Mental Health Act 2014
Information for private psychiatric hostels

Purpose of this document

The *Mental Health Act 2014* (2014 Act) will replace the *Mental Health Act 1996* (1996 Act) on **30 November 2015**.

Like the 1996 Act, the 2014 Act primarily relates to the treatment and care of involuntary patients. Therefore, the changes will mostly impact service delivery in authorised hospitals. However, some aspects of the 2014 Act will affect other services providing treatment and care for people experiencing mental illness. This document is intended to assist staff in private psychiatric hostels.

Key changes for private psychiatric hostels

1. Referral process

The referral process under the 2014 Act is similar to the process under the 1996 Act. A medical practitioner or an authorised mental health practitioner (AMHP) conducts an **assessment** and, if they reasonably suspect that the person is in need of an involuntary treatment order, they may refer the person for **examination** by a psychiatrist.

For a private psychiatric hostel, this will most commonly mean that a psychiatrist or other medical practitioner, or an AMHP, assesses a resident and may refer the resident for examination by a psychiatrist at an authorised hospital or other place.

Other places may include:

- an emergency department;
- a general hospital (public or private);
- a community mental health clinic;
- a regional nursing post;
- in some circumstances, a **hostel** or a residential home.

A referral is made using **Form 1A** and lasts **3 days** (previously 7 days). In a non-metropolitan area[1], this may be extended for **another 3 days**, in some circumstances.

The medical practitioner or AMHP who made the referral may revoke a referral where satisfied that the person is no longer in need of an involuntary treatment order. Another medical practitioner or AMHP may revoke the referral following consultation with, or efforts to consult with, the referring practitioner. The revocation section of **Form 1A** must be completed.

1.1 Assessment

Generally the assessing practitioner must be in the physical presence of the person or, if that is not practicable, must be able to hear one another without using a telephone or other communication device. In a non-metropolitan area an assessment may be conducted using videoconferencing in some circumstances.

The assessing practitioner may have regard to information from the person, from any other person, and from the person's medical record. However, a reasonable suspicion that the person is in need of an involuntary treatment order cannot be based solely on information from another person and/or the person's medical record. The practitioner must have regard to information from, and observations of, the person themselves. If the person being assessed is of Aboriginal or Torres Strait Islander descent, and it is **practicable and appropriate to do so**, the assessment must involve Aboriginal or Torres Strait Islander mental health workers **and** significant members of the person's community, including elders and traditional healers.

[1] An area of the State that is serviced by the WA Country Health Service.

1.2 Detention

Under the 2014 Act a referred person may be detained if they **need to be detained to enable an examination by a psychiatrist**. For example, where the person is at risk and is threatening to leave. Only a medical practitioner or an AMHP can make a detention order. The detention order is made using a **Form 3A** and it lasts for up to 24 hours.

A medical practitioner or an AMHP may extend the detention using **Form 3B**. Detention can only be extended where the practitioner determines that the person still needs to be detained to enable an examination by a psychiatrist. The Form 3B lasts 24 hours, and can be used twice. This means that detention (initial detention and continued detention) can be for a **total of 3 days**. This is the same period as a referral, although detention ends if the referral expires beforehand. In a non-metropolitan area, this may be extended for **another 3 days**, in some circumstances. If required, reasonable force can be used to detain the person under a duty of care. A person can no longer be detained and must be allowed to leave if either the detention order or the referral expires.

Where a person is detained for examination, they may be searched, and items that pose a risk may be seized. The staff member conducting the search should first seek agreement, although consent is not required. It is recommended that clinicians **refer to the Clinicians' Practice Guide** published by the Office of the Chief Psychiatrist for further information regarding the operation of search and seizure powers. **Forms 8A and 8B** are used to document search and seizure and how any seized articles were dealt with.

1.3 Transport

Ideally a person who needs to be transferred from a private psychiatric hostel to a place of examination will be transported by a family member or carer, or by ambulance if required. However, as with the 1996 Act, if there is no other safe means of transporting the person reasonably available, a transport order may be made. A transport order can be made by a medical practitioner or an AMHP by completing **Form 4A**. A transport orders lasts for the length of the referral.

The key change from the 1996 Act is that a transport order may be undertaken by a 'transport officer' or a police officer. Further information regarding transport officers will be provided closer to 30 November. A **Form 4A** may only specify a police officer as the person responsible for carrying out a transport order where:

- there is a significant risk of serious harm to the person being transported or to another person; or
- a transport officer will not be available within a reasonable time and the delay would pose a significant risk of harm to the person being transported or to another person.

A transport order lasts for the period of the referral, unless revoked beforehand. A medical practitioner or an AMHP may revoke a transport order where the referral has been revoked, or where satisfied that the transport order is no longer needed. The revocation section of **Form 4A** must be completed. The police or transport officer must be notified.

2. Examination

Where appropriate in the circumstances, a psychiatrist may conduct an examination of a resident in a private psychiatric hostel, for the purpose of deciding whether or not the person is in need of an involuntary treatment order. Even if the assessing practitioner was a psychiatrist, the examining psychiatrist must not be the assessing psychiatrist. It is recommended that psychiatrists **refer to the Clinicians' Practice Guide** for further information regarding the conduct of an examination.

A psychiatrist who examines a resident of a private psychiatric hostel can make any one of the following orders:

- an inpatient treatment order in a general hospital **(Form 6B)**;
- a community treatment order **(Form 5A)**;
- an order authorising reception and detention at an authorised hospital for examination by a psychiatrist **(Form 3A)**; or
- an order that the person cannot continue to be detained (and is no longer a referred person) **(Form 3E)**.

A psychiatrist who examines a person without a referral having been made may make a community treatment order. However, this must be confirmed by another psychiatrist or, if that is not possible, another medical practitioner or an AMHP. If the community treatment order is not confirmed within **3 days**, it is no longer in force.

An inpatient treatment order in a general hospital can only be made where the person is in need of an inpatient treatment order, but their physical condition is such that they cannot safely be detained at an authorised hospital. For example, a person who has an eating disorder or who has engaged in deliberate self-harm could be made an involuntary inpatient in an observations ward of a general hospital. Further, approval from the Chief Psychiatrist is required. The examining psychiatrist cannot make an inpatient treatment order in an authorised hospital, as this can only occur where a person is examined at an authorised hospital.

3. Criteria for an involuntary treatment order

A medical practitioner or an AMHP can only refer a person for examination by a psychiatrist where they reasonably suspect the following requirements are met. A psychiatrist can only make an involuntary treatment order where he or she determines that all of the requirements are met.

3.1 Inpatient treatment order

The criteria for an **inpatient treatment order** are, in summary:

- the person has a mental illness requiring treatment;
- because of the mental illness there is a significant risk to the health or safety of the person or to the safety of another person, or a significant risk of serious harm to the person or to another person;
- the person does not demonstrate the capacity to make a treatment decision;
- treatment in the community cannot reasonably be provided; and
- there is no less restrictive option.

The 2014 Act defines 'mental illness', and requires decisions regarding whether or not a person has a mental illness to be made in accordance with DSM-V and ICD-10.

The criterion regarding refusal of treatment in the 1996 Act is replaced with a capacity-based test under the 2014 Act (see below).

3.2 Community treatment order

The criteria for a **community treatment order** are, in summary:

- the person has a mental illness requiring treatment;
- because of the mental illness there is a significant risk to the health or safety of the person or to the safety of another person, or a significant risk of serious harm to the person or to another person, or a significant risk of the person suffering serious physical or mental deterioration;
- the person does not demonstrate the capacity to make a treatment decision;
- treatment in the community can reasonably be provided; and
- there is no less restrictive option.

4. Decision making capacity

Whether or not a person has decision making capacity is relevant in four key ways:

- whether or not an assessing practitioner reasonably suspects that a person meets the **criteria for an involuntary treatment order** (and therefore needs to be examined by a psychiatrist);
- whether or not an examining psychiatrist determines that a person is **in need of an involuntary treatment order**;
- whether or not a person has **capacity to provide informed consent** to treatment for mental illness; and
- whether or not a person has the **capacity to make decisions other than decisions about treatment** for mental illness (such as whether to take pain relief for a headache).

There is a **presumption that adults have decision making capacity, and that children do not**. However, an adult may demonstrate that they do not have decision making capacity, and conversely a child may demonstrate that they do have decision making capacity. There is a higher threshold for capacity to make a treatment decision under the 2014 Act. It is recommended that clinicians **refer to the Clinicians' Practice Guide**, or sections 15 and 18 of the 2014 Act, for further information regarding determination of capacity.

5. Treatment

5.1 Meaning of treatment

Treatment means any psychiatric, medical, psychological or psychosocial intervention intended to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of mental illness. For example, psychiatric medication, electroconvulsive therapy, immediate medical treatment following deliberate self-harm, or the use of nasogastric intubation for a patient with an eating disorder.

5.2 Informed consent to treatment

A resident of a private psychiatric hostel may be provided with treatment for mental illness where they provide informed consent (if they have capacity to do so) or a substitute decision maker[2] provides informed consent (where the substitute decision maker has capacity and the resident does not have capacity). This is aligned with the *Guardianship and Administration Act 1990*. Treatment can be provided without consent where emergency psychiatric treatment is needed (see below). It is recommended that medical practitioners **refer to the Clinicians' Practice Guide**, or sections 16 to 20 of the 2014 Act, for further information regarding provision of informed consent. Guardians and enduring guardians will still have the power to make treatment and accommodation decisions, where they have the relevant authority.

[2] Substitute decision maker means a person who can provide informed consent to the provision of treatment on behalf of another person. The 2014 Act does not change this.

5.3 Emergency psychiatric treatment (EPT)

Treatment for mental illness can be provided to a resident (including a referred person) with informed consent (from the person or a substitute decision maker), or where EPT is needed. A medical practitioner can provide EPT where psychiatric treatment is needed to save the person's life, or to prevent the person from behaving in a way that is likely to result in serious physical injury to the person or another person.

Provision of EPT must be recorded in **Form 9A**. A copy of the Form must be provided to the Chief Psychiatrist and to the person.

5.4 Emergency medical treatment

The ability to provide urgent non-psychiatric treatment to a resident of a private psychiatric hostel is not affected by the 2014 Act.

6. Explanation of rights

Where a resident is referred for an examination by a psychiatrist, they will need to have their rights as a referred (and possibly detained) person explained to the person and to a personal support person. The explanation must be provided orally and in writing.

If the person is detained, they will also need to be actively given the **opportunity and means to contact** any personal support person, the Mental Health Advocacy Service (see below), and any health professional currently providing the person with treatment (such as their general practitioner).

7. Notifying personal support persons

7.1 Definition of personal support person

'Personal support person' means any of the following:

- guardian or enduring guardian of an adult;
- parent or guardian of a child;
- a close family member;
- a carer;
- nominated person (nominated by the person using **Form 12A**).

7.2 Notifiable events

There are 25 'notifiable events' listed in the 2014 Act and every time one of these events occurs at least one personal support person must be notified. The notifiable events most relevant to private psychiatric hostels are:

Event	Form	Who is responsible for notification
The making of a detention order	**Form 3A**	The practitioner who makes the order
Absence without leave of a referred person who is on a detention order	N/A	The person in charge of the hostel
Release from detention because person cannot continue to be detained	N/A	A medical practitioner or an AMHP
Release from detention because the referral has been revoked	**Form 3A**	The practitioner who revokes the referral
The making of a transport order	**Form 4A**	The practitioner who makes the order
The making of an involuntary treatment order	**Form 5A** or **Form 6B**	The psychiatrist who makes the order
The making of an order than the person cannot continue to be detained	**Form 3E**	The psychiatrist who makes the order

The exceptions to the requirement to notify a personal support person are:

- where the person responsible for the notification (see table above) determines that this would not be in the best interests of the referred person; or
- where, despite reasonable efforts, a personal support person cannot be contacted.

8. Oversight by the Chief Psychiatrist

The Chief Psychiatrist is responsible for overseeing the treatment and care of residents of private psychiatric hostels who are being provided with treatment or care for mental illness. Staff members and services must comply with the Chief Psychiatrist's standards, and must have regard to the Chief Psychiatrist's guidelines.

Where the Chief Psychiatrist has a reasonable suspicion that proper standards of treatment and care have not been, or are not being, maintained by the mental health service, the Chief Psychiatrist (or delegate) may visit a private psychiatric hostel without notice. The Chief Psychiatrist (or delegate) may inspect the hostel, interview residents, and require staff members to provide documents or other information. It is an offence for a staff member to interfere with these powers.

9. Mandatory reporting

A staff member who becomes aware of a 'reportable incident' must report it to the person in charge of the hostel or to the Chief Psychiatrist. A reportable incident means unreasonable use of force by a staff member against a hostel resident, or unlawful sexual contact between a staff member and a hostel resident.

The person in charge of the hostel who becomes aware of a 'notifiable incident' must report it to the Chief Psychiatrist. A notifiable incident means:

- a reportable incident;
- a serious medication error; or
- any other incident in connection with the provision of treatment and care to the person that has had, or is likely to have, an adverse effect on the person.

Reports to the Chief Psychiatrist must be in the form available on the Office of the Chief Psychiatrist website.

Failure to report a notifiable incident is an offence.

10. Mental Health Advocacy Service (MHAS)

The MHAS replaces the Council of Official Visitors established under the 1996 Act. A resident of a private psychiatric hostel may contact the MHAS seeking advocacy support, including where they have been referred for examination by a psychiatrist. If the person asks the hostel to arrange access to the MHAS, the hostel must inform the MHAS within 24 hours. If the resident is a referred person who has been detained to enable examination by a psychiatrist, a mental health advocate will visit or otherwise contact the person within 3 days. In any other case, a mental health advocate will visit or otherwise contact the person as soon as practicable.

Mental health advocates have a range of powers when visiting private psychiatric hostels, including viewing the resident's medical records and asking the staff questions which they must answer.

11. Complaints

All private psychiatric hostels must have an **internal complaints procedure** and ensure that up-to-date copies are readily available. Residents may complain to the hostel or to the Health and Disability Services Complaints Office (HaDSCO). The complaints provisions in the 2014 Act are more comprehensive than under existing legislation.

12. Information sharing

The 2014 Act authorises the sharing of 'relevant information' (including personal information) between hospitals providing treatment and care for people with mental illness, private psychiatric hostels, and community mental health services.

Relevant information means information relevant to:

- the treatment or care of a person who has been, is being, or will or may be, provided with treatment or care by the mental health service;
- the health, safety or wellbeing of a person who has been, is being, or will or may be, provided with treatment or care by the mental health service; or
- the safety of another person with respect to which there is a serious risk because of a person who has been, is being, or will or may be, provided with treatment or care by the mental health service.

This means that **relevant information can be shared between services** without the person's consent and without breaching confidentiality.

13. Charter of Mental Health Care Principles

Private psychiatric hostels must have regard to the Charter of Mental Health Care Principles, which is set out in the **Appendix**. The Charter is a set of 15 rights-based principles which broadly lists what people experiencing mental illness can expect from services.

Forms

The Chief Psychiatrist has approved approximately 50 forms for use under the 2014 Act. The forms provide a standardised way of recording certain information, and they include comprehensive instructions as to how they need to be completed and what needs to happen after they are completed. The table below sets out the forms that it is expected private psychiatric hostels will use most frequently.

Mental Health Act 2014 **form name**	***Mental Health Act 2014*** **form number**	***Mental Health Act 1996*** **equivalent form number**
Referral for examination by psychiatrist	**Form 1A**	Form 1
Detention order	**Form 3A**	No equivalent
Continuation of detention	**Form 3B**	No equivalent
Order that person cannot continue to be detained	**Form 3E**	No equivalent
Transport order	**Form 4A**	Form 3
Records relating to search and seizure	**Form 8A** and **Form 8B**	No equivalent
Record of emergency psychiatric treatment	**Form 9A**	No equivalent

Further resources

eLearning package:	www.mhc.wa.gov.au
Clinicians' Practice Guide:	www.chiefpsychiatrist.wa.gov.au
Mental Health Act Handbook:	www.mhc.wa.gov.au
Chief Psychiatrist's standards and guidelines:	www.chiefpsychiatrist.wa.gov.au
Approved forms:	www.chiefpsychiatrist.wa.gov.au
Enquiries to the Mental Health Commission:	legislation@mhc.wa.gov.au

Appendix: Charter of Mental Health Care Principles

Purpose

The Charter of Mental Health Care Principles is a rights based set of principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness. The Charter is intended to influence the interconnected factors that facilitate recovery from mental illness.

Principle 1: Attitude towards people experiencing mental illness

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.

Principle 2: Human rights

A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

Principle 3: Person centred approach

A mental health service must uphold a person centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including by recognising life experiences, needs, preferences, aspirations, values and skills, while delivering goal oriented treatment, care and support.

A mental health service must promote positive and encouraging recovery focused attitudes towards mental illness, including that people can and do recover, lead full and productive lives and make meaningful contributions to the community.

Principle 4: Delivery of treatment, care and support

A mental health service must be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is consistent with their needs.

Principle 5: Choice and self determination

A mental health service must involve people in decision making and encourage self-determination, cooperation and choice, including by recognising people's capacity to make their own decisions.

Principle 6: Diversity

A mental health service must recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

Principle 7: People of Aboriginal or Torres Strait Islander descent

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and

appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

Principle 8: Co-occurring needs

A mental health service must address physical, medical and dental health needs of people experiencing mental illness and other co-occurring health issues, including physical and intellectual disability and alcohol and other drug problems.

Principle 9: Factors influencing mental health and wellbeing

A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, accommodation, recreation, education, financial circumstances and employment.

Principle 10: Privacy and confidentiality

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

Principle 11: Responsibilities and dependants

A mental health service must acknowledge the responsibilities and commitments of people experiencing mental illness, particularly the needs of their children and other dependants.

Principle 12: Provision of information about mental illness and treatment

A mental health service must provide, and clearly explain, information about the nature of the mental illness and about treatment (including any risks, side effects and alternatives) to people experiencing mental illness in a way that will help them to understand and to express views or make decisions.

Principle 13: Provision of information about rights

A mental health service must provide, and clearly explain, information about legal rights, including those relating to representation, advocacy, complaints procedures, services and access to personal information, in a way that will help people experiencing mental illness to understand, obtain assistance and uphold their rights.

Principle 14: Involvement of other people

A mental health service must take a collaborative approach to decision making, including respecting and facilitating the right of people experiencing mental illness to involve their family members, carers and other personal support persons in planning, undertaking, evaluating and improving their treatment, care and support.

Principle 15: Accountability and improvement

A mental health service must be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the treatment, care and support of people experiencing mental illness, including their family members, carers and other personal and professional support persons.