



Mental Health Act 2014

Information for private psychiatric hospitals

New mental health legislation

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 clinicians in authorised hospitals. However, some aspects of the 2014 Act will affect private psychiatric hospitals that are not authorised. This document is intended to assist clinicians in the following private psychiatric hospitals – The Marian Centre, Perth Clinic, Abbotsford Hospital, and Hollywood Clinic.

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Key changes for private psychiatric hospitals

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 hospital, this will most commonly mean that a psychiatrist or other medical practitioner assesses an inpatient and may refer the inpatient for examination by a psychiatrist at an authorised hospital or other place (such as an emergency department).

A referral is made using **Form 1A** and lasts **72 hours** (previously 7 days).

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

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 (for example, by being able to hear one another through a door).

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.

1.2 Detention

Under the 2014 Act a referred person may 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 72 hours**. This is the same period as a referral, although detention ends if the referral expires beforehand.

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 hospital 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**.

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 available closer to 30 November.

A **Form A** 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

A medical practitioner (or an AMHP) at a private psychiatric hospital may assess a patient and refer them for examination by a psychiatrist, using a **Form 1A**. The examining psychiatrist can make any 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 3C**); or
- an order that the person cannot continue to be detained (and is no longer a referred person) (**Form 3E**).

In a situation where the referring practitioner was a psychiatrist, a different psychiatrist must examine the person.

Alternatively, 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 **72 hours**, it is no longer in force.

It is recommended that psychiatrists **refer to the Clinicians' Practice Guide** for further information regarding the conduct of an examination.

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 inpatient 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. 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).

It is recommended that clinicians **refer to the Clinicians' Practice Guide**, or section 25 of the 2014 Act, for information regarding the criteria for a community treatment order.

4. Decision making capacity

Whether or not a person has decision making capacity is relevant in four key ways (in the context of private psychiatric hospitals):

- 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 patient has the **capacity to make decisions other than decisions about treatment** for mental illness.

Capacity to make treatment decisions is different from capacity to make other kinds of decisions. Examples of other decisions include whether or not a patient would like a family member to be informed and involved, and whether or not to accept minor 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

As with the 1996 Act, treatment for mental illness can only be provided to a voluntary inpatient in a private psychiatric hospital with informed consent. Treatment can be provided without consent where emergency psychiatric treatment is required (see below). If the patient has capacity to make a treatment decision (see above), then the patient can provide informed consent for himself or herself. If the patient does not have capacity to make a treatment decision, then another person (a 'substitute decision maker'¹) may provide informed consent to treatment. Informed consent, and who provided it, must be recorded in the patient's medical record.

Informed consent can only be provided after the patient has received a comprehensive description of treatment, including risks and possible alternative treatments. The patient must also be given sufficient time to consider their decision, and a reasonable opportunity to discuss treatment with others (such as their general practitioner). 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.

5.3 Physical examination upon admission

A **medical practitioner** must attend every voluntary inpatient in a private psychiatric hospital within **12 hours** of admission to conduct a medical examination. If the patient has capacity to decide whether or not they want a physical examination, they can refuse, and therefore the examination cannot be conducted. If the patient does not have this capacity, the physical examination can only be conducted with the consent of a substitute decision maker.

5.4 Emergency psychiatric treatment (EPT)

Treatment for mental illness can be provided to a voluntary inpatient (including a referred person) with informed consent (from the patient 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 patient.

5.5 Electroconvulsive therapy (ECT)

A mental health service can only provide ECT where the Chief Psychiatrist has authorised the service as a provider of ECT.

¹ Substitute decision maker means a person who can provide informed consent to the provision of treatment on behalf of a patient. The 2014 Act does not change this.



Adult voluntary patients will still be able to be provided with ECT with informed consent from the patient (if they have capacity) or from their substitute decision maker (if the patient does not have capacity). **Child voluntary patients** can only be provided with ECT where there is informed consent and the approval of the Mental Health Tribunal (replacing the Mental Health Review Board). Emergency ECT provisions in the 1996 Act do not apply. Emergency ECT cannot be provided to voluntary patients.

Mental health services providing ECT must provide monthly statistics to the Chief Psychiatrist, using **Form 13**. ECT must be provided in accordance with the Chief Psychiatrist's standards for the provision of ECT.

Provision of ECT to outpatients is subject to the same requirements as set out above in relation to inpatients.

5.6 Emergency medical treatment

The ability to provide urgent non-psychiatric treatment to a voluntary inpatient in a private psychiatric hospital is not affected by the 2014 Act.

6. Explanation of rights

Voluntary inpatients in private psychiatric hospitals will need to be given a **comprehensive description of their rights under the 2014 Act**, both orally and in writing. These include:

- the Charter of Mental Health Care Principles (see the **Appendix**);
- an explanation of their status as a voluntary patient, including the need for informed consent before treatment can be provided;
- the right to an explanation of proposed treatment and to sufficient time for consideration;
- the right to access their medical record upon request; and
- the right to make a complaint to the hospital or to the Health and Disability Services Complaints Office (HaDSCO).

If the patient is referred for examination by a psychiatrist, they will need to have their additional rights as a referred (and possibly detained) person explained to them.

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



7. Informing and involving 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 patient 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 hospitals 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	Not applicable	The person in charge of the hospital
Release from detention because person cannot continue to be detained	Not applicable	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.

7.3 Informing and involving personal support persons

Personal support persons generally need to be informed of certain matters, and involved in decision making and provision of support. There are different requirements depending on whether or not the patient has capacity to make the relevant decision.



A voluntary inpatient in a private psychiatric hospital who **has capacity** can consent to their personal support person/s being informed and involved regarding certain matters.

In the case of a voluntary inpatient in a private psychiatric hospital who **does not have capacity**, the hospital can inform and involve a close family member, carer and nominated person without breaching confidentiality. These personal support persons are not required to be informed and involved in the following circumstances:

- where, in the opinion of the patient's psychiatrist, this would not be in the best interests of the patient; or
- where, despite reasonable efforts, a personal support person cannot be contacted.

Information to be provided includes diagnosis; proposed treatment and care; the patient's progress; and services available to meet the patient's needs. Involvement includes involvement in treatment decisions; provision of care and support; and the preparation of any treatment, support and discharge plan. Where a patient is referred for examination by a psychiatrist, the person's rights need to be explained to the person and to at least one personal support person.

8. Admission of a child to a private psychiatric hospital

The 2014 Act reflects the need to protect children who are admitted to adult wards. A child can only be admitted to a private psychiatric hospital that is usually for adults where this would be appropriate having regard to the child's age, maturity, gender, and other individual circumstances. The hospital must provide a **written report** to the child's parent or guardian and to the Chief Psychiatrist as to the reasons why admission to the hospital is appropriate, and how the hospital will protect the child and ensure that they are provided with appropriate treatment, care and support.

9. Mandatory reporting

A staff member who becomes aware of a 'reportable incident' must report it to the person in charge of the hospital or to the Chief Psychiatrist. A reportable incident means:

- unreasonable use of force by a staff member against a patient;
- unlawful sexual contact between a staff member and a patient; or
- unlawful sexual contact between two patients.

The person in charge of the hospital 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 referred person may contact the MHAS seeking advocacy support. If a referred person asks the hospital to arrange access to the MHAS, the hospital must inform the MHAS within 24 hours. If the referred person is under a detention order, a mental health advocate will visit or otherwise contact the patient within 72 hours. If the referred person is not under a detention order, a mental health advocate will visit or otherwise contact the patient as soon as practicable. Mental health advocates have a range of powers at hospitals, including viewing the patient's medical records and asking the staff questions which they must answer.

11. Complaints

All private psychiatric hospitals **must have an internal complaints procedure** and ensure that up-to-date copies are readily available. A voluntary inpatient in a private psychiatric hospital may complain to the hospital 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. Chief Psychiatrist's standards and guidelines

The Chief Psychiatrist has oversight of all voluntary inpatients in private psychiatric hospitals. Clinicians and services must comply with the Chief Psychiatrist's standards, and must have regard to the Chief Psychiatrist's guidelines.

13. Information sharing

The 2014 Act authorises the sharing of 'relevant information' (including personal information) between mental health services, including private psychiatric hospitals, authorised hospitals, emergency departments providing treatment to patients, 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 mental health services** without the patient's consent and without breaching confidentiality.

14. Charter of Mental Health Care Principles

All mental health services must have regard to the Charter of Mental Health Care Principles. The 15 Principles are set out in the **Appendix**.



Additional information

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. These forms will be available from the Office of the Chief Psychiatrist's website from November 2015. The table below sets out the forms that it is expected private psychiatric hospitals will use most frequently.

<i>Mental Health Act 2014</i> form name	<i>Mental Health Act 2014</i> form number	<i>Mental Health Act 1996</i> 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
Statistics about ECT	Form 13	No equivalent

Psychiatrists in private practice

The 2014 Act does not apply to psychiatrists in private practice treating outpatients in the community, unless the psychiatrist refers a patient for examination by a psychiatrist or places the patient on a community treatment order.

Day therapy programs

The 2014 Act does apply to day patients admitted to a private psychiatric hospital to participate in a therapy program. The patient can only be provided with treatment (which includes psychological and psychosocial treatments) with informed consent. Informed consent must be recorded in the patient's medical record. A psychiatrist or other medical practitioner who assesses the patient may refer them for examination by a psychiatrist at an authorised hospital or other place.



Eating disorders

The meaning of 'treatment' in the 2014 Act includes medical treatment for a condition that is a consequence of mental illness. This includes provision of treatment for an eating disorder using nasogastric intubation or similar. Informed consent is required unless the person is made an involuntary patient.

Provision of treatment to patients with alcohol or other drug problems

The 2014 Act defines 'mental illness'. The fact that a person uses alcohol or other drugs is not enough, in itself, for a clinician to decide that the person has a mental illness. However, the 2014 Act states that this does not prevent the serious or permanent physiological, biochemical or psychological effects of the use of alcohol or other drugs from being regarded as an indication that a person has a mental illness.

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.