Changes to the Mental Health Act
Webinar for General Practitioners

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Chief Psychiatrist
Summary

- How the new Mental Health Act will affect you in your practice
- What you need to know prior to the implementation of the new Mental Health Act
- Where you can get help and access resources about the Mental Health Act
Mental Health Act 2014 (MHA 2014)

- Passed by Parliament in October 2014
- Commences on 30 November 2015
- Legislates for current best practice in mental health
Key features of MHA 2014

- Charter of Mental Healthcare Principles
- More rights for patients
- More rights for carers
- Greater accountability for clinicians
- A “Capacity”- based Act
Scope of MHA 2014

• Generally same scope as *Mental Health Act 1996*

• Focus is on involuntary patients
  – *Inpatient treatment orders*
  – *Community treatment orders*

• When and how to refer someone for an examination by a psychiatrist under the Act
Referral Process

Core process unchanged:

- Person assessed by practitioner
- Practitioner considers whether person meets criteria for involuntary treatment
- If yes, practitioner refers person to psychiatrist for an examination by completing form
- Person may be detained/put on transport order to make sure they get to place of examination

...however some key changes to practice....
Who can refer under the Act?

Same as under current law:

• Authorised mental health practitioners

• Medical practitioners
When can a referral under the Act be made?

Same as under current law:

- If the practitioner assesses the person and *reasonably suspects* that the person meets the criteria for an involuntary treatment order.

OR

- The practitioner assesses a person on a community treatment order and *reasonably suspects* that the person needs to be on an inpatient treatment order.
How is Mental Illness defined?

• Broad: “…disturbance of thought, mood, volition, perception, orientation or memory…significantly impairs (temporarily or permanently) judgement or behaviour.”

• Note exclusions, eg not *just* because using alcohol or drugs, or behaving badly

• But Drug-induced Psychosis *is* mental illness
Criteria for involuntary treatment order

• Mental Illness
• Risk
  – Significant risk to health/safety of person or others
  – Significant risk of harm to person or others
• No less restrictive option available
• Person does not demonstrate the capacity to make a treatment decision
Capacity

A person has decision making capacity to make a specific decision if (at the relevant time) they have the capacity to do all of the following:

• understand any information or advice about the decision
• understand the matters involved in the decision,
• understand the effect of the decision,
• weigh up the above factors for the purpose of making the decision, and
• communicate the decision in some way.
Capacity- in short…

• Can the person:
  
  – Practically understand the impact of a decision?
  
  – Weigh up the pros and cons?
  
  – Communicate this in some way?
Capacity

• To assess capacity: must provide appropriate information to a person, in a way that they can understand, and with enough time for them to consider it.

• It can be very difficult to give information and allow time if someone is very acutely unwell- the Act understands this.
Children

• <18 years old are assumed to lack capacity (unless shown to have capacity)
How must an assessment be conducted?

• Face to face (or able to hear each other without a communication device – e.g. through door)
  – Not over the telephone

• If person is in **non-metro area** and it is not practicable to assess face-to-face, can use AV
  – Health professional must be with the person at all times
  – Can’t use AV in metro are to refer
How to make referral

- Must make referral within 48 hours after completing assessment
- From 1A – Referral for examination by psychiatrist (info given to the referred person)
- Place of examination either authorised hospital or other place
- Attachment to Form 1A – Information provided by another person in confidence (not given to the referred person)
What do I write on the Form 1A

• Write why you suspect the person meets the criteria for involuntary status- see the “Criteria” slide above

• Remember:
  – It’s not appropriate to write one or two words, but be brief in describing criteria
  – It’s not designed to be a clinical handover document- you still need to write a clinical handover to the psychiatrist
Example

• Direct observation: “Mr Smith has evidence of significant psychosis that are placing him/others at risk- he lacks capacity”

• Third party information: “ Mr Smith has been keeping a weapon under his pillow” (1A or on 1A Attachment?)
  – You cannot refer a patient on third party observations only - you must see the person
  – Can refer based on third party information if you see them but person not speaking to you
Form 1A and 1A Attachment

- Patient will see a copy of the Form 1A

- Ensure sensitive third party information is only written on the 1AAttachment (not for release)
Timeframe for referral

• Valid for 72 hours (3 days) from when it is made

• Can be revoked if no longer needed (revocation section is on the front of form)

• In non-metropolitan areas can be extended for another 72 hours (total of 6 days) using a Form 1B – Variation of Referral
Detention powers

• Person can be detained if needed to ensure that they get to the place of examination
• Now a Form for this: Form 3A – Detention Order.
• If necessary, reasonable force can still be used under common law duty of care
• Detention order means that if they leave, they are considered to be ‘absent without leave’ and an Apprehension and Return order can be made
Detention timeframes

• Form 3A – Detention Order valid for 24 hours

• Can be extended for additional periods of 24 hours using a Form 3B – Continuation of Detention

• Person cannot be detained if referral expires/is revoked
Transport orders

- Person can be taken to place of examination, by family or staff member
- Only if no other safe means reasonably available, transport order can be used
- New form: Form 4A – Transport Order
- New role: Transport officer
- Police should now only be asked to carry out transport order in limited circumstances
Transport timeframes

• Transport order is valid for same length of time as referral

• If referral extended (Form 1B), transport order is automatically extended

• If referral revoked, transport order is automatically revoked
Emergency Psychiatric Treatment - EPT

- *Psychiatric* treatment can only be given to referred persons with informed consent

- However *psychiatric* treatment can be provided under MHA 2014 without consent if needed:
  - to save the person’s life, or
  - prevent the person from causing serious physical injury to themselves or others

- Duty of care?
Seclusion and Restraint

- This is a FAQ: under the MHA 2014, seclusion and restraint (and associated extensive reporting) refers to *authorised hospitals* only

- Detention outside authorised hospitals is a separate issue
Cultural considerations

• Information to be provided in language and form that person will understand (use interpreter if needed)
• Where possible/appropriate assess person of Aboriginal or Torres Strait Islander (ATSI) descent in collaboration with ATSI mental health worker or significant member of the person’s community
Notifiable Events

- Notifiable Events for referrers:
  - Making a Form 3A – Detention Order
  - Releasing a person on a Form 3A because referral revoked or they cannot continue to be detained
  - Making a Form 4A – Transport order

- At least one “personal support person” must be informed - GP needs to contact carer

- Exception: “best interests” or uncontactable
Person’s Rights

• Must give referred person information about their rights. These include:
  – Having opportunity and means to contact people while being detained
  – Right to access Mental Health Advocacy Service
  – Right to be provided with information about why the referral was made, and a copy of all other forms
  – Right to make a complaint
What happens once in an authorised hospital?

• Psychiatrist must assess

• May be kept on an involuntary treatment order for 21 days (children 14 days)

• Can be potentially extended but Mental Health Tribunal will automatically review and determine whether patient stays involuntary
What about Community Treatment Orders (CTO)?

- GPs cannot commence these but a GP may be asked to **confirm** a CTO written by a psychiatrist
  - the same criteria for involuntary care, but
  - a person must be able to be managed in the community, and
  - Can also be used to prevent a person’s physical and mental health from deteriorating
CTO

• A GP can review a patient on a CTO for a psychiatrist, and provide a report to that psychiatrist
Summary: remember...

- Referral: you must have seen the person with last 2 days to refer under MHA
- Referral lasts 3 days (can extend to 6 days outside metro)
- Can refer to authorised hospital, or another place (if you know a psychiatrist will be there within 24 hours of arrival)
Remember

- Form 1A (plus Attachment)- Referral
- Form 3A- Detention Order
- Form 4A- Transport Order
Remember

• Discard your old MHA 1996 Forms on 30 November
  – (best to also discard the MHA 1962 Forms…)

• Notifying carers is now part of the MHA 2014 (see previous slide)
What do you need to do?

• Every doctor in WA will receive the package:

  “Information for Referring Practitioners”

• Brief (5 page) information, plus Charter
• Has a referral flow chart

(Please read it…)
What do you need to do?

• Access the new MHA 2014 Forms for use from 30 November 2015 (form Chief Psychiatrist’s website)

• Be prepared to give information about the MHA 2014 to referred persons (brochure available)
Further Training

• Referrers’ eLearning Package
  – 1 hour online

• Clinicians’ eLearning Package
  – 3 hours online
More information/resources

• Clinicians’ Practice Guide (reference)

• Chief Psychiatrist Standards and Guidelines

• Information for consumers and carers

• Mental Health Act 2014
Where to go to get training/resources

• www.chiefpsychiatrist.health.wa.gov.au

• www.mentalhealth.wa.gov.au
Asking for help
Helpdesk for Clinicians – (08) 9222 4217

Available 24/7 between
30 November 2015 and 30 June 2016

(Remember: use your local Mental Health Service for advice wherever possible)