

Mental Health Act 2014

Information for Referring Practitioners

Medical Practitioners, General Practitioners, Psychiatric Registrars
and Authorised Mental Health Practitioners

Introduction to the *Mental Health Act 2014 (MHA14)*

The MHA14 received Royal Assent on 3 November 2014 and will commence on 30 November 2015. It will replace the *Mental Health Act 1996* which will remain in force until 29 November 2015.

All clinicians must make every effort to comply with the Charter of Mental Health Care Principles when providing treatment, care and support to people experiencing mental illness. The Charter can be found in Schedule 1 of the MHA14

There are new Approved Forms for the MHA 14 (see Approved Forms on Office of Chief Psychiatrist (OCP) website). The clinician needs to complete the required legal information on the Approved Form, additional referral information can be provided separately.

Referring Practitioners Role and Responsibility under MHA14

1.0 Who can refer?

- 1.1 Medical practitioners and Authorised Mental Health Practitioners (AMHP's) can refer a person, for an examination by a psychiatrist at either an authorised hospital or other place.
- 1.2 Police have the power to apprehend a person they suspect has a mental illness that requires assessment, and take them to a place where they can be assessed by a medical practitioner or an AMHP.

2.0 What are the criteria for referral?

- 2.1 A practitioner can only refer a person for examination by a psychiatrist where they reasonably suspect that:
 - 2.1.1 the person is in need of an involuntary treatment order, or
 - 2.1.2 if the person is currently on a community treatment order, the person is in need of an inpatient treatment order.
- 2.2 The assessing practitioner must have regard to the criteria for an involuntary treatment order which are:
 - 2.2.1 the person has a mental illness requiring treatment, and
 - 2.2.2 because of their mental illness there is a significant risk to the persons health or safety or to the health or safety of another person, or
 - 2.2.3 there is a significant risk of harm to the person or another person, and
 - 2.2.4 the person does not demonstrate the capacity to make a decision about treatment, and
 - 2.2.5 there is no lesser restrictive way of providing them with treatment

3.0 What is the definition of mental illness MHA14 (s.6)

3.1 A person has a mental illness if the person has a condition that:

3.1.1 is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and

3.1.2 significantly impairs (temporarily or permanently) the person's judgment or behavior

3.2 Just because a person uses alcohol or other drugs does not mean they have a mental illness. However the use of alcohol and drugs does not preclude the suspicion that a person who is intoxicated has an underlying mental illness and may need to be referred.

4.0 Conducting the assessment

4.1 A practitioner cannot refer a person unless the practitioner has assessed the person and the assessment must have been completed within the previous 48 hours.

4.2 The assessment must be conducted in the least restrictive way and in the least restrictive environment.

4.3 The person and the practitioner should be in each other's physical presence, for example in the same room. If that is not practicable, for example if the person has locked themselves in a room, then an assessment can still be conducted if the practitioner and the person are able to hear each other and communicate. This does not include the use of a telephone but it could include, for example, communicating through a locked door.

5.0 Conducting an assessment using Audio Visual means in non-metropolitan areas only

5.1 A medical practitioner or an AMHP may conduct an assessment using audio visual (AV) means if the person being assessed is in a non-metropolitan area, it is not practicable for the practitioner and the person to be in one another's physical presence and there is a health professional with the person being assessed.

5.2 A health professional is either a medical practitioner, a nurse, an occupational therapist, a psychologist, a social worker or in relation to a person of Aboriginal or Torres Strait Islander (ATSI) descent either an ATSI mental health worker or a health professional.

6.0 Making a referral for an examination by a psychiatrist

6.1 A referral can only be made by completing a **Form 1A** (Referral for an examination by a psychiatrist).

6.2 **Form 1A** is valid for 72 hours, however in non-metropolitan areas the Order can be extended for another 72 hours **Form 1B** (Variation of referral) (maximum of 144 hrs).

6.3 Referrals can be made to an authorised hospital or other place where a psychiatrist can examine a person, such as an emergency department, a mental health clinic or a general hospital.

6.4 If the referred person has a physical illness, which would prevent the person being transported to, or receiving treatment in an authorised hospital, the referral can be made for the person to be examined by a psychiatrist in another place such as an emergency department for consideration of an involuntary inpatient order in a general hospital.

6.5 The person must be provided with the information about the referral and this is best done by giving the referred person a copy of the **Form 1A**.

6.6 If information is provided in confidence by a third party this information should be recorded in the **Attachment to Form 1A** and a copy of that attachment **must not** be given to the referred person.

7.0 Detention of a Referred Person

7.1 If the referring practitioner or another practitioner is satisfied that the referred person needs to be detained to enable the referred person to be taken to the examination they can be detained for up to 24 hours by completing a **Form 3A** (Detention order).

7.2 It should not be routine to make a detention order at the same time as a referral.

7.3 The **Form 3A** can be extended for further periods of 24 hours up to a maximum of 72 hours or to the end of the Referral Order by completing a **Form 3B** (Continuation of detention).

7.4 The detained person must be given a copy of the **Form 3A**.

- 7.5 When a Form 3A is completed, a personal support person must be notified as this is a notifiable event.
- 7.6 If the Form 3A expires or the person is not transported, the person must be released or reassessed to determine ongoing risk. If the person is released a personal support person must be notified
- 7.7 During the period of detention the referred person must be given the opportunity and the means to contact a carer, close family member or other personal support person, a health professional who is currently providing the person with treatment and the Chief Mental Health Advocate as soon as practicable and at all reasonable times while the person is being detained.
- 7.8 A person's detention cannot continue if:
 - 7.8.1 the referral is revoked;
 - 7.8.2 the referral expires before the person has been taken to the authorised hospital or other place; or
 - 7.8.3 the order for their detention expires and has not been, or cannot be, extended and the person has not been taken to the authorised hospital or other place and has not been apprehended under a transport order.
- 7.9 Note that the provisions for the reporting of seclusion and restraint under the MHA14 only apply in authorised hospitals, but that does not limit the need for clinical documentation when a person is restrained.

8.0 Transport Order Form 4A

- 8.1 If the referring practitioner believes that the person can travel safely with their personal support person, a health professional or community staff member to the place where the psychiatric examination will take place then that is the preferred method of transport.
- 8.3 If the referring practitioner believes that there is no other safe means reasonably available for taking the person for the examination then the practitioner can make a Transport Order by completing Form 4A authorising a transport officer or a police officer to apprehend the person and transport them.

- 8.2 Police should only be used if:
 - 8.3.1 there is a significant risk of serious harm to the person being transported or to another person,
 - 8.3.2 or that a transport officer is not available to carry out the Order in a reasonable time and any delay is likely to pose a significant risk to the person being transported or to another person.
- 8.4 A Transport Order is valid for 72 hours or is automatically cancelled when a referral order is revoked or expires.
- 8.5 A Transport Order can be revoked by completing the revocation section on the Form 4A if the Order is no longer required and the transport officer or police officer must be informed.
- 8.6 The personal support persons must be notified when a Transport Order is made, revoked or expires.
- 8.7 The person must be given a copy of the Transport Order Form 4A.

9.0 Changing the place where the examination is to be conducted (Form 1B variation of referral)

- 9.1 A patient may be referred to a particular authorised hospital or other place, but that place may not be able to receive the person or the place may be inappropriate or unable to receive the person.
- 9.2 When changing the place of examination, the medical practitioner or AMHP must consult with clinicians at the new location, and where appropriate receive advice from the bed-flow service, and change the place where the psychiatric examination will take place by completing Form 1B – Variation of Referral.
- 9.3 The person responsible for taking the patient to the place of examination must be told about the change of destination.

10.0 Revocation of a Referral Order Form 1A

- 10.1 At any time following a referral being made, a medical practitioner or AMHP may revoke the referral if they are satisfied that the person being referred is no longer in need of an involuntary treatment order. The revocation section of Form 1A needs to be completed.

- 10.2 An order can be revoked by:
- 10.2.1 the practitioner who made the order; or
 - 10.2.2 another practitioner, as long as he or she consults with or attempts to consult with the referring practitioner as to why the order should be revoked; or
 - 10.2.3 if that is not practicable then another practitioner may revoke the order by completing the revocation section on the Form 1A

11.0 Referred person on a Detention Order leaves the place where they are detained

- 11.1 If the referred person leaves the place where they are being detained (Form 3A or 3B) every effort should be made to return the person to the place where they were detained.
- 11.2 If that is not possible the medical practitioner or person in charge of the hospital can make an Apprehension and Return Order (**Form 7D**) authorising the police or a staff member of a mental health service to apprehend the referred person and return them to the place where they were detained.
- 11.3 The Apprehension and Return Order is valid for up to 14 days and cannot be extended.
- 11.4 Apprehension and Return orders can be revoked, for example if the person is returned without the use of police or hospital staff and the person authorised to apprehend be informed.
- 11.5 An apprehension and return order can only be made in relation to a referred person if they were subject to a detention order under Form 3A or 3B.

12.0 Providing psychiatric treatment to referred persons

- 12.1 Referred persons, like voluntary patients, must provide informed consent to treatment if treatment is needed.
- 12.2 Emergency Psychiatric Treatment (EPT) can be provided to a person, including referred persons and voluntary patients, without the requirement of informed consent, in order:
- 12.2.1 to save the person's life, or
 - 12.2.2 to prevent the person from causing serious physical injury to themselves or another person.

- 12.3 If EPT is provided a **Form 9A** must be completed and a copy sent to the Chief Psychiatrist.
- 12.4 Emergency electroconvulsive therapy cannot be given to a referred person.
- 12.5 Historically emergency treatment has been provided under the 'doctrine of necessity' (duty of care).

13.0 Cultural Considerations

- 13.1 When assessing a person of ATSI descent either by AV means or face to face, the practitioner must, to the extent that it is practicable and appropriate, conduct the assessment in collaboration with an Aboriginal and Torres Strait Islander (ATSI) mental health worker and significant people from the person's community including elders and traditional healers.
- 13.2 Any communication with a person must be in a language, form of communication and terms that a person is likely to understand using any means of communication that is practicable and using an interpreter if necessary and practicable.

14.0 Notifying a personal support person (notifiable events)

- 14.1 A Personal Support Person is a carer, a close family member, a guardian or enduring guardian, a parent or legal guardian of a child, a nominated person (who could be a friend, neighbour or partner who is not a legal defacto)
- 14.2 At least one personal support person must be notified when certain events occur (notifiable events). (**See Table 14.6*)
- 14.3 Consent is not needed from the person who has been referred to notify a personal support person of these events but it would be good practice to seek it.
- 14.4 Every effort should be made to contact at least one personal support person, until either contact is made or it can be reasonably assumed the person cannot be contacted.
- 14.5 A personal support person should not be notified if the referrer believes it is not in the referred persons best interest. The Chief Mental Health Advocate must be informed if this occurs.
- 14.6 List of notifiable events that apply to referred/detained persons:

* Table 14.6

Where a MHA14 Approved form prompts the making of a notification to a Personal Support Person			Responsibility
1	s. 28(8)	Making Form 3A – Detention order in respect of a referred person (Refer to Form 3A)	The medical practitioner or AMHP who makes the order
2	s. 28(12)	Releasing a person because they cannot continue to be detained under a Form 3A – Detention Order	The medical practitioner or AMHP
3	s.29(4)	Making a transport order to take a referred person to the place of examination (Refer to Form 4A)	The medical practitioner or AMHP who makes the order
4	s. 31(7)	Releasing a person who was being detained under a Form 3A – Detention order, because the referral was revoked (Refer to Form 3A)	The medical practitioner or AMHP who revokes the referral
5	s.97(3)	When the person is absent without leave from a place where they were being detained.	The person in charge of the hospital or other place (where the person was being detained)

15.0 Informing a referred person about their rights

15.1 A referred person must be informed of their rights, which include:

- 15.1.1 having the opportunity and means to contact personal support persons and others
- 15.1.2 the right to be provided on request with advocacy from the Mental Health Advocacy Service who must make contact with the person if the person is detained within 3 days
- 15.1.3 the right to be provided with information on the Form 1A, excluding the Form 1A attachment.
- 15.1.4 the right to a copy of the forms 1B, 3A, 3B, 3D, 3E, 4A and 4B.

Information for Referring Practitioners will be reviewed 12 months from commencement of MHA14

16.0 Guidelines and information

The following sources of information are available for those who would like to find out more about the MHA14. The Chief Psychiatrist would encourage all clinicians to access relevant MHA14 information and education tools via the links below:

- 16.1 The MHA14, the Regulations to the MHA14 and the Transitional arrangements *Mental Health Legislation Amendment Act 2014* can be accessed on: http://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13537_homepage.html
- 16.2 The Clinicians' Practice Guide (CPG) can be accessed on www.chiefpsychiatrist.health.wa.gov.au/act
- 16.3 The Clinicians ELearning Package (CELP) can be accessed on OCP [website](#)
- 16.4 The Referrers ELearning Package can be accessed on OCP [website](#)
- 16.5 The Chief Psychiatrist Standards and Guidelines can be accessed on OCP [website](#)
- 16.6 Information for carers, consumers and the general public is available on the MHC website www.mentalhealth.wa.gov.au/mentalhealthchanges/mh_legislation.aspx

Helpdesk for clinicians - 9222 4217
Available Mon – Fri 8.30 – 4.30
(30 Nov 2015 – 30 June 2016 available 24/7)

Flowchart for Referring Practitioners

This flowchart must be read in conjunction with the 'Information for Referring Practitioners' (MHA14)

Medical Practitioner (MP) or Authorised Mental Health Practitioner (AMHP) conducts an assessment on a person either face to face or in non-metro areas by Audio-visual (AV) means.

The referrer reasonably suspects the person is in need of an involuntary treatment order and completes a **Referral Order - Form 1A** within 48 hrs of assessment.

The **Referral Order - Form 1A** lasts for up to 72 hrs to enable the person to be taken to the place of examination, which can be either an authorised hospital or other place where a psychiatrist can examine the person. The person must be given a copy of information in Form 1A, excluding confidential information in **Attachment to Form 1A**

In non-metro areas if the Form 1A will expire before the person arrives at the place of examination, it can be extended for further 72 hrs (maximum 144 hrs)
Variation of Referral Order - Form 1B

If a practitioner forms the opinion that the referred person no longer requires involuntary treatment the practitioner can revoke the referral by completing the **revocation section** of a **Referral Order - Form 1A**.

If the person needs to be detained to enable them to get to the place of examination, the referrer or another practitioner may detain the referred person for up to 24 hrs - **Detention Order - Form 3A**. Personal support person must be notified

The referrer or another practitioner may detain the referred person for further periods of 24 hrs - **Continuation of Detention Order - Form 3B**. The maximum period a person can be detained is until the referral expires, which is 72 hours in metro areas (or in non-metro areas, if the referral is extended then 144 hours)

If the condition of the person is such that transport by a Transport Officer or Police is required, the referrer can make a **Transport Order - Form 4A**. Personal support person must be notified

In non-metro areas if the Referral Order is extended, the Transport Order is automatically extended, and will expire when the Referral Order expires.

If a Referral Order is revoked the Transport Order is automatically revoked. A Transport Order can also be revoked without the Referral Order being revoked if the Transport Order is no longer required - **revocation section** of a **Transport Order Form 4A**

The referrer or another practitioner may change the place where the examination will be conducted after consulting with practitioners at the new destination, and must advise the person carrying out the transport - **Variation of Referral - Form 1B**

Person received at authorised hospital or other place and can be detained for 24 hours for examination by psychiatrist. (The Referral Order then no longer applies)

Charter of Mental Health Care Principles

Mental Health Act 2014

The Charter of Mental Health Care Principles are 15 principles that mental health services aspire to when providing treatment, care and support to consumers, their families and carers.

The Charter of Mental Health Care Principles are:

1. An organisational culture of dignity, equality, courtesy and compassion

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and meet the standards expected by the community. It must not discriminate or stigmatise them.

2. Protection of human rights

A mental health service protects and upholds the human rights of people experiencing mental illness and acts in accordance with national and international standards including United Nations Principles and Conventions.

3. Unique care for each individual

A mental health service provides care which is unique for each person and recognises the importance of life experiences, needs, preferences, aspirations, values and skills. The service must strive to obtain the best possible outcome for people experiencing mental illness and actively form partnerships with consumers and carers to achieve this. This includes the development of clear goals for treatment, care and support. A mental health service promotes and encourages positive recovery focused attitudes towards mental illness, including knowledge that people can and do recover and live a positive life while making meaningful contributions to the community.

4. Safe and accessible services

A mental health service provides a service when it is needed in order to provide the maximum benefit to those in need. It should be easily accessible and safe. Should the service be unable to provide a specific service, the person is given information, direction, support and assistance to access another appropriate service.

5. The opportunity for consumers to make their own decisions

A mental health service involves people in making their own decisions. The service will support and encourage people with mental illness to be responsible in making their own choices.

6. Welcoming all from diverse backgrounds

A mental health service must be sensitive and respond to diverse individual and family and carer circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices. If required, services will seek advice and refer patients to services where there is more knowledge or familiarity with particular diverse issues.

7. Care that respects Aboriginal culture and spirituality

A mental health service provides treatment and care to people of Aboriginal or Torres Strait Islander descent and must consider their cultural and spiritual beliefs and practices. The service will respect the views of their families and, where possible, the views of members of their community, including elders and traditional healers.

8. Addressing physical, medical and other co-occurring health issues

A mental health service equally addresses physical and medical health needs of people experiencing mental illness including dental health. These physical or health issues may be a consequence of mental illness or side-effects of treatment. Care and treatment also needs to address co-occurring health issues including physical and intellectual disability and alcohol and other drug problems.

9. Recognition of social factors that influence mental health and wellbeing

A mental health service recognises the circumstances which influence mental health and wellbeing of a person with mental illness. Services take a holistic approach to support recovery and to reduce risk of relapse. This includes addressing social and wellbeing problems such as homelessness, unemployment and relationships.

10. A respect for privacy and confidentiality

A mental health service must respect and maintain privacy and confidentiality.

11. Consideration for personal responsibilities and commitments

A mental health service acknowledges the impact of mental illness extends beyond the person. Families including dependents such as children, friends and colleagues of the person are all affected by these issues. The needs of children and other dependents should inform the recovery plan.

12. Clear information about mental health and treatments

A mental health service provides and clearly explains, information about the mental illness and treatment including any risks, side effects and alternatives, to people experiencing mental illness in a way which will help them to understand and to express views or make decisions.

13. Clear information about legal rights

A mental health service provides and clearly explains information about legal rights. These include information regarding representation, advocacy, compliments and complaints procedures, services and access to personal information, in a way which will help people experiencing mental illness to understand, obtain assistance and uphold their rights.

14. Planning which includes families and carers

A mental health service, at all times, respects and facilitates the rights of people experiencing mental illness. This includes the involvement of their family members, carers, and other personal support persons in every aspect of the person's treatment, care and support.

15. Commitment to continuous improvement with consumers, carers and families

A mental health service has a model of treatment and care which considers the wellbeing and quality of life for the person with a mental illness.

The service strives to continually improve the care it delivers, and takes a partnership approach to addressing issues and solving problems. This involves everyone, including carers and other support persons, who provide treatment care and support of people experiencing mental illness. For people of Aboriginal and Torres Strait Islander descent, this will include meeting the needs of their culture, spiritual beliefs and practices throughout all phases of care.

