

OFFICE OF THE CHIEF PSYCHIATRIST

2006 Supplement

CLINICIANS' GUIDE

MENTAL HEALTH ACT 1996



DEPARTMENT OF HEALTH

INTRODUCTION

The third edition of the Clinicians' Guide was published in 2004 and included advice received from the State Solicitor and the Legal and Legislative Services of the Department of Health. That advice clarified information in the guide and included information on which the *Mental Health Act 1996* (MHA) was silent.

This 2006 Supplement to the Clinicians' Guide includes information:

1. That details functions and processes under the MHA, which were not or only partially included in previous guides;
2. That explains matters which are required to be reported to the Chief Psychiatrist;
3. Which relates to delegations made by the Chief Psychiatrist.

This Supplement is an adjunct to the Chief Psychiatrist's Operational Circulars that can be accessed through:
www.chiefpsychiatrist.health.wa.gov.au

APPENDIX - lists the relevant Operational Circulars.

It is expected that Clinicians will at all times comply with the obligations and functions of the MHA, apply sound clinical practice and maintain a high standard of documentation. Evaluation of the actions taken as directed by this Supplement will occur at the regular Clinical Governance Reviews of Mental Health Services conducted by the Office of the Chief Psychiatrist.

This 2006 Supplement to the 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).

While this Supplement to the 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. Any perceived error or omission should be brought to the attention of the Manager, Office of the Chief Psychiatrist, Department of Health (DoH).

For general inquiries and additional copies, contact:

Office of the Chief Psychiatrist
Department of Health
2c, 189 Royal Street
East Perth, WA 6004

Telephone: (08) 9222 4462 Facsimile: (08) 9222 4244

Copies may also be downloaded from the website of the Chief Psychiatrist.

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PROCESSES AND FUNCTIONS UNDER THE MENTAL HEALTH ACT 1996

- 1.0 Assessments and Detaining at Non-Authorized Facilities**
(Relevant to Operational Circular OP2052/06- Psychiatric examination at non-authorized facilities)
- 1.1 Referral for examination by a psychiatrist (s.29)**
- (1) A medical practitioner or an authorized mental health practitioner (AMHP) who suspects on reasonable grounds that a person should be made an involuntary patient may refer the person for examination by a psychiatrist.
- (2) The referral is to be for examination either:
- (a) in an authorized hospital; or
- (b) at some other place where to the knowledge of the referrer the examination can be carried out, as determined by the referrer.
- (3) A medical practitioner or AMHP is not to exercise a power of referral if the practitioner is a relative, guardian, partner, principle or assistant of the person (s.194).
- 1.2 Referral to a non-authorized facility**
- 1.2.1 A person may be referred by a medical practitioner or an AMHP to a non-authorized facility such as an Emergency Department, General Hospital or Community Clinic where to the knowledge of the referrer a psychiatrist is available to carry out the examination.
- 1.2.2 This type of referral is appropriate for those cases where it is important for the person to have a psychiatric examination but immediate admission to an authorized hospital may not be possible or necessary. It may also be appropriate in a rural setting where a psychiatric examination can be provided thereby avoiding transport of the person to an authorized hospital in the metropolitan area.
- 1.2.3 When referring a person to a non-authorized facility referrers must consider safety and security issues and only refer a person to another place when it is safe and appropriate to do so.
- 1.2.4 If the condition of the person is such that police assistance is required then the referrer may complete a Form 3, Transport Order, authorizing the police to apprehend and transport the person for the examination. Once the person has been transported under the Form 3 and arrived at the non-authorized facility for the examination by the psychiatrist the Form 3 has fulfilled its purpose and is no longer valid. The referred person is then only subject to the referral, the Form 1.

- 1.2.5 The purpose of referral to a non-authorized facility is for an examination by a psychiatrist not a medical practitioner. If the condition of the person is such that it is not possible to wait until an examination by a psychiatrist can be completed then either a medical practitioner or an AMHP may complete another Form 1 referring the person to an authorized facility. It is not legal for any other person including a medical practitioner or AMHP to alter the place of destination on a Form 1, completed by another practitioner.
- 1.2.6 The original referrer should be notified of the change of circumstances in that another Form 1 is required and the event documented in the patient's medical record.
- 1.2.7 If the person referred to a non-authorized facility is examined by a psychiatrist, he or she may decide whether the person should be:
- (a) Admitted as a voluntary patient to an authorized or non-authorized hospital. Patient and staff safety need to be considered in deciding if the non-authorized facility is the most appropriate environment.
 - (b) Made subject to a Community Treatment Order (CTO) by completing a Form 10. The psychiatrist making the CTO must liaise with the community mental health service who will supervise the CTO. The Form 10 must include the name of the supervising psychiatrist, the responsible practitioner, an outline of treatment, and where and when treatment will be administered.
 - (c) Continuing the referral process to an authorized hospital by completing a Form 5 as the psychiatrist has decided that the person needs to be detained in an authorized hospital for treatment. If the condition of the person is such that police assistance is required to transport the person to the authorized hospital then a Form 3 (Transport Order) may be completed by the psychiatrist.
 - (d) If the person does not require admission or involuntary status the person may either be referred elsewhere such as a General Practitioner (GP), seen as an out-patient of the mental health service or informed that they do not require treatment.

1.3 Detaining a Referred Person in a non authorized facility

- 1.3.1 The Form 1 is not an order to detain and the person is entitled to leave the non-authorized facility. If the person wishes to leave and the condition of the referred person is such that the clinician having care of the person feels they have 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.
- 1.3.2 There are two situations which apply. Firstly, where the referred person does not have the mental capacity to make an informed

decision and secondly, where the referred person has the capacity but is making a decision which puts at significant risk his or her own or another persons health or safety.

1.3.3 With regard to the first situation the referrer needs to consider 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. Capacity can be evaluated using the following criteria:

- (1) The person must be able to understand and communicate the choices available;
- (2) The person must understand the information relevant to making a decision;
- (3) The person must appreciate the situation and consequences of consent or refusal of treatment.
- (4) The person must demonstrate that they can use the information rationally.

1.3.4 The assessment of competency requires among other elements a consideration of the accuracy of the patient's "appreciation" of the nature of their condition. 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. Details of the basis on which it is assessed that the person lacks capacity to consent should be recorded.

1.3.5 With regard to the second situation, if a person has the relevant capacity but has indicated an intention not to stay until the psychiatric examination has been completed, 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. 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.

1.3.6 Risk factors that may justify detention of a referred person with capacity could include fresh threats made to physically harm him/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.

- 1.3.7 If treatment such as medication is required it may be provided either with the consent of the person or through the provision of Emergency Psychiatric Treatment (see 4.0 of this supplement).
- 1.3.8 The use of other hospital staff or security guards may be necessary in the detaining of the person. Detaining may include providing a safe room or area with supervision. Mechanical bodily restraint (MBR) should only be required if the behaviour of the person is such that there are no other safe means of detaining or restricting the person. If MBR is used the procedures must comply with the MHA and Mental Health Regulations (ss.121 to 124 and Regulations 14, 15 and 16).
- 1.3.9 Detaining in these circumstances should be for the shortest time possible as the purpose of the detention is for an examination by a psychiatrist either in a non-authorized or authorized facility. Prolonged detention and restraint in a non-authorized facility without sound justification as described should not occur.
- 1.3.10 The above information also applies if the psychiatrist having examined the referred person decides to continue the referral to an authorized facility using a Form 5. The Form 5 is not an order to detain. Police assistance may be authorized using a Transport Order (Form 3) and while awaiting police the person may be detained under the same conditions as described above.

2.0 Changes to the Referral Process:

Not acting on a Form 1

Not acting on a Form 3

(Relevant to Operational Circular- 2054/06 Not acting on a Form 1 or Form 3)

2.1 Referral for examination by a psychiatrist (s.29)

- (1) A medical practitioner or an authorized mental health practitioner (AMHP) who suspects on reasonable grounds that a person should be made an involuntary patient may refer the person for examination by a psychiatrist.
- (2) The referral is to be for examination either:
 - (a) in an authorized hospital; or
 - (b) at some other place where to the knowledge of the referrer the examination can be carried out, as determined by the referrer.
- (3) A medical practitioner or AMHP is not to exercise a power of referral if the practitioner is a relative, guardian, partner, principle or assistant of the person (s.194).

2.2 Referral process

- 2.2.1 The completion of a Form 1 by a medical practitioner AMHP indicates that the referrer suspects on reasonable grounds that the person may meet the criteria for involuntary status and therefore an examination by a psychiatrist is required. The Form 1 is valid for up to seven (7) days.

2.3 Change of mental state

- 2.3.1 During the time between the referral form being completed and the referred person being either received into an authorized hospital or examined by a psychiatrist in a non-authorized setting there may be a change in the mental state of the referred person.
- 2.3.2 This change in mental state may be noted during an assessment by a medical or mental health practitioner and the conclusion reached that, under the principle of least restrictive option, a referral for a psychiatric examination is no longer required.
- 2.3.3 Essentially this is a matter of risk management while also upholding human rights under the *Mental Health Act 1996* (MHA). While current mental state is a good indicator of whether referral should continue other factors such as previous history, alcohol or drug issues and community support would all influence the decision.
- 2.3.4 The MHA is silent on the issue of not acting on a Form 1. The Chief Psychiatrist in upholding the objectives of the MHA (s. 5(a)) provides the following operational advice.

2.4 Not acting on a Form 1

- 2.4.1 Any decision not to progress the referral process should only be made after consultation with the referrer, unless that is not possible (see 2.4.3). The referrer having been informed of the change in mental state may agree that the referral process should not continue. If the referrer believes that the process should continue, the reasons for that belief should be further discussed and a decision made as to whether to progress the referral or not.
- 2.4.2 If agreement cannot be reached and the medical or mental health clinician progressing the referral believes it is not ethical or within the spirit of the MHA to continue with the referral then he or she may choose to withdraw from the process. It is then a task for the referrer to progress the referral if he or she believes the referral should continue.
- 2.4.3 Every effort should be made to contact the referrer, however, if the referrer cannot be contacted then the medical or mental health practitioner may make a decision in line with good practice not to continue with the referral and make a note of that in the patient's medical record. The referral form, which is not progressed, should remain on the patient's medical record.
- 2.4.4 In reaching this decision the medical or mental health practitioner should be aware of why the referral was made in the first place and the risks and clinical issues which the referrer thought were important. The decision not to progress the referral should be well informed and take into consideration the person's and community's best interest.

2.5 Not acting on a Form 3

- 2.5.1 At the time of completing a Form 1 the referrer may deem that the condition of the person is such that police assistance is required to transport the person and there is no suitable alternative available (s.34).
- 2.5.2 However while awaiting the attendance of the police the mental state of the person may change so that the condition of the person is such that police are no longer required and a more suitable manner of transport is available.
- 2.5.3 This may be due to the person receiving medication or due to an improvement in the person's mental state.
- 2.5.4 The MHA is silent on the issue of not acting on a Form 3. The Chief Psychiatrist in upholding the objectives of the MHA (s. 5(a)) provides the following operational advice.
- 2.5.5 Where police assistance is no longer required, the referrer, or if the referrer is not available, a medical practitioner or mental health

practitioner may decide, in line with the objects of the MHA for the least restrictive option and good practice, to request police not to act on the Form 3, in effect withdrawing the Form 3. The Form 3 should not be destroyed, but placed in the person's medical record with a note as to why the decision was made to withdraw the authorization of police assistance.

2.5.6 The police should be informed of the decision and requested not to attend or if having attended that their services are no longer required.

2.5.7 In making this decision the referrer or other practitioner must be aware of the potential risk issues and only withdraw the Form 3 if it is clear that police assistance is no longer required.

2.6 Informing the Office of the Chief Psychiatrist

2.6.1 When a decision is made not to act on a Form 1 or a Form 3 the Office of the Chief Psychiatrist (OCP) should also be provided with information regarding the decision. This can be done by writing to The Manager, Office of the Chief Psychiatrist, Department of Health, 2c 189 Royal Street, East Perth, WA 6004 or by e-mail to janet.peacock@health.wa.gov.au.

3.0 Completion of Transport Order (Form 3)

(Relevant to Operational Circular 2053/06 Completion of a Transport Order)

3.1 Transport Orders

3.1.1 Either a medical practitioner or an AMHP may refer a person they suspect of having a mental illness and who would meet the criteria for involuntary status for an examination by a psychiatrist at an authorized hospital or other place (s.29).

3.1.2 If the condition of the person is such that police assistance is required and no suitable and safe alternative is available the referrer may also make a written order (Form 3 - Transport Order) authorizing a police officer to apprehend and transport the referred person (s.34).

3.1.3 A Form 3 may also be completed when a psychiatrist has examined a referred person in another place and referred them on to an authorized hospital (Form 5, s.41); or when a Supervising Psychiatrist revokes a CTO authorizing that the patient be taken to an authorized hospital (Form 11, s.71); or when a patient on a CTO has failed to comply with an Order to Attend and police take the person to a place as indicated on the form for treatment (Form 14, s.84).

3.1.4 In any of the above circumstances where police involvement is required the condition of the person/patient must be such that police assistance is required and no suitable alternative is available. It should not be custom and practice to complete a Form 3 (Transport Order) when completing a Form 1 (Referral for Examination).

3.1.5 The types of behaviour identified in the *Protocol between the Police and the Mental Health Division* include aggressive or unpredictable behaviour, a high risk of absconding, or refusing to attend. Essentially a Transport Order should only be completed when either the person or others may be at risk of harm if the Police were not involved in the transportation.

3.1.6 A Transport Order should not be completed at the request of another agency such as the Ambulance Service unless the condition of the referred person requires police assistance. The Ambulance Service may transport referred persons only on a Form 1.

3.2 Provision of information

3.2.1 The referrer will provide to the police adequate information to assist the police in making their own risk assessment. The police will then be in a position to decide when and how the referred person should be transported to the authorized hospital. This can

be done verbally. There is also a space provided on the Form 3 '*Special factors or other important details*'. This section should be completed providing the police with important information regarding risk issues. The information provided will further assist the police in their decisions as to the form of transport and number of police required.

- 3.2.2 Additionally the police may require the completion of a Police Priority Form. This form, the result of consultation between the Police and the Office of Mental Health, is designed to assist the police in prioritising the transport. The priority form may be faxed to the relevant police service. If no faxing service is available the information on the form can be given via the telephone.
- 3.2.3 Police should not be provided with a copy of the Form 1 as it may contain confidential information on matters, which do not concern the issue of safe transport.

3.3 Form 3

- 3.3.1 The referrer must complete a Form 3 and at some point a referred person/patient must be given a copy of the order. If it is not possible to give the referred person/patient a copy of the order at the time of transport it must be provided later.
- 3.3.2 Medical practitioners or AMHPs who refer a person and complete a Transport Order tick Box 1 on the form. The other three boxes are for a psychiatrist to tick in those particular circumstances outlined on the form.
- 3.3.3 A Form 3 for a person to be transported to an authorized hospital lasts for 72 hours from the time it was made. If the place of referral is a non-authorized facility then the Form 3 lasts for 24 hours from the time it was made. These time lines indicate that Police assistance is required as soon as practicable. If the referred person/patient has not been received at the authorized hospital or the person not transported to the non-authorized facility within those time frames, the Form 3 lapses.
- 3.3.4 The Form 1 continues to be valid for up to seven (7) days from the time it was made.
- 3.3.5 The referrer (the clinician who completed the Form 1) may complete another Form 3 if the person has not been apprehended and transported. Only the referrer is able to complete a Form 3. If a Form 1 is completed and a Form 3 required at a later stage only the referring practitioner who completed the Form 1 may complete the Form 3.
- 3.3.6 If the referrer is not available to complete a Form 3 or a new Form 3 the other Form 3 having expired then it would be necessary for a

medical practitioner or AMHP to complete a fresh examination and complete a new Form 1 along with the Form 3 if police assistance is required.

3.4 Responsibility

3.4.1 The Form 3 authorizes the police to apprehend and transport, it does not compel them to take these actions. However, if the police fail to act when authorized they may be held liable for any subsequent serious incident or traumatic event.

3.4.2 Police are responsible for the referred person from the time they apprehend them under the Form 3 until they are received in an Authorized Hospital.

3.4.3 Although the police have overall responsibility for the person during this process their presence and the form of transport may be negotiated with mental health service staff. This is particularly relevant when a referred person is being transported from a rural region to the metropolitan area and a break in the transport may be necessary.

3.4.4 Referred persons may be transported by health department vehicle, ambulance, Royal Flying Doctor Service or in a police vehicle. However no matter the form of the transport the police remain responsible with assistance from mental health services.

3.5 Not acting on a Form 3

3.5.1 For further information read the relevant section in 2.5 of the Supplement.

4.0 Emergency Psychiatric Treatment and issues of consent (Relevant to Operational Circular 2055/06 Emergency psychiatric treatment and issues of consent)

4.1 Consent to treatment (Div 2, Part 5)

4.1.1 A clinician must seek valid consent from a person before providing psychiatric treatment. Valid consent is consent freely and voluntarily given and a failure to offer resistance to treatment does not of itself constitute consent to treatment.

4.1.2 Before consent is given the patient is to be given a clear explanation of the proposed treatment including sufficient information such as warnings of risks and what is known or not known about the effects of the treatment in order to make a balanced judgement about the treatment.

4.1.3 The extent of the information given should be sufficient for a reasonable person in the patient's position to regard as significant.

4.1.4 The information should be conveyed in a form that would enable the patient to readily understand the issues, including the use of information in other languages or the use of interpreters.

4.1.5 Sufficient time should be given to the patient to consider the information provided including whether to seek advice and assistance from other sources.

4.1.6 As a general rule a person can refuse treatment if they are:

- (a) a voluntary patient;
- (b) a person being assessed in the community, including assessment in an Emergency Department, as to whether they should be referred for examination by a psychiatrist;
- (c) a person who has been referred (Form 1) and is waiting to be transported to an authorized hospital;
- (d) a person who has been examined by a psychiatrist in a non-authorized facility and the decision made to continue the referral process on to an authorized hospital (Form 5);
- (e) a person who has been received into an authorized hospital but not as yet examined by a psychiatrist;
- (f) a person who having been examined by a psychiatrist in an authorized hospital has the referral time extended for up to 72 hours from the time of receipt (Form 4).

4.1.7 In certain circumstances, a clinician may be able to treat a person without acquiring consent such as when a clinician is acting out of a perceived duty of care for the person. In these circumstances the clinician is not acting under statutory legislation and may be held liable for their actions. It would therefore be preferable to use

statutory legislation such as the *Mental Health Act 1996* (MHA) when a person requires emergency psychiatric treatment (see 4.8).

4.2 Definition of Emergency Psychiatric Treatment (EPT) (s.113)

4.2.1 EPT means psychiatric treatment that it is necessary to give to a person to save the person's life, or to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.

4.2.2 Psychosurgery is not permissible as an emergency psychiatric treatment.

4.3 Electroconvulsive Therapy (ECT)

4.3.1 A person is not to perform ECT on a person who is not an involuntary patient or a mentally impaired defendant who is in an authorized hospital unless the person has given informed consent to the treatment.

4.3.2 This applies even though the person may be a child or adolescent or subject to a guardianship order. A parent or guardian cannot give permission on behalf of another person for the administration of ECT.

4.3.2 ECT may be given as EPT if it meets the criteria in 4.2.1.

4.3.3 However, as ECT is usually a planned treatment the Chief Psychiatrist must be made aware when ECT is being provided as EPT. It would be preferable if the Office of the Chief Psychiatrist (OCP) is informed before the treatment is given.

4.3.4 In addition to the report to the Mental Health Review Board (MHRB) as required by s.115(b) the Chief Psychiatrist will be provided with a report outlining the circumstances and reasons for the treatment.

4.4 Seclusion

4.4.1 Seclusion as described by s.116 of the MHA or any other intervention whereby a person is placed in a room from which they cannot leave of their own accord is not EPT.

4.5 Consent or approval dispensed with (s.114)

4.5.1 EPT may be given without any consent or approval that would be required for a voluntary patient or a referred person.

4.5.2 However consent should always be sought and only if consent is not freely given or the patient is not capable of giving informed consent should treatment be given without consent or approval.

4.6 Duties of person giving emergency treatment

4.6.1 A person who gives EPT, is to ensure that a record is made of the treatment including:

- (a) Particulars of the treatment (type, dose and method of administration of the treatment);
- (b) The date and time the treatment was given;
- (c) The place where treatment was given;
- (d) The circumstances which necessitated the use of EPT;
- (e) The names of all the persons involved in the giving of the treatment such as the medical practitioner who prescribed the treatment and the staff involved in administering the treatment.

4.6.2 A template EPT reporting form is available from the Resources and Publications page of the OCP website:
(www.chiefpsychiatrist.health.wa.gov.au).

4.6.3 Having completed a record of the treatment a copy must be forwarded to the MHRB at GPO Box Y3063, East St George's Terrace, PERTH WA 6832 or fax to 9219 3163. The MHRB maintain a database on EPT.

4.6.4 Documentation of the EPT must also be placed on the patient's medical record.

4.7 Settings

4.7.1 No matter what the setting, a clinic, a GP's surgery, an emergency department, a police lock-up, a person's home or a hospital, the duties under 4.6 apply.

4.7.2 These duties apply to the person who gives the treatment, usually the medical practitioner or nursing staff.

4.8 Duty of Care or EPT

4.8.1 Treatment may be provided to a person as part of the duty of care the health professional has for the person.

4.8.2 However, it is the view of the Chief Psychiatrist that EPT, as it is within statutory legislation, is the preferred way of managing the issue of giving medication to behaviourally disturbed mental health patients.

4.8.3 It is required by legislation and also results in the use of EPT being tracked/monitored by the MHRB, an independent agency.

5.0 Request for another opinion on psychiatric treatment (Relevant to Operational Circular 2059/06 Request for another opinion on psychiatric treatment)

5.1 Opinion of another psychiatrist may be requested (s.111)

5.1.1 Where an involuntary patient either detained in an authorized hospital or on a Community Treatment Order or a mentally impaired accused is being given psychiatric treatment without their consent and is dissatisfied with the treatment the patient may:

- (a) Request that an opinion as to whether the treatment should be given be obtained from a psychiatrist who has not previously considered the matter; or
- (b) Request the Chief Psychiatrist to arrange for the opinion of a psychiatrist to be obtained as to whether the treatment should be given.

5.1.2 This opinion may be given after the psychiatrist and the patient have been in communication with one another either directly or by audio-visual means (teleconferencing).

5.2 Process

5.2.1 It is an important right for an involuntary patient who is dissatisfied with his or her treatment to be able to obtain another opinion regarding that treatment from a psychiatrist who has not previously considered the matter.

5.2.2 This right refers to psychiatric treatment but does not include Electroconvulsive Therapy (s.108).

5.2.3 An involuntary patient may make this request either to his or her psychiatrist or the Chief Psychiatrist. If it is to the latter the Chief Psychiatrist has delegated his powers of arranging for another opinion to the Head of Service or the psychiatrist acting in that position.

5.2.4 It would be preferable for this other opinion to be obtained from a psychiatrist who is not employed by the mental health service who is providing care and treatment for the involuntary patient.

5.2.5 The exception to this principle is when the patient is agreeable for another opinion from another psychiatrist from within the mental health service providing care and treatment. This agreement may be because of shorter time lines to obtain that opinion or because of patient preference.

5.2.6 While it is understood that certain mental health services particularly in the rural and remote areas have difficulty in providing another opinion from a psychiatrist from another service it would still be preferable for that principle to be adhered to. The

MHA allows the use of audio-visual means to provide this other opinion.

- 5.2.7 If another opinion is provided by a psychiatrist who is from within the same service as the treating psychiatrist, it is still a valid opinion.

5.3 Other opinion from a Private Psychiatrist

- 5.3.1 Patients are entitled to request another opinion from a private psychiatrist.

- 5.3.2 If the patient is an involuntary detained patient any face-to-face examination should occur in the authorized hospital.

- 5.3.3 If, in the opinion of the treating psychiatrist, the patient's condition is such that he or she can be examined in a setting external to the authorized hospital then the treating psychiatrist may authorize leave for that examination to occur.

- 5.3.4 The patient is responsible for any costs that are incurred for an examination by a private psychiatrist.

5.4 Recommendations from another opinion

- 5.4.1 If the other opinion does not recommend any change to treatment then s.112 of the MHA, further remedy where person remains dissatisfied, does not apply.

- 5.4.2 The other opinion may indicate that psychiatric treatment should be modified or discontinued.

- 5.4.3 However, the treating or supervising psychiatrist may decide not to act on the views of the other opinion given by the psychiatrist.

- 5.4.4 The treating or supervising psychiatrist should note that, having decided not to act on the views of the other opinion, the patient may exercise his or her right to seek a review by the MHRB citing the other opinion as part of the evidence. The MHRB does not have the power to change the treatment but they may make the patient no longer involuntary or if the patient is on a CTO transfer the responsibility of supervision to another psychiatrist.

- 5.4.5 If the treating or supervising psychiatrist decides not to modify or discontinue the treatment or for any other reason the patient remains dissatisfied he or she may request that the Chief Psychiatrist take steps as outlined in 5.5.

5.5 Further remedy when person dissatisfied (s.112)

- 5.5.1 If another opinion obtained indicates that the psychiatric treatment should be modified or discontinued and the person concerned continues to be dissatisfied with the treatment, the Chief

Psychiatrist is required, on becoming aware of the person's continued dissatisfaction, to either transfer responsibility for treating the person from the treating psychiatrist to another psychiatrist; or refer the matter to the MHRB.

- 5.5.2 The responsibility as outlined in 5.5.1 has been delegated by the Chief Psychiatrist to Heads of Service or a psychiatrist acting in that position.

- 6.0 Revocation of a Community Treatment Order (CTO)**
(Relevant to Operational Circular 2060/06 Revocation of a CTO)
- 6.1 Directions and delegation regarding treatment**
- 6.1.1 The Chief Psychiatrist may at any time review any decision of a psychiatrist as to the treatment of any involuntary patient and vary or rescind the decision or substitute another decision for it (s.12).
- 6.1.2 The Chief Psychiatrist may delegate to another psychiatrist a function under the *Mental Health Act 1996* (MHA), other than this power of delegation (s.16).
- 6.2 Community Treatment Orders (CTOs)**
- 6.2.1 A psychiatrist may make a person an involuntary patient on a CTO by completing a Form 10.
- 6.2.2 The Form 10 notes the name of a Supervising Psychiatrist who will be responsible for supervising the carrying out of the order. (s.68).
- 6.3 Revocation of a CTO**
- 6.3.1 The Supervising Psychiatrist may revoke a CTO with or without making an order that the person be admitted to and detained in an authorized hospital for a period of up to 28 days (s.70).
- 6.3.2 If the purpose is to make the patient no longer an involuntary patient the Supervising Psychiatrist should complete a Form 8 and give the patient a copy.
- 6.3.3 If the purpose is to return or admit the person to an authorized hospital the Supervising Psychiatrist should complete a Form 11 which revokes the CTO and orders the patient's return to the authorized hospital.
- 6.3.4 In those circumstances the Form 11 acts like a Form 6 when the person is returned or admitted and no new Form 6 is required.
- 6.4 Revocation of a CTO when the Supervising Psychiatrist is not available**
- 6.4.1 The MHA is silent as to the revocation of a CTO when the Supervising Psychiatrist is not available.
- 6.4.2 In those circumstances the Chief Psychiatrist has detailed a process (6.5) for the care of the patient and delegated certain powers to a psychiatrist who is head of a mental health service or acting in that position.

6.5 Process

- 6.5.1 A mental health clinician believes that a patient on a CTO needs to be returned or admitted to hospital. To facilitate that process the CTO needs to be revoked.
- 6.5.2 The revocation can be done by the Supervising Psychiatrist. However, despite attempts being made the Supervising Psychiatrist is not contactable or available to assist.
- 6.5.3 Because of the condition of the patient it is decided that the patient requires treatment in an authorized hospital and the matter cannot wait until the Supervising Psychiatrist is available or can be contacted.
- 6.5.4 In those circumstances the mental health clinician should contact the head of service or if the Head of Service is not available the psychiatrist on duty and inform them of the situation.
- 6.5.5 Using the Chief Psychiatrist's power of delegation the Head of Service or psychiatrist on duty may, if he or she feels it is appropriate, make the patient no longer an involuntary patient and complete a Form 8.
- 6.5.6 A medical practitioner or an AMHP may then having examined the person refer the person for examination by a psychiatrist at an authorized hospital or other place by completing a Form 1.

6.6 Reason for this Process

- 6.6.1 It is not acceptable practice for a psychiatrist other than the Supervising Psychiatrist to revoke a CTO in order that the person be detained in an authorized hospital for up to 28 days.
- 6.6.2 The process described allows for an assessment by a medical practitioner or AMHP and a further review by psychiatrist places a more appropriate responsibility on practitioners who have assessed or familiar with the patient rather than the Head of Service who may have very limited information on the patient.

7.0 Patients access to personal records

(Relevant to Operational Circular 2056/06 Patients access to personal records)

7.1 Access to personal records (s.160)

7.1.1 Personal records are any relevant document, that relates to a patient or former patient that is in the possession of, or under the control of the person in charge of a hospital or any person employed in the department.

7.1.2 This may include electronic data including personal information on PSOLIS, LAMIS, TOPAS and E-Mails.

7.1.3 A person who is or has been a mentally impaired defendant detained in an authorized hospital, or an involuntary patient, whether or not detained in an authorized hospital, has the right to inspect and be given an accurate reproduction of any relevant document.

7.1.4 Section 160 gives patients a right without restriction to copies of any forms, apart from forms 1 and 7 (s.159) and the right that a person may have under any other law (eg: Freedom of Information Act) to inspect or be given a reproduction of a document.

7.2 Right to access personal records

7.2.1 A person who is or has been an involuntary patient at any time either in hospital or living in the community, or a mentally impaired defendant detained in an authorized hospital, has the right to inspect and receive copies of any document pertaining to themselves.

7.2.2 If consent has been provided then this right extends to the person's representative or another person acting on behalf of the person.

7.2.3 This right is separate from the right of a patient to seek access to personal records through the *Freedom of Information Act 1992*.

7.2.4 The access should be granted in a timely manner, unless the exceptions as detailed under 7.3, are applicable. Granting more timely access is particularly relevant when the access is sought to assist representation before the MHRB.

7.2.5 In taking instructions to represent the patient, the representative may request access to the medical record of the patient in preparation for the review. Every effort to allow access to a patient's medical record must be taken, though exceptions to this right need to be taken into consideration as access to a representative is similar as access to the patient.

7.2.6 The MHRB may at times adjourn a review so that proper access to medical records may be completed.

7.2.7 Care should be exercised in granting access as the medical record remains confidential to the individual and a private location should be made available for access and copies of records kept in a safe place.

7.3 Exceptions to this right

7.3.1 The right to access personal records (s.160) is qualified by exceptions to this right (s.161), which limits in certain circumstances a patient or his or her representative's access to personal records. These circumstances are:

(a) That disclosure would have a substantially adverse effect on the health and safety of the patient, former patient or any other person;

(b) Reveal personal information about another individual, whether living or dead;

(c) Reveal information of a confidential nature obtained in confidence. The limitation placed on the disclosure of confidential communications includes all communications passing between Legal and Legislative Services and hospital/health services or Departmental staff for the dominant purpose of obtaining or Legal and Legislative Services giving legal advice (and includes the legal advice itself).

7.3.2 In order to ascertain whether these exceptions apply the person in control of the medical record, usually the psychiatrist responsible for treatment or supervision, or another person nominated on behalf of that person should examine the medical record.

7.3.3 If no exceptions are noted then the person should be provided with access to the medical record or a copy of the record.

7.3.4 If exceptions do apply then the person in charge of the medical record may decide not to permit access either to the person or his or her representative.

7.3.5 Access may be granted if a person, other than the patient, who has provided confidential or personal information (ie a 'third party') permits the access (s.161(1)(b)(c)). Access should not be granted until this is confirmed in writing.

7.3.6 Any exceptions do not prevent access to parts of the medical record where the exceptions are not relevant. In those circumstances the person or his or her representative should be informed that they are being allowed partial access.

7.4 Suitably qualified person

- 7.4.1 Should the patient be deemed unable to access their medical record then the patient or former patient may nominate a 'suitably qualified person' access to their medical record.
- 7.4.2 A 'suitably qualified person' is a consultant psychiatrist.
- 7.4.3 A patient's legal representative does not have the authority to withhold information from their client of the type described above and as such is not deemed a 'suitably qualified person' by the Chief Psychiatrist.

8.0 The Council of Official Visitors and Access to Medical Records

(Relevant to Operational Circular 2057/06 Council of Official Visitors access to personal records)

8.1 Powers of an official visitor (s.190)

8.1.1 An Official Visitor (OV) or a panel appointed by the Council of Official Visitors (COV) may, whether or not notice has been given, visit a place where any 'affected person' is detained, cared for, or treated.

8.1.2 An 'affected person' is an involuntary patient, a mentally impaired accused person who is in an authorized hospital or a person who is socially dependant because of mental illness and who resides, and is cared for or treated, at a licensed private psychiatric hostel (s.175).

8.1.3 The visit may be at any time and for as long as the OV or panel sees fit.

8.1.4 In the course of the visit the OV or any person on the panel may:

- (a) Inspect any part of the place;
- (b) See any affected person at the place who has not declined to be seen;
- (c) Make enquiries relating to the admission, detention, care, treatment, or control, of affected persons;
- (d) Subject to the affected person's right to decline inspect:
 - (i) any medical record or other document or any thing relating to an affected person; or
 - (ii) any other record or document required by this Act to be kept at the place.

8.1.5 An affected person has the right to decline to be seen by an OV or any person on the panel, and the right to deny an OV or any person on the panel access to the person's medical records.

8.1.6 A person having any official capacity at the place visited such as a nurse or hostel manager is to give any assistance that may be requested by the OV so that the OV can carry out his or her duties. They should also answer any enquiry by the OV that may be made in regard to these duties.

8.2 Access to a patient's medical records

8.2.1 Under the *Mental Health Act 1996* (MHA) OVs have a number of responsibilities. These include ensuring that the rights of affected persons are observed and being accessible to hear, inquire into and seek to resolve complaints.

- 8.2.2 OVs may visit involuntary patients and affected persons and in the course of the visit inspect any medical records or other documents or any thing relating to an affected person unless limitations apply.
- 8.2.3 The limitation placed on this power is that the affected person has the right to decline seeing an OV and a right to decline access to his or her medical records.
- 8.2.4 The power given by ss.(4) to inspect medical records may be exercised only where the patient concerned has been given the opportunity to consider whether to grant or deny access to the person's medical records. A person cannot be said to have a "right" to deny access to medical records if the person has not been given the opportunity to make that decision.
- 8.3 Process for seeking access**
- 8.3.1 The seeking of permission from the patient for an OV to have access to his or her medical file is a task for the staff of the mental health service.
- 8.3.2 This places a responsibility on the staff of the mental health service to speak to the patient or affected person and inform them of the request from the OV and their right to decline that request.
- 8.3.3 An information brochure outlining the role of the COV could be helpful to the patient.
- 8.3.4 To assist the patient in their decision-making it may also be necessary to seek information, either written or verbal, from the OV as to the reason for the access to the medical record. This will enable the patient to be fully informed as to why the request is being made.
- 8.3.5 If necessary, patients should be given time to consider their decision.
- 8.3.6 The objective of this is to ensure the patient makes their decision, whether to grant access or not, freely and with as much information as possible.

- 9.0 Seclusion, Restraint and 'Time Out'**
(Relevant to Operational Circular 2058/06 Seclusion, Restraint and Time Out)
- 9.1 Seclusion**
- 9.1.1 The *Mental Health Act 1996* (MHA) (s.116) states that seclusion means *sole confinement in a room that it is not within the control of the person confined to leave*.
(For further information refer to page 28 of the Clinician's Guide)
- 9.2 Restraint**
- 9.2.1 The MHA only refers to Mechanical Bodily Restraint or the police use of reasonable force (see pages 29 and 43 of the Clinician's Guide)
- 9.2.2 Any other forms of restraint are allowable in line with duty of care and the doctrine of necessity.
- 9.3 Principles**
- 9.3.1 Seclusion and restraint as defined under the MHA are safety interventions of last resort and are not treatment interventions.
- 9.3.2 Seclusion and restraint should never be used for the purposes of discipline, coercion, or staff convenience such as managing inadequate staffing levels.
- 9.3.3 The use of seclusion and restraint creates significant risks for people with mental illness. These risks include serious injury or death, re-traumatisation of people who have a history of trauma, loss of dignity and other psychological harm.
- 9.3.4 In light of these potential serious consequences, seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible.
- 9.3.5 All mental health services should endeavour to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained staff.
- 9.4 Good Practice standards can be met by-**
- 9.4.1 Early identification and assessment of individuals who may require these interventions of last resort though this does not suggest that seclusion be listed as a planned treatment on a management plan.
- 9.4.2 High quality, active treatment programs conducted by trained and competent staff who effectively employ individualised alternative strategies to prevent and defuse escalating situations.

- 9.4.3 Policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures.
- 9.4.4 Effective quality assurance programs to ensure standards are met and to provide a methodology for continuous quality improvement.
- 9.4.5 Close monitoring of any occasions of use of these interventions and reporting as required by the MHA.
- 9.5 Time Out**
- 9.5.1 In an authorized facility, 'time out' where a door is locked preventing a person from leaving is 'seclusion' and all the necessary procedures under the MHA are to be complied with.
- 9.5.2 In a non-authorized facility placing a person in a room from which they cannot leave may be a breach of s.333 of the Criminal Code. A person may only be placed in a room from which they cannot leave if there are justifiable and proper reasons for doing so.
- 9.5.3 These may include exercising a duty of care to the patient or others and where there is no safe alternative other than placing a person in a room from which they are unable to leave.
- 9.5.4 'Time out' may be part of a treatment or behaviour modification plan. However even as part of a plan whereby the patient agrees to go into a 'time out' room no patient should be placed in a room from which they are unable to leave.
- 9.6 Provision of Basic Needs**
- 9.6.1 Section 120(a) of the MHA states that *'appropriate provision is made for the basic needs of the patient, including bedding, clothing, food, drink and toilet facilities'*.
- 9.6.2 Only in the most exceptional of cases would it be justifiable not to comply with this requirement.

MATTERS TO BE REPORTED TO THE CHIEF PSYCHIATRIST

(Relevant to Operational Circular 2061/06 matters to be reported to the Chief Psychiatrist)

1.0 Principles

1.1 Matters to be reported to the Chief Psychiatrist apply in regard to serious incidents and deaths, which occur in mental health services throughout Western Australia (WA).

1.2 Timeliness of Reporting

Reporting to the Chief Psychiatrist is to be undertaken as matter of priority.

1.3 Multiple Reporting

The reporting to the Chief Psychiatrist is required despite services being required to report to their internal management structures, the Director General, Minister for Health, the Office of Safety and Quality Sentinel Event Review Group, AIMS, Internal Audit and Accountability the Corruption and Crime Commission (CCC) and the Coroner.

1.4 Provision of Information to the Chief Psychiatrist

As well as the provision of the details listed below regarding a death or a serious incident services are to provide copies of briefings, reports and summaries of investigations even if the Chief Psychiatrist does not specifically request them.

1.5 Corruption and Crime Commission (CCC)

1.5.1 In complying with the reporting requirements of the CCC, health services are not restricted from complying with reporting to the Chief Psychiatrist'.

1.5.2 The CCC recommendation that matters can be communicated to the Chief Psychiatrist where they are relevant to the responsibility of ensuring an adequate standard of care to patients.

1.5.3 The CCC (s.7B(3)) is to help public authorities (ie the Chief Psychiatrist) to deal effectively and appropriately with misconduct by increasing their capacity to do so while retaining power itself to investigate cases of misconduct, particularly serious misconduct.

1.5.4 The CCC has the power to prevent the Chief Psychiatrist from investigating an incident of alleged misconduct however aside from this the Chief Psychiatrist is not prevented from exercising his powers under the *Mental Health Act 1996* to conduct a concurrent investigation into matters of alleged misconduct.

2.0 Deaths

2.1 The Chief Psychiatrist is to be informed as a matter of priority, of any death of a patient while under the care of any mental health service. This applies to voluntary and involuntary inpatients and patients cared for in the community.

2.2 The information to be provided includes:

- (a) Name of patient;
- (b) Date of birth;
- (c) Address;
- (d) Voluntary patient, referred person or involuntary patient, (specify whether detained involuntary or on a CTO);
- (e) In-patient or community care patient;
- (f) Where death took place;
- (g) Probable cause of death, eg: Suicide/ accident/medical cause (this may be just hypothetical until Coroner's findings);
- (h) Known self-harm risk;
- (i) Involvement of mental health services;
- (j) Involvement of relatives or carers;
- (k) Involvement of community members;
- (l) Special factors - eg: on special watch, in seclusion, on leave from hospital, recently discharged, person not referred or referred person not admitted, known threats of self-harm or harm to others, medical condition;
- (m) Any media interest;
- (n) Any possible breach of mental health care;
- (o) Any other factors.

3.0 Serious Incidents

3.1 The Chief Psychiatrist is to be notified as a matter of priority, of any serious incident and associated issue that may reflect on the standards of mental health care in WA.

3.2 The reporting will include advice as to the potential for media or public implications in regard to the incident or associated issue.

3.3 Serious incidents may include, but are not confined to the following examples:

- (a) Serious assaults on or by staff, other patients or visitors;
- (b) Alleged sexual assault on or by staff, other patients or visitors;
- (c) Serious medication error which may require review;
- (d) Absconding of any forensic patient;
- (e) Absconding of any detained involuntary patient at serious risk of self-harm or harm to others;
- (f) Serious misuse or mistake of a function performed under the MHA;
- (g) Involvement of any government or non-government organisation which is contrary to functions under the MHA;
- (h) Serious or significant criminal activity, which occurs either in the community or a mental health facility, reported at a mental health

facility, and which may receive attention by the media or the police service;

- (i) Any incident which by its nature or persons involved may receive attention by the media or the wider community.

3.4 The information to be provided includes:

- (a) Name of patient;
- (b) Date of birth;
- (c) Address;
- (d) Voluntary patient, referred person or involuntary patient, (specify whether detained involuntary or on a CTO);
- (e) In-patient or community care patient;
- (f) Details of the incident;
- (g) Involvement of mental health services;
- (h) Involvement of relatives or carers;
- (i) Involvement of community members;
- (j) Any media interest;
- (k) Any possible breach of mental health care;
- (l) Any other factors.

4.0 Reporting

4.1 Reporting of Serious Incidents and Deaths can be made via e-mail or phone call to the Chief Psychiatrist with a cc to the Manager, Office of the Chief Psychiatrist as soon as possible after the incident.

4.2 Should all details of the incident not be available at the time of initial priority reporting then subsequent e-mail or phone advice to the Manager, Office of the Chief Psychiatrist is indicated.

Contact details are:

Mrs Janet Peacock
Phone: 9222 4462
Fax: 9222 4244
E-mail: janet.peacock@health.wa.gov.au

CHIEF PSYCHIATRIST DELEGATIONS

(Relevant to Operational Circular 2062/06 Chief Psychiatrist's delegations)

Power of Delegation by the Chief Psychiatrist

The Chief Psychiatrist may delegate to another psychiatrist a function under the *Mental Health Act 1996* (MHA), other than this power of delegation (s.16). The *Health Legislation Administration Act 1984*, s9 empowers the Chief Psychiatrist to delegate his powers and responsibilities under the MHA.

1.0 Revocation of a Community Treatment Order (CTO)

- 1.1 In relation to a patient subject to a CTO the Chief Psychiatrist delegates the power to make the patient no longer an involuntary patient to any psychiatrist who is head of the mental health service or acting in that position.
- 1.2 For further details of the process see Revocation of a Community Treatment Order in this Supplement.

Delegation

The Chief Psychiatrist may at any time review any decision of a psychiatrist as to the treatment of any involuntary patient and vary or rescind the decision or substitute another decision for it (s.12). The Chief Psychiatrist has delegated the responsibility of revoking a CTO and making a person no longer involuntary to the Heads of Mental Health Services or if the Head of Service is not available the psychiatrist acting in that position.

2.0 Medical treatment may be approved by the Chief Psychiatrist (s.110)

- 2.1 A person who is in an authorized hospital as an involuntary patient or a mentally impaired defendant may be given medical treatment, other than psychiatric treatment or treatment referred to in s.108 of the MHA (Prohibited treatments, psychosurgery and electroconvulsive therapy) if it has been approved in writing by the Chief Psychiatrist.
- 2.2 The MHA does not permit treatment, other than psychiatric treatment to be given against the person's wishes, where involuntary patients or mentally impaired defendants are capable of providing consent. Consent should be sought from the patient for medical treatment on all occasions
- 2.3 In relation to involuntary patients and mentally impaired defendants who are not deemed capable of providing consent to treatment, then medical treatment may be provided with the written approval of the Chief Psychiatrist or those with delegated authority.
- 2.4 Approval for medical treatment for involuntary patients and mentally impaired defendants who are not deemed capable of providing consent to treatment can also be sought under s.119 of

the *Guardianship and Administration Act 1990*. Further information is provided at www.justice.wa.gov.au.

Delegation

The Chief Psychiatrist has delegated this responsibility of providing approval for medical treatment to the Heads of Mental Health Services or if the Head of Service is not available the psychiatrist acting in that position.

The Chief Psychiatrist is to be provided with a report when this delegation is used.

3.0 Access to certain information about a patient (s.205)

3.1 A person may ask the Chief Psychiatrist to inform the person whether a particular person has been admitted to, or is detained in, an authorized hospital.

3.2 If the Chief Psychiatrist thinks that the inquirer has a proper interest in the matter, the Chief Psychiatrist is to give the required information to him or her, including particulars, where applicable, of the date of admission and the date of the person's discharge, release or death.

Delegation

The Chief Psychiatrist has delegated this responsibility to the Heads of Mental Health Services or if the Head of Service is not available the psychiatrist acting in that position.

The Chief Psychiatrist is to be provided with a report when this delegation is used.

4.0 Opinion of another psychiatrist may be requested (s.111, 112)

4.1 For further information see Request for another opinion on psychiatric treatment in this supplement.

Delegation

The Chief Psychiatrist has delegated the responsibility of arranging for the opinion of a psychiatrist to be obtained as to whether treatment should be given (s.111 (2)(b)) and the responsibility, on becoming aware of continued dissatisfaction, of transferring responsibility to another psychiatrist (s.112 (2)(a)) or referring the matter to the MHRB (s.112 (2)(b)) to the Heads of Mental Health Services or if the Head of Service is not available the psychiatrist acting in that position.

PSYCHIATRIST POSITIONS WITH DELEGATED AUTHORITY

North Metropolitan Area Health Service

Area Executive Director, Mental Health
Clinical Director, Adult Mental Health Program
Clinical Director, Older Adult Mental Health Program
Graylands Hospital, Head of Clinical Service
Inner City Mental Health Service, Head of Clinical Service
Inner City Mental Health Services for Older Adults, Head of Service
Joondalup Older Adult Mental Health Service, Head of Service
Joondalup/Clarkson Community Mental Health, Head of Clinical Service
Mirrabooka Community Mental Health, Head of Clinical Service
Morley Adult Mental Health Centre, Consultant Psychiatrist
Osborne Community Mental Health, Head of Clinical Service
Osborne Older Adult Mental Health Service, Head of Service
Selby Older Adult Mental Health Service, Head of Service
Sir Charles Gairdner Department of Psychiatry, Head of Clinical Service
State Forensic Mental Health Service, Director
Forensic Mental Health Service (Frankland Centre), In-patient Director
Forensic Community Mental Health Service, Director
Subiaco Community Mental Health (Avro House), Head of Clinical Service
Swan Adult Mental Health Service, Head of Clinical Service
Swan Elderly Mental Health Service, Head of Service
Ursula Frayne Unit, Mercy Hospital, Consultant Psychiatrist
Warwick CAMHS, Consultant Psychiatrist/Team Leader

South Metropolitan Area Health Service

Area Director, Mental Health
Armadale Mental Health Service, Clinical Director
Bentley Mental Health Service, Clinical Director
Fremantle Mental Health Service, Clinical Director
Peel & Rockingham Kwinana (PaRK) Mental Health Service, Clinical Director

WA Country Health Services

Central West Mental Health Service, Regional Consultant Psychiatrist
Great Southern Mental Health Service, Clinical Director Mental Health
Kalgoorlie Boulder Mental Health Inpatient Unit, Consultant Psychiatrist
Northwest Mental Health Service, Regional Consultant Psychiatrist Director
Wheatbelt Mental Health Service, Regional Consultant Psychiatrist
South West Mental Health Service, Consultant Psychiatrist on Duty at APU
Bunbury or Consultant Psychiatrist on Call

Women's and Children's Health Service

Women's and Children's Health Service, Chair, Psychological Medicine
Clinical Care Unit

APPENDIX:

CHIEF PSYCHIATRIST'S OPERATIONAL CIRCULARS

TITLE	Number
Processes and functions under the <i>Mental Health Act 1996</i>:	
Psychiatric Examination at Non-Authorized Facilities s.29 (2) (b) of the <i>Mental Health Act 1996</i>	2052/06
Completion of a Transport Order (Form 3) <i>Mental Health Act 1996</i> (sections 34,41,71,84)	2053/06
Request for a another opinion on Psychiatric Treatment s.111/112 of the <i>Mental Health Act 1996</i>	2059/06
Patients Access to Personal Records s.160, 161 of the <i>Mental Health Act 1996</i>	2056/06
Seclusion, Restraint and Time Out <i>Mental Health Act 1996</i>	2058/06
Not Acting On A Form 1 ('Referral For Examination By A Psychiatrist') and Form 3 ('Transport Order') <i>Mental Health Act 1996</i>	2054/06
Council Of Official Visitors Access To Personal Records <i>Mental Health Act 1996</i>	2057/06
Revocation of a community treatment order (CTO) <i>Mental Health Act 1996</i> (ss 68 and 70)	2060/06
Emergency psychiatric treatment and issues of consent <i>Mental Health Act 1996</i> (ss 113 -115 and part 5, div 2)	2055/06
Matters to be Reported to the Chief Psychiatrist	2061/06
Chief Psychiatrist Delegations	2062/06
Use of SSRI and SNRI antidepressants in children and adolescents- Provision of information by the Chief Psychiatrist under the Mental Health act 1996	1926/05
Risk of hyperglycaemia and diabetes mellitus associated with use of antipsychotic drugs - provision of information by the Chief Psychiatrist under the Mental Health Act 1996	1912/05