a Form 8 and give the patient a copy of the order (s.78).

A CTO may also be revoked if the patient on a CTO becomes unwell again and needs to be detained as an involuntary patient, or fails to comply with the order and needs to be detained as an involuntary patient in an authorised hospital [Form 11] (s.70 and 78). Once received into the authorised hospital the patient becomes an involuntary detained patient and may be detained for up to 28 days. In effect the Form 11 acts like a Form 6.

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 a patient the subject of a CTO becomes unwell again and 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 no longer be an involuntary patient. A Form 1, referring the person to an authorised hospital, may then be completed by a medical practitioner or AMHP (Office of the Chief Psychiatrist Operational Circular OP 1645/03).

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 use of the Form 1 or Form 6, which may already have been completed, it would be appropriate for the supervising psychiatrist to revoke the CTO by completion of a Form 8, and informing the MHRB.

### **Voluntary Admission of a Patient on a CTO**

A patient on a CTO can be admitted voluntarily to an authorised hospital. The CTO may remain in force but not be applicable while the patient is a voluntary in-patient. When the patient is discharged the CTO may be enforceable again. It is good practice for the treating team to review the CTO and decide whether it should remain or be revoked.

The CTO cannot be used to detain the patient or enforce treatment while that person is a voluntary patient. CTOs, as their name implies, have validity in the community, not in any hospital (see definition of 'treatment in the community' s. 3). If a person has to be detained or given treatment against his or her will, then the option of revoking the CTO may be considered.

### **Community Treatment Orders, A Practitioners' Guide**

This publication by the Office of the Chief Psychiatrist gives a comprehensive step-by-step guide to the use of community treatment orders in Western Australia. Copies of the Guide can be obtained from the Office of the Chief Psychiatrist or downloaded from the Chief Psychiatrist's website.

## 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 MHRB, the MHA meets this principle.

### **Establishment and Membership**

The Governor of Western Australia, on the recommendation of the Minister for Health, appoints members of the MHRB (s.125). The MHRB comprises 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.

### **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.

### **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. Such a review will occur unless a review has already been requested by or on behalf of the patient (s.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). It is within the MHRBs power to conduct a review at any time (s.144).

### **Request for Review**

A request for review may be made in writing to the MHRB 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).

## **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 a person, giving such directions as it thinks fit, or, if the person is already subject to a CTO, vary the order and give such directions as it feels fit (s.142);
- order that a person detained in an authorised hospital be transferred to another authorised hospital;
- order that a person's care, both supervision and treatment, under a CTO be transferred to another supervising psychiatrist;
- order that, where ECT is recommended for a person and the second psychiatrist does not concur with that recommendation, resulting in a referral to the MHRB, the person the subject of the review be recommended for 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).

## **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 at which it will be held (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 in the 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)).

### **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 MHRBs 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).

### **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 wilfully 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).

## **Appeals**

If dissatisfied with the MHRBs decision, patients or other interested parties have the right to appeal to the Supreme Court (s.149). Grounds for appeal are that the MHRB 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 MHRBs decision, unless the MHRB 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 list).

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

With the passing of the State Administrative Tribunals (SAT) Bill the MHRB will be subsumed within SAT.

## **COUNCIL OF OFFICIAL VISITORS (COV)**

Members of the COV are known as Official Visitors, and are concerned with people termed 'affected persons'. These people include involuntary patients, mentally impaired defendants in authorised hospitals and those who are socially dependent and reside in psychiatric hostels. The work of Official Visitors includes acting as patient advocates, listening to and resolving complaints and assisting in the preparation and presentation of MHRB reviews. They also visit and inspect authorised hospitals and private psychiatric hostels.

### **Establishment, Membership and Administration**

The Minister for Health 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.

### **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, including involuntary patients, have been informed of their rights;
- ensuring that the rights of affected persons, including involuntary patients, 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.

### **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 and other records. Though the affected person has the right to deny an Official Visitor access to their personal medical records.

### **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.

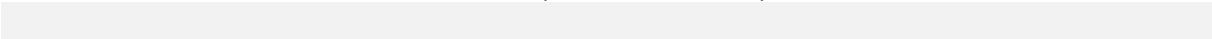
### **Offences (s.191)**

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

### **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).



## 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.

### **Taking a Mentally Ill Person into Protective Custody**

The police have the power to 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 order to do this 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 (s.198). 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).

Once the person has been apprehended, the police must arrange as soon as is practicable for that person to be examined by a medical or AMHP, the result of which could be referral for examination by a psychiatrist under s.29. In such cases the person has not been arrested but only apprehended in order that a medical practitioner or AMHP determine whether an examination by a psychiatrist is necessary.

This assessment can be conducted in the place the person was apprehended, for example in the person's home and 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, ED, or if those places were not available or appropriate, the police station, so that either a medical practitioner or an AMHP can assess and refer the person if necessary.

### **Dealing with an Arrested Person – 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). If the police apprehend a person, they may in certain circumstances and in accordance with interstate agreements deal with him or her under the mental health legislation of another State or Territory (s.89).

### **Dealing with an Arrested Person – 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 Defendants) Act 1996) or grant bail (Bail Act 1982), with a condition that the defendant 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 defendant be admitted as a voluntary patient to an authorised hospital for examination by a psychiatrist.

### **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, which address the issue, 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.

### **Transport Orders 1 – Referral from a Medical or Authorised Mental Health Practitioner**

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 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.

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. The order lapses at the times stated above or at the end of the seventh day after the referral was made, if that is sooner than the times stated above. 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 1651/03.

### **Transport Orders 2 - Referral from a Psychiatrist**

A psychiatrist who examines a person 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 the person and transport him or her 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, or the person is received into an authorised hospital.

### **Transport Orders 3 – Referral in Regard to Revocation of CTOs**

When revoking a CTO [Form 11], a supervising psychiatrist may make a written order [Form 3] authorising a police officer to apprehend the patient and transport him or her to the hospital (s.71). A patient so apprehended 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, or until the person is admitted to hospital (s.72).

### **Transport Orders 4 – Referral in Regard to Breach of a CTO**

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).

A person so 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.

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

A person who, while subject to an order for detention as an involuntary patient, is 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).

**For further information, refer to the protocol between the Western Australian Police Service and the Mental Health Division of the Department of Health.**

## 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.

### **Forms**

Fourteen forms have been devised 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.

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.

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

The person in charge of an authorised hospital must ensure that proper records are kept. Records 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 is to be kept (Mental Health Regulations, no. 19).

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

A person who is or has been an involuntary patient or a mentally impaired defendant (except for mentally impaired defendants under the Prisons Act 1981) has the right to inspect and be given copies of relevant documentation. However, if a psychiatrist is of the opinion that the information it contains 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).

### **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 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 file, held by the hospital or the department. With the patient's authority this right extends to the patient's representative. The legal representative should have access to the patient's entire clinical file (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's representative 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 file by medical records prior to access by the patient's representative. It should be noted that due to the client lawyer relationship that any information provided to the representative may be shared with the consumer.

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).

## **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 or six months' imprisonment (s.206).

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.

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 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.

### **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. For further information see Office of the Chief Psychiatrist Operational Circular OP 1650/03.

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.

## MISCELLANEOUS

### **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 her functions under the MHA.

### **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).

### **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.

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

There are certain restrictions on the authority of psychiatrists, medical practitioners and authorised mental health practitioners. No practitioner 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).

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

Mental health services are to report to the Chief Psychiatrist occurrences of unexpected deaths and serious incidents. For further information see Office of the Chief Psychiatrist Operational Circular OP 1646/03, or contact the Manager, Office of the Chief Psychiatrist.

<b>List of Approved Forms</b>		
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<b>No.</b>	<b>Form</b>	<b>Section</b>
1	Referral for examination by a psychiatrist	29
2	Order for detention when voluntary patient referred	30(3)
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