CHIEF PSYCHIATRIST
of Western Australia

26 May 2022

Chief Psychiatrist's Community of Practice
Mental Health Act 2014 (*MHA 2014*) - Questions and Answers

Welcome

On National Sorry Day, we acknowledge the strength and resilience of the Stolen Generations people and remember the impact of the government policy and legislation…that led to intergenerational trauma and continues to affect the mental health of Aboriginal families and communities today.

This summary of third session is available on the website of the Office of the Chief Psychiatrist (OCP). Please share the summary with colleagues.

Juliette Stevens, Principal Officer Reviews, Office of the Chief Psychiatrist

Introduction to Community of Practice

I acknowledge National Reconciliation Week next week, the key message "Be Brave. Make Change."

These sessions started because in services, there are limited opportunities to come together between HSPs, and the OCP is keen to support that.

The great response by clinicians to these sessions is appreciated, thank you for being involved and taking time away from your busy day to contribute.

Dr Emma Crampin, Deputy Chief Psychiatrist

Key Messages

If legal orders or periods of detention for examination have expired, there is no capacity under MHA 2014 to retrospectively complete legal orders. Protecting a person's rights, freedoms, choices and safety is a priority.

- This applies whether the person is in the community, on a general ward, voluntary or involuntary on a mental health ward.
- A new assessment and new forms are completed if still required.
- Having a visual tracking process for busy teams to plan for renewals is good practice.

A warm handover to the receiving clinicians, alongside the *MHA 2014* forms, is good practice.

- Trust your clinical judgement about what will keep that person safe and comfortable through transit and the emergency department (ED). Who do they trust accompany them? With reduced staff, pick up the phone.

Managing behavioural disturbance with intoxication is a challenge in remote areas, with very limited staff and police availability – what is available under the *MHA 2014*?

- If intoxicated, and mental illness cannot be ruled out, with a reasonable suspicion the Form 1A can be used.
- A clear escalation pathway and person at a regional hospital to contact for challenging decisions and support, including out of hours, is beneficial.
- Accept that it may not be possible to hold the person - work with police to manage them.
- Consider both what legal and practical processes will keep everyone safe in your circumstances. Safety is what is most important.

Questions to Kay Pak- Principal Officer Statutory Education, OCP

If a person is on a Community Treatment Order (CTO) and they are admitted to an authorised hospital as a voluntary patient, the CTO is suspended. What happens if the CTO expires while they are in hospital?

- If the CTO has expired; it has ended, even if it's whilst they are a voluntary inpatient. Once the end date has occurred, whether it's 5A or 5B extension order, the CTO expired and becomes historical.
- When the voluntary patient is discharged from hospital and they still meet the criteria for a CTO, a new CTO needs to be written.

If a person is on a Community Treatment Order (CTO) and is a voluntary patient on an authorised hospital and while they are there, they go to a general medical ward does the CTO get reinstated?

- If the person was admitted voluntarily to an authorised hospital, when they are transferred to the general hospital and there are no other legal forms, the CTO is unsuspended.
- If the person then wanted to leave the medical ward and there was a concern about risk, there would need to be an urgent assessment to determine whether the person met the requirements for a Form 1A.

If there has been a failure to extend an inpatient treatment order in an authorised hospital, can the psychiatrist complete this retrospectively?

- No. If the legal order has expired, the process needs to start again. At this point the person is a voluntary patient and needs to be reassessed to determine if a Form 1A referral is required. This is to protect the person's rights, their choices, freedoms and their safety.
- If the person is at significant clinical risk and wishes to leave, the person in charge of the authorised ward can write a Form 2, which is a 6-hour holding power, to enable reassessment.
- Within that 6-hour period, an AMHP or medical practitioner needs to assess the person to decide whether a Form 1A referral is required. If the Form 1A is written, it can only be written to the mental health unit where the patient is located, and person is immediately detained at that point.
- The 24-hour period for the psychiatrist's examination starts at the time that the Form 2 was written.

If someone comes in with challenging in behaviour, under the influence of substances, we can't make a fair assessment. In that period where you are waiting for them to sober up, is there anything under the MHA 2014 that we can do to hold them somewhere? In some regions there is no ED or police station to keep them. Are there allowances for regional staff to utilise in these situations? Remote Service, AMHP (sole practitioner)

- Consider options, if the person is intoxicated but you cannot rule out a mental illness, you can use a Form 1.
- There are two sides to consider –the legal aspect and the practical aspect of what is possible. The *MHA 2014* has no exclusion for whether a person is intoxicated at the time. Staff can be overly concerned to have a certain blood level before assessment, however there is nothing in the *MHA 2014*. There needs to be a reasonable suspicion that they meet the category.
- The Royal Australian & New Zealand College of Psychiatrists (RANZCP) and the Australian College of Emergency Medicine (ACEM) will soon release a joint statement on intoxication as a barrier to mental health care, which will greatly aid how we manage this issue.
- There should be clear escalation pathways to a psychiatrist or senior medical practitioner to discuss and support decisions about whether to hold the person or let the person leave.
- The *MHA 2014* allows functions to be carried out using audio-visual means in areas of the state, defined in the *MHA 2014*. To do this, the infrastructure for assessments, supported by WACHS, is required.
- The most important things are keeping the person safe, keeping yourself safe and keeping other people safe. We acknowledge that in some areas there may be limited capacity and, in these situations, you have to make the best decision you can to balance all aspects of safety.

If a person is placed on a Form 1 then transported to the ED, is there an expectation that a mental health clinician should go with them?

- If you are concerned about the complexity of the person's needs or worried that there may be issues in transit, you may wish to have a mental health practitioner go with them.
- The main issue is handover. We would expect there to be a handover between the referrer and the receiving practitioner. In many cases it needs to be notes, but a warm handover (conversation) in addition is preferred.