



Family and Carer Handbook to the Mental Health Act 2014

Version 2
12/9/2015

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Acknowledgements

The *Mental Health Act 2014* provides for the treatment, care and protection of people experiencing mental illness, particularly involuntary patients. The legislation reflects the fact that, very often, families and carers play an important role in promoting a person's recovery from mental illness.

This Family and Carer Handbook to the *Mental Health Act 2014* has been prepared to help you navigate the mental health system, to provide support to your loved one, and to uphold their legal rights, as well as your own.

Preparation of this handbook has been coordinated by the Mental Health Commission, to provide families and carers with a high quality, informative and accessible resource. To make this handbook user friendly and relevant for families and carers, it has been written by people with a lived experience of mental illness, including the lived experience of caring for someone with mental illness. The Commission extends special thanks to Ms Jo Kirker and Ms Helena Pollard for their enthusiasm, dedication and diligence in preparing the content. The Commission also appreciates the input of the numerous consumers and carers who have shared their lived experiences and who are quoted throughout the handbook.

Although care has been taken to ensure that information is accurate and comprehensive, mental health law can be complex. The application of the law can vary depending on an individual's own personal circumstances. Therefore, this handbook should be used as a guide only.

Introduction

Why was this handbook developed?

The Parliament of Western Australia passed a new Mental Health Act in November 2014, which replaces the existing Mental Health Act from 1996.

People's rights under the *Mental Health Act 2014* have changed and the Mental Health Commission is responsible for informing people who use mental health services, and the people who care for them, about the new legislation.

How is this handbook structured?

This handbook has been developed around the concept of navigating the mental health system, from the perspective of someone who cares for a person experiencing mental illness.

Each section reflects a different experience that you and the person you care for may have while in contact with mental health services, either in hospital or in the community.

Every section is structured around a series of **questions and answers**. We have created a '[Glossary of Terms](#)' where you will find explanations of the terms you may come across when you access mental health services.

There is also a [List of Approved Forms](#) so that you will know about the legal forms that mental health service providers use.

In this handbook for families and carers, we have tried to differentiate, where necessary, between information that relates to voluntary patients and information that relates to involuntary patients.

There is also the 'Consumer Handbook to the *Mental Health Act 2014*', a handbook for mental health service patients (sometimes known as 'users' or 'consumers'). It contains similar information from their perspective and states your right to be part of their recovery process.

In addition to the handbooks, there is a **Community Services Directory** that provides contact details for the most commonly used community services for people with a mental illness and those who care for them. This directory is located on the [Mental Health Commission](#) website.

How should I use this handbook?

We have not assumed that every section will be relevant to you, so each one is self-contained and can be read on its own. In other words, you should not need to read the whole handbook to find out what you need to know. If there is information relevant to a topic in another section, we have included an underlined cross-reference to that section.

Who had input to this handbook?

As you read through the handbook you will see quotes (written in *italics*) from people like you, who have a lived experience of caring for someone with a mental illness.

These are the people who have written and together reviewed this handbook.

We hope you will find our experiences useful for you and the person you care for.

1. Caring for Someone with a Mental Illness

In this section:

- What is a mental illness?
- What does recovery mean?
- What is expected of me and how can I help?
- Where can I get support for myself as a carer?

What is a mental illness?

- Good mental health involves a sense of wellbeing, confidence and self-worth. It enables us to fully enjoy and appreciate other people, day-to-day life, our environment and ourselves. However, sometimes people can lose their sense of wellbeing and become mentally unwell. One in five Australians will suffer from a mental illness in any given year.
- A mental illness is diagnosed where a specific set of symptoms meet certain criteria as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).
- Examples of specific mental illnesses diagnoses include: generalised anxiety disorder, bipolar affective disorder, borderline personality disorder, major depressive disorder, eating disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and schizophrenia.
- There are numerous organisations and resources that provide information about mental illness and some are listed in the Community Services Directory available on the [Mental Health Commission](#) website.

What does recovery mean?

- There are many views regarding the meaning of recovery in the context of mental illness.
- You may hear many definitions of recovery and there is no one definition that fits everyone's situation. Recovery can be described as a personal, unique journey involving changing attitudes, values, feelings, goals, skills and/or roles, and that is oriented towards rediscovering a state of mental wellbeing in a way that enables a person to stay in the community and live a satisfying, hopeful and contributing life.
- Personal recovery is about being able to create a meaningful and contributing life in the community, with or without the presence of mental health issues. Recovery involves gaining and retaining hope, understanding personal abilities and difficulties, and having a meaningful and purposeful life with a sense of positive self-worth.
- Remember that you are not alone in caring for someone with mental illness. People with mental illness can and do recover.

"It took my teenage son about two years to recover from his illness. As his parents, we were only part of his support team, which involved his school and a multi-disciplinary team from Princess Margaret Hospital. His case manager made herself available to us on a regular basis, as well as coordinating his care. However, it was my son who was in the driver's seat and worked the hardest to recover. I am enormously proud of the courage and determination he showed in doing everything it took to get well again."

What is expected of me and how can I help?

- You may find yourself caring for someone with a mental illness for the first time and this can be a challenging experience, especially if you are a younger person caring for a parent, friend, brother or sister. It can be difficult to know what is expected of you and how you can help.
- Here are some ideas about how you can give **practical support** to the person you care for:
 - Provide mental health practitioners with key information about the person you care for, such as their name, date of birth, medical history, their family situation, any advance health directive they have made, and a history of recent events.
 - Given that there will often be changes in the mental health service team, be prepared to communicate the same information again to a new team.

- Write important things down, such as the names and contact details of people who are treating the person you care for, the key people in the person’s life, dates of appointments and any questions they or you might want to ask.
 - Keep records of what information has been provided to whom and important events or milestones, such as dates of admission and discharge from hospital.
 - Store in a safe place any documents you are provided with, including documents given to the person, if they are not able to do this for themselves.
 - Actively participate in discussions about treatment, discharge and care plans.
 - Find out more about their particular illness and the proposed treatment and care, for example by asking a medical practitioner, reading about it, or asking others about their experiences.
 - Find out about community services that can support the person you care for.
 - Discuss with the person you care for what you can do to help them stay as well as possible, and work with them to make plans to support their wellbeing and recovery.
 - Discuss how to avoid or reduce triggers for their mental illness, and plan ahead with them on how to respond if they show signs of becoming unwell.
 - If they have to go to hospital, help to arrange and bring any medications, clothes, toiletries and important documents they need, and take away any valuables that they do not need for safekeeping.
 - Ensure you have plans in place to deal with a crisis or emergency, ideally that you discuss with the person you care for when they are well.
- Here are some ideas about how you can give **emotional support** to the person you care for:
 - Let them know that you want to support them and care for them.
 - Keep in close, regular contact with them, by visiting, writing letters or emails, videoconferencing via the internet and/or phoning them.
 - Find out what they want and need, then speak up for them if they are not willing or able to speak for themselves.
 - Help them prepare a list of questions they want to ask, and be prepared to ask on their behalf if they are not willing or able to themselves.
 - Be persistent about pursuing the things that matter most to them and you.
 - Listen to what is said in meetings and ask questions if you do not understand, especially as you may have to explain things later on.
- Here are some ideas about how you can **protect your rights** and the rights of the person you care for:
 - Maintain their confidentiality, for example, be cautious about posting information on a social media site about their wellbeing and situation.
 - Understand, and stand up for your rights and their rights.
 - Obtain legal advice or contact a mental health advocate if you are not sure about your rights or their rights, or how to uphold them (see Section 13 [Mental Health Advocacy Service](#)).
 - Speak out about anything that concerns you about the way you or they are being treated; if necessary make a formal complaint.
- You may wish to hear or read other people’s **personal stories** of caring for someone with a mental illness:
 - [Arafmi Mental Health Carers Australia: A Carer’s Story](#)
 - [Arafmi Mental Health Carers Australia: Our National Voice](#)
 - [Mental health carers as partners in recovery: Caring Together Project](#)
 - [Children of Parents with a Mental Illness \(COPMI\): Real Stories from Kids](#)
 - [Children of Parents with a Mental Illness \(COPMI\): Real Stories from Teens](#)
 - [Mental Health Commission WA: A Carer's Story](#)
 - [Western Australian Association for Mental Health: Video Gallery](#)

“The amount of time you give to caring for someone with a mental illness is your choice. You may feel like you do not have a choice because they are relying on you, but you have to consider what you need to remain well because you are no use to them if you ‘burn out’.”

“Be prepared for the best of times and not so good times when you are caring for someone with a mental illness. It can be a long journey to recovery for everyone involved, but it is worth it.”

Where can I get support for myself as a carer?

- Here are some ideas about what you can do to care for yourself:
 - Get practical and emotional support for yourself – you do not have to manage on your own.
 - Be clear about what you can and cannot manage.
 - Try to maintain as normal a routine as possible – keep time for the things you enjoy, including socialising with other people.
 - Keep a journal or other record of what has happened to you.
 - Take a break if events are starting to overwhelm you.
- For information about services that offer carers help and advice, refer to ‘Carer Support Services’ in the Community Services Directory available on the [Mental Health Commission](#) website.
- Some additional sources of **practical help**:
 - You have a right to ask for an interpreter; if you or the person you care for need one, call the [Translating and Interpreting Service](#) (TIS) on 131 450. They will contact who you need to talk to whilst on the phone with you. Once you have registered with them, they will be able to organise any required interpreting or translation services in advance before contacting you.
 - If you or the person you care for are hearing impaired, contact the [Auslan Interpreter Service](#) on 1300 287 526. The [National Relay Service](#) offers a phone solution for people who are hearing impaired or have a speech impediment; contact them on 1800 555 660 (voice) or 1800 555 630 (teletypewriter or TTY).
 - If you live in a rural or remote area and need to access services in another place, you can apply for a subsidy towards your travel and accommodation through the Department of Health’s [Patient Assisted Travel Scheme](#).
- At some point, you may need to find **professional help** for the person you care for, or yourself. Professional help could be needed from a general practitioner (GP), psychologist, community nurse, counsellor, pharmacist, occupational therapist or social worker, as examples. Here are some characteristics of what ‘good’ professional help looks like to other people:

Honest – Friendly – Approachable – Accepting – Focuses on me as a person – Understands my culture

Understands people of my age – Caring – Compassionate – Supportive – Listens well – Communicates well

Open-minded – Thoughtful – Respectful – Non-judgmental – Balanced – Flexible

Wants me to take personal responsibility – Emphasises self-care and self-determination

Interested in my opinion – Positive – Hopeful – Trustworthy – Maintains confidentiality

Professional – Educated – Reputable – Experienced – Skilful – Knowledgeable – Motivated

Willing to acknowledge and remedy any mistakes – Affordable – Accessible – Willing to see me regularly

Gives me the time I need – Willing to work with others.

- Finding good professional help can be difficult and sometimes it can be hard to know where to start. A recommendation from someone you trust, like another health professional, a family member, a friend or another carer in your situation can be a good starting point. Some people find a list of possible health care providers from the internet and then contact them to find out more about them and their service. It is okay to interview the health care professional before you try their services. If you find the health care provider does not suit you, you always have the choice to try someone else.
- In addition to mainstream health services, you may want to explore the non-government **community services** that can help you support the person you care for and also to look after yourself – refer to the Community Services Directory available on the [Mental Health Commission](#) website.
- People who have cared for someone with a mental illness say that having a strong **personal support system** is as important to the carer as to the person they care for. You need people you can reach out to when you need practical or emotional help and support. They may be family or friends, but they may

also be people you meet along the way who also have an experience of caring for someone with a mental illness (known as peers). Other people who care for someone with a mental illness have described a 'good' personal supporter as someone who:

You feel you can trust – Makes you feel comfortable – Respects you

Is willing to learn more about your situation – Listens to you without judgment – Keeps things confidential

Empathises with what you are going through – Cares for you as a person – Treats you compassionately

Lets you freely say what you want to say – Gives good advice when you need it

Gives honest feedback when you ask for it – Accepts you in your good and bad moments

Is willing to be there for you when you need them – Will offer practical as well as emotional support

Is prepared to take action if you ask for their help – Will work with you to figure out what to do next

Is positive and hopeful.

- You might wish to join a **peer support group** or an **online forum** where people who care for someone with mental health issues share their experiences – refer to the Community Services Directory available on the [Mental Health Commission](#) website.

“Remember, as a carer of someone with a mental illness, you are not alone – there are people out there to support you too. You being supported is as important to the person you care for as them being supported in their recovery journey.”

2. Charter of Mental Health Care Principles

In this section:

- What is the primary focus of the *Mental Health Act 2014*?
- What is the Charter of Mental Health Care Principles?

What is the primary focus of the *Mental Health Act 2014*?

- The primary focus of the legislation is the rights of people who require involuntary treatment for mental illness.
- The purposes, or aims, of the legislation are:
 - to ensure that people experiencing mental illness are provided with the best possible treatment and care, in the least restrictive way and with respect for their dignity;
 - to recognise the role of families and carers in the treatment, care and support of people with mental illness;
 - to recognise and facilitate the involvement of people with mental illness and their personal support people in the consideration of the options that are available for their treatment and care;
 - to help minimise the effect of mental illness on family life;
 - to ensure the protection of people who have or may have a mental illness; and
 - to ensure the protection of the community.
- A clinician or any other person performing a function under the legislation must have regard to these objects. The objects are reflected in the Charter of Mental Health Care Principles – see ‘What is the Charter of Mental Health Care Principles?’ below.

“When you first come in contact with the mental health services, you have no idea what it even means to be a voluntary or involuntary patient. You hear this thing about being ‘put on forms’ but you have no idea what that means until it happens to you.”

What is the Charter of Mental Health Care Principles?

- The legislation is built around 15 principles described in a Charter of Mental Health Care Principles.
- Mental health services and private psychiatric hostels must always consider these principles when they are providing treatment, care and support to a person experiencing mental illness.
- The Charter applies to voluntary and involuntary patients.
- In summary, mental health services are expected to treat people experiencing mental illness with dignity and respect, which includes respecting their right to make decisions about their own lives.
- Services must not discriminate against or stigmatise people with mental illness.
- They must recognise and try to respond to individual needs; promote collaboration, choice and independence; and focus on recovery.
- They must provide information to, listen to, and involve families, carers and other personal support people.
- They must treat people fairly, be accountable for their actions and consult others before making decisions.
- They must focus on providing the best possible service, in the least restrictive way, to the people they are there to help.

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.

“I hope that the new legislation will bring about a positive culture change in mental health services.”

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 focus

- 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 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.

“I just wanted them to see me as a person and understand all the difficulties we were going through as a family. We needed someone to care enough to reach out and help us get through this difficult time.”

Principle 4: 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-responsibility, cooperation and choice, including by recognising people’s capacity to make their own decisions.

Principle 6: Diversity inclusive

- 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.

“English is Mum’s third language behind Mandarin and Indonesian so it was important that mental health staff recognise that she had difficulty being able to express her needs and what was going on for her due to the language barrier.”

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 alcohol and other drug problems.

“When you are dealing with an eating disorder, you cannot help but see that a person’s mental and physical health go hand in hand. With other mental illnesses, the connection is sometimes not so obvious, but it’s important to treat people’s health and wellbeing holistically.”

Principle 9: 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.

“Mental illness affects everyone in the family one way or another, so of course relationships are impacted; therefore recovery and treatment needs to meet the needs of the whole family.”

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: Providing 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, at all times, respect and facilitate the right of people experiencing mental illness to involve carers, families and other personal and professional support persons in planning, undertaking and evaluating 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 carers, families and other personal and professional support persons.

3. Rights of Personal Support People

In this section:

- Personal support people
- Who is considered to be a guardian or an enduring guardian?
- Who is considered to be a close family member?
- Who is considered to be a carer?
- Who is a nominated person?
- Identifying a close family member and a carer
- How will I know where my loved one is?
- I am a close family member or carer – will I be informed and involved?
- What a psychiatrist must do with regard to a close family member and carer
- What a psychiatrist must do with regard to a nominated person
- What if English is not my first language?
- What do I need to know about confidentiality?
- Will I be able to visit and contact my loved one?
- What happens if I am unhappy about the treatment being provided?
- What rights do I have if there is a Mental Health Tribunal hearing?
- What if I have a complaint about the way I have been treated?

Personal support people

The legislation defines a ‘personal support person’ as any of the following:

- a guardian or enduring guardian of an adult
- the parent or guardian of a child
- a close family member
- a carer
- a nominated person.

“When someone in your family is experiencing mental distress or illness then the whole family is affected. This is why it’s important to take a holistic (whole of life) view of recovery that involves everyone.”

Who is considered to be a guardian or an enduring guardian?

- If you are caring for an adult, then the State Administrative Tribunal may have appointed a guardian to make decisions on their behalf for times when they are unwell.
- Alternatively, the person you are caring for may have themselves appointed an enduring guardian when they were well. If, or when, the person does become unwell, the enduring guardian can make decisions for the person, and can help uphold any treatment decisions they made when they were well.
- For more information on guardianship you can refer to the *Guardianship and Administration Act 1990* and the resources available on the [Office of the Public Advocate](#) website.

Who is considered to be a close family member?

A close family member can be any family member and can include relationships through marriage as well as de facto, written law or natural relationships. These are:

- a spouse or de facto partner
- a child
- a step child
- a parent
- a step parent
- a foster parent
- a sibling
- a grandparent

- an aunt or uncle
- a niece or nephew
- a cousin
- if the person is of Aboriginal or Torres Strait Islander descent — any person regarded under the customary law, tradition or kinship of his or her community as equivalent to the people listed above.

Who is considered to be a carer?

A carer is a person who provides ongoing care or assistance to someone who has a mental illness. This definition is taken from the *Carers Recognition Act 2004* and is the same definition used in the *Mental Health Act 2014*. It does not include someone who is paid or is doing voluntary work with an organisation to provide care and assistance for someone.

It is recognised that very often a carer is actually a family member. It is also recognised that when a family member provides ongoing care and assistance they do not necessarily consider themselves to be a carer, and that the person they care for may not call them a carer either. In this instance there is no need to use the term carer, but it is useful to know that they do perform the role of a carer. Mental health staff must acknowledge and respect that role.

Who is a nominated person?

While in the mental health system, the person you care for may nominate one person, such as a friend, to support them. The role of the nominated person is to help the patient uphold their rights and to ensure that their wishes and interests are taken into account by the treating team. A nominated person is one of the personal support people that have rights under the legislation. The rights of the nominated person do not take away the rights of a close family member or carer. To be a nominated person, you need to sign the legal form that formalises the nomination. The patient can cancel the nomination at any time.

Identifying a close family member and a carer

On admission a patient will be asked whether they have a family member or carer, or both. If they do, they will be asked whether they consent to them being informed about and involved in aspects of their treatment and care. The patient can ask for limits to be placed on this, and they can consent or withdraw consent at any time. However, there are times when information will be shared with a family member or carer, and you will be involved, even without the consent of the patient.

How will I know where my loved one is?

It is important that at least one personal support person knows where their loved one is at any given time. Therefore, at least one personal support person will be notified when a person is detained or moved to another service. These times include:

- The making of a detention order, if the person has been referred for examination by a psychiatrist.
- The making of a transport order, for the person to be taken to the place of examination.
- The making of an inpatient treatment order or a community treatment order.
- When the person is transferred between hospitals.

I am a close family member or carer – will I be informed and involved?

As a close family member, carer or nominated person, you may have the right to the following information:

- The mental illness for which the patient is being provided with treatment and care.
- If the person is an involuntary patient, the grounds for the involuntary treatment order.
- The treatment and care that is proposed and any other treatment options that are available.
- The treatment that has been provided to the patient and how they are progressing.
- The use of seclusion or bodily restraint, if either needs to be used.
- The services available to meet the patient's needs.

Under the legislation you are entitled to information about the patient’s rights and how those rights can be upheld; as well as information about your own rights in your role as a close family member, carer or nominated person.

You may also be entitled to be involved in some aspects of care, including:

- decisions around treatment and care;
- the provision of support; and
- the preparation and revision of any treatment, support and discharge plan.

The [Consumer and Carer Involvement in Individual Care Standard](#) gives you the right to be actively involved in discussions regarding treatment and care. Services need to actively seek information from you in relation to the person you care for, during their assessment process, while in treatment, and to inform their ongoing care. A record of this consultation must be made in the patient’s medical record. If relevant, the service must also engage you in discussions around the transfer of care to another service, including planning what to do to prevent relapse and ensuring continuity of care with the new service.

You have the right to decide the extent to which you would like to be informed and involved.

Under the legislation you have rights to information and involvement, but you do not have the right to admit a person to, or discharge a person from, a mental health service.

“One of the mental health nurses gave me a pamphlet specifically targeted towards carers and family members which helped to explain what happens when someone is admitted to hospital, my rights, and how I can best support my family member.”

What a psychiatrist must do with regard to a close family member and carer

As a close family member or carer, the patient’s psychiatrist must ensure that you are informed and involved where required by the legislation. If the patient does not have a psychiatrist, this is the responsibility of the person in charge of the mental health service.

In deciding whether or not you should be informed and involved, the psychiatrist (or person in charge of the mental health service) will consider: whether the person is a voluntary or involuntary patient; whether they have the capacity to decide whether or not to inform and involve you; and, the patient’s best interests.

The laws regarding when a close family member and/or carer can be informed and/or involved are set out in the table below.

Legal status as a patient	Capacity to decide whether to inform and/or involve	Obligations on psychiatrist or person in charge of mental health service
Voluntary patient	With the capacity to decide	Can only inform and involve a close family member and/or carer with the patient’s consent
Voluntary patient	Without the capacity to decide	Must inform and involve a close family member and/or carer, unless this would not be in the patient’s best interests
Involuntary patient	With the capacity to decide	Must inform and involve a close family member and/or carer, unless the patient refuses to consent and this refusal is found to be reasonable
Involuntary patient	Without the capacity to decide	Must inform and involve a close family member and/or carer, unless this would not be in the patient’s best interests

If a close family member or carer is not informed or involved on 'best interests' grounds, this will be documented, with reasons. The record must be given to the patient and the Mental Health Advocacy Service (MHAS).

If you, as a close family member or carer, believe you are entitled to information or involvement which has not been provided, you can request information or involvement. If your request is not met, then you are entitled to information about the decision and the reasons. You can request that this be provided to you in writing.

In order to inform and involve you, the service needs to make reasonable efforts to make contact with you.

"You may think 'this will be too much information to take on board', but I think it is better to be involved as a partner in providing care than to be kept in the dark. A few years ago, even as parents, we had no idea what was happening to our teenage son when he became an involuntary patient."

What a psychiatrist must do with regard to a nominated person

Nominated persons have the same rights to information and involvement as close family members and carers. However, given that the patient has nominated the person themselves, their consent is not required (unless the patient cancels the nomination). The service must inform and involve a nominated person unless this would not be in the best interests of the patient or if, despite making reasonable efforts, the service cannot get in contact with the nominated person.

If you, as nominated person, believe you are entitled to information or involvement which has not been provided, you can request information and involvement. If your request is not met, then you are entitled to information about the decision and the reasons. You can request that this be provided to you in writing.

What if English is not my first language?

Information must be provided to you in a language and form of communication that you are most likely to understand. You have the right to request an interpreter – see Section 1 [Caring for Someone with a Mental Illness](#).

What do I need to know about confidentiality?

Patient information can be disclosed to you in accordance with your rights (as detailed above), without this being a breach of confidentiality.

If you provide information to a clinician that you do not want to be disclosed to the patient, you need to tell the clinician. In this situation, information you have provided can be recorded separately from information that needs to be provided to the patient.

However, there is a chance that the patient will come across the information at a later date, most likely under freedom of information laws that can allow a patient (or another person on their behalf) to access their medical record.

Will I be able to visit and contact my loved one?

You can visit during visiting hours and talk on the phone at reasonable times.

However, a psychiatrist can restrict visits and a patient's phone use. This decision can only be made in the best interests of the patient and it must be reviewed every day. You will be notified if this happens.

What happens if I am unhappy about the treatment being provided?

If the person you care for is made an involuntary patient, the legislation allows you to request a further opinion – see Section 6 [Treatment Options](#).

What rights do I have if there is a Mental Health Tribunal hearing?

If there is a Mental Health Tribunal hearing for the patient, you will be informed beforehand so that you can attend. You will be able to speak during the hearing, and you will have your views considered – see Section 14 [Mental Health Tribunal](#).

What if I have a complaint about the way I have been treated?

Mental health services must have regard to the Carers Charter, which is set out in the *Carers Recognition Act 2004*. This requires that:

- Carers be treated with dignity and respect;
- The role of carers be recognised by including carers in the assessment, planning, delivery and review of services that impact on carers and the role of carers;
- The views and needs of carers be taken into account along with the views, needs and best interests of people receiving care when decisions are made that impact on carers and the role of carers; and
- Complaints made by carers (in relation to services that impact on carers and the role of carers) be given due attention and consideration.

If a service does not comply with the Carers Charter, you can complain to the service or to the Health and Disability Services Complaints Office (HaDSCO).

The same applies to the [Charter of Mental Health Care Principles](#). Failure to comply with the Charter of Mental Health Care Principles is grounds for a complaint to the service or to HaDSCO.

There are other matters that you can complain about, or you can support a patient to complain about – see Section 16 [Compliments, Complaints and Feedback](#).

4. Assessment, Referral and Examination

In this section:

- What is an assessment?
- What is a referral?
- How does a referral work?
- Can a referred person be detained?
- Can the police become involved?
- What is a transport order?
- What happens when the referred person gets to the place of examination?
- What can happen after the examination?
- Can I make a complaint?

What is an assessment?

- A **medical practitioner** (a doctor, including a psychiatrist) or an **authorised mental health practitioner** (a highly qualified and experienced mental health nurse, psychologist, occupational therapist or social worker) may conduct an assessment under the *Mental Health Act 2014*. (For definitions of who these people are, see the [Glossary of Terms](#) included in this handbook.)
- An assessment must take place in the least restrictive (confining) way and in the least restrictive environment. The person being assessed must be able to communicate directly with the practitioner (ideally face to face).
- In metropolitan areas, assessments must be conducted in person.
- In non-metropolitan areas (also called regional, remote or rural areas), sometimes an assessment can be conducted using audiovisual communication (also called videoconferencing). However, this can only occur when the person being assessed is not in at an authorised hospital and if there is a health professional with the person at the time of the assessment. (For the definition of a health professional, see the [Glossary of Terms](#) included in this handbook.)
- Although the assessing practitioner can take into account information in the person's medical record, and information from other people (such as your personal support people), they cannot make a referral without considering their own observations of the person from speaking with them and interacting with them generally.
- If the person being assessed is of **Aboriginal or Torres Strait Islander descent**, the practitioner must try to involve an Aboriginal or Torres Strait Islander mental health worker and significant members of the person's community (such as traditional healers and elders). However, this will generally not happen if the person does not agree to it, or in a crisis or emergency situation.
- If English is not the person's first language or they have a hearing impairment, they will be entitled to a language or Auslan interpreter – see Section 1 [Caring for Someone with a Mental Illness](#).
- If the person has a mental illness, an assessment can be the first step in ensuring that they receive the treatment they need.

What is a referral?

- A **medical practitioner** or an **authorised mental health practitioner** who assesses a person may make a referral. A referral requires the person to be examined by a psychiatrist. The examination may be at an authorised hospital, or at some other suitable place.
- A referral can only be made where the assessing practitioner assesses the person and decides that they may need to be placed on an involuntary treatment order. The assessing practitioner must consider the criteria for an involuntary treatment order – see Section 5 [Becoming an Involuntary Patient](#).
- The assessing practitioner makes a referral by completing a legal form.
- Only a psychiatrist can make an involuntary treatment order – see Section 5 [Becoming an Involuntary Patient](#).

"I find the idea that my GP can refer me for examination by a psychiatrist unsettling, but I have come to trust that they would only do this if they thought it was absolutely necessary, because they respect my wish to be treated as much as possible in the community."

How does a referral work?

- A referral order cannot be made more than 48 hours after the assessment.
- A referral is valid for 72 hours; however, in non-metropolitan areas where it may take longer for the person to get to the place of examination, the order can be extended by another 72 hours, making the maximum length 6 days.
- The practitioner who made the referral can change the destination (the place of examination) at any time, if it is clear that the original destination is no longer appropriate.
- The practitioner who made the referral, or sometimes another practitioner, must revoke (cancel) the referral if they decide that the person no longer meets the criteria for involuntary status.
- The person will be given a copy of the forms used to make a referral, extend or revoke a referral.

Can a referred person be detained?

- If the person is on a referral it is because a practitioner decided that they need to be examined by a psychiatrist. In some situations a referred person may need to be placed on a detention order, to enable the examination. For example, if the referred person attempts to leave an emergency department and it would be unsafe for them to leave.
- If a person is referred for examination by a psychiatrist and a practitioner decides that they need to be detained to enable the examination to take place, then the practitioner may make a detention order.
- The practitioner can make the detention order by filling out a legal form. The person will receive a copy of this form.
- At least one personal support person will be notified that the person has been placed on a detention order (unless this would not be in the person's best interests or the service cannot get in contact with a personal support person).
- A detention order lasts 24 hours. However, if a practitioner reviews the person at least every 24 hours and decides that they still need to be detained, then they can extend it.
- The maximum length of a detention order is 72 hours in a metropolitan area; or 144 hours (6 days) in a non-metropolitan area.
- If a practitioner revokes (cancels) the referral, then the detention order is cancelled too.
- Detention is only used as a means to ensure that a person is properly cared for and kept safe prior to being transported to the place of examination. It is not the same as being detained as a suspect in a police station.
- While the person is detained, the service must ensure that they are able to contact the MHAS, their personal support people, and any health professional who provides them with treatment for mental illness (for example, their GP or psychologist).
- Detention can also be used if the person is already in hospital as a **voluntary patient** but is trying to leave against medical advice. Then the person in charge of the ward (usually a senior mental health nurse) can detain the person for up to 6 hours for an assessment. The assessment would be conducted by a medical practitioner or an authorised mental health practitioner, and the purpose would be to see whether or not the person is in need of a referral for an examination by a psychiatrist.
- If the person runs away when they are on an order for detention then a police officer, a transport officer, or mental health service staff, can collect them and return them to the place. This is known as an **apprehension and return order**.

Can the police become involved?

- There are a few ways in which police could become involved.
- Firstly, a police officer might see a person in the community and form the opinion that they may have a mental illness that is creating significant risk. The police officer can take the person to a place (such as an emergency department) for an assessment, even if they do not want to go. This does not mean that

they are on any criminal charges or have to go to court. It is because the police officer is concerned for their welfare.

- Secondly, if a police officer suspects a person has committed an offence and that they also have a mental illness, the person can be admitted to hospital. When they are discharged, they may still be charged with an offence.
- Thirdly, the police may become involved if a person is on a transport order (see below, 'What is a transport order?').
- A police officer can search a person who is apprehended or arrested. If he or she finds anything that might harm the person or others, they can keep it locked away and only return it when they believe it is safe to do so. Illegal items will not be returned.

What is a transport order?

- Often a referred person can be taken to the place of examination by a family member, by ambulance, or by mental health service staff, as examples.
- However, this is not always a safe option for people who are very unwell and at risk.
- If a medical practitioner or an authorised mental health practitioner decides that the person is at risk, he or she can place them on a **transport order**. A transport order allows the person to be taken to the place of examination by a police officer or a transport officer.
- **Transport officers** are trained people employed by or through mental health services, who have some powers to transport people under the *Mental Health Act 2014*. Using transport officers rather than the police is intended to reduce the waiting time for the person and to avoid possible distress to the person (and to you as a family member or carer) from being transported by the police. However, the police will become involved if you or other people are at significant risk of serious harm.
- To make a transport order, the practitioner must complete a legal form. The person will be given a copy of the form.
- At least one personal support person will be notified when a transport order is made (unless this would not be in the person's best interests, or the service cannot make contact with any of the identified personal support people).
- In some situations yourself or another personal support person may be able to travel with the person you care for while they are being transported.
- A person may be searched by staff or by a police officer or a transport officer before or during transportation. Any dangerous items found will be taken away and not returned until it is safe to do so. Illegal items will not be returned.

What happens when a referred person gets to the place of examination?

- If the person does not arrive at the place of examination (such as an authorised hospital) before their referral expires, they are free to leave – unless they were a voluntary inpatient in an authorised hospital just before the referral was made.
- Staff can search the person. If they find anything that might harm the person, they can keep it locked away and only return it when safe to do so. This may include things like prescription medication, alcohol, belts, razors, scissors, phone chargers and cables. Illegal items will be given to the police or destroyed.
- A psychiatrist will then examine the person and decide whether they need to be made an involuntary patient – see Section 5 [Becoming an Involuntary Patient](#).
- In metropolitan areas, the examination must happen within 24 hours of the person reaching hospital. In non-metropolitan areas, this time can be extended by 48 hours, reflecting the fact that psychiatrists in regional and remote areas are not always immediately available. If the person is already a voluntary inpatient in an authorised hospital, then they must be examined within 24 hours of being referred. If they are not examined within these time periods, they are free to leave.
- In metropolitan areas, examinations must be conducted in person.
- In non-metropolitan areas (also called regional, remote or rural areas), sometimes an examination can be conducted using audiovisual communication (also called videoconferencing). However, this can only

occur if the person is not at an authorised hospital and if there is a health professional with them at the time of the examination. (For the definition of a health professional, see the [Glossary of Terms](#) included in this handbook.)

- If the person is of **Aboriginal or Torres Strait Islander descent**, the examining psychiatrist must try to involve an Aboriginal or Torres Strait Islander mental health worker and significant members of their community (such as traditional healers and elders). However, this will generally not happen if the person does not agree to it, or in a crisis or emergency situation.
- If English is not the person's first language or they have a hearing impairment, they will be entitled to a language or Auslan interpreter – see Section 1 [Caring for Someone with a Mental Illness](#).
- While the person is detained, the service must ensure that they are able to contact the MHAS, their personal support people, and any health professional who provides them with treatment for mental illness (for example, their GP or psychologist).
- While the person is waiting to be examined, they may be looked after in an open or locked ward, or some other place they have been taken to.
- The person may be offered treatment while they are detained. Usually the person will have the right to refuse treatment – see Section 6 [Treatment Options](#).

“A comprehensive assessment approach that supports empowerment is essential for effective rehabilitation. For many of us with a lived experience on this ever-evolving journey towards recovery, the methods used will vary greatly and are very much determined by the needs of the patient – from a clinical approach with careful monitoring to one that encompasses a wide range of therapeutic counselling, wellbeing and self-help programs.”

What can happen after the examination?

After examining the person, the psychiatrist must decide on one of the following:

- The person does not need to become a patient and they are free to leave (unless they were originally arrested and referred for assessment by the police – see above ‘Can the police become involved?’); or
- They have a mental illness that needs treatment but they are able to be treated as a voluntary patient; or
- They need to be an involuntary patient but can be treated in the community (see Section 5 [Becoming an Involuntary Patient](#) and Section 12 [Community Treatment Orders](#)); or
- They need to be an involuntary inpatient in hospital (see Section 5 [Becoming an Involuntary Patient](#) and Section 8 [Caring for Someone in Hospital](#)); or
- The person needs to see another psychiatrist before a decision can be made.

“At the time, I could not understand why I had to be treated under the Mental Health Act. I knew something was amiss with me, but it was okay to think and act the way I did – it was my life – as difficult and out of control I felt. I may not have had the overall choice about whether I wanted the treatment, or to be in hospital, but I had some choices. I learnt that there were always negotiables within the non-negotiable. Talking with my team helped them to understand the best way to support me to help myself.”

Can I make a complaint?

- You can make a complaint yourself, or assist your loved one.
- Firstly, you should discuss the matter with the service. You can make an internal complaint to the service.
- You can complain to the Health and Disability Services Complaints Office (HaDSCO).
- In making a complaint you can seek the help of the Mental Health Advocacy Service (MHAS) or a lawyer.
- For more detail on how the complaints process works, see Section 16 [Compliments, Complaints and Feedback](#).

5. Becoming an Involuntary Patient

In this section:

- What is an involuntary treatment order?
- How does a person become an involuntary patient?
- What are the criteria for an involuntary treatment order?
- What does 'capacity' to make a treatment decision mean?
- How long does an inpatient treatment order last?
- How long does a community treatment order last?
- What happens if the person I care for disagrees with the involuntary treatment order?

What is an involuntary treatment order?

- An involuntary treatment order can be an inpatient treatment order or a community treatment order.
- A person who is on an inpatient treatment order may be referred to as an involuntary inpatient.
- A person who is on a community treatment order may be referred to as an involuntary community patient. A community treatment order is often called a 'CTO'.
- If the person you care for is on an inpatient treatment order, they can be detained in a hospital and given treatment for mental illness, without the need for consent.
- If the person you care for is on a CTO, they can be given treatment for mental illness, without the need for consent, but without them being detained in hospital.
- Given that a person of any age can experience severe mental illness that creates risk, a person of any age can be placed on an involuntary treatment order. However, there are specialised mental health services for children and for older adults.
- An involuntary treatment order should be in force for as short a time as possible, be reviewed regularly and must be revoked (cancelled) if the person no longer meets all of the criteria for an involuntary treatment order (see below 'What are the criteria for an involuntary treatment order?').

How does a person become an involuntary patient?

- Only a psychiatrist can make an involuntary treatment order.
- A psychiatrist can only make an involuntary treatment order after conducting an **examination**. The examination involves the psychiatrist observing the person and asking them questions.
- The psychiatrist will take into consideration the person's mental and physical condition and history, and any other relevant information that they, or you, or some other person (such as another personal support person or another doctor) provides at the time.
- The psychiatrist will want to gather information about things like the person's history of physical or mental illness, family history of physical or mental illness, medications taken, relationships in the person's life, and people who depend on the person (such as children).
- If the person is of **Aboriginal or Torres Strait Islander descent**, the psychiatrist must, to the extent that it is practical and appropriate, involve an Aboriginal or Torres Strait Islander mental health worker and significant people from their community such as elders and traditional healers.
- If English is not the person's first language, or if they have a hearing impairment, they can ask for the help of a free **interpreter**. You can support the person to do this.
- In metropolitan areas, examinations must be conducted in person. In **non-metropolitan areas** (also called rural, regional and remote areas), if the person is not in an authorised hospital and it is not possible for a psychiatrist to conduct the examination in person, then they can examine the person using audiovisual communication (also called videoconferencing). This allows the person to stay in their community rather than be transported great distances for an examination. However, another health professional must be with the person during the examination. (For the definition of a health professional see the [Glossary of Terms](#) included in this handbook.)
- Whether the person then becomes an **involuntary patient** will depend on whether they meet all of the strict criteria outlined in the *Mental Health Act 2014*.

- You (or another personal support person) will be notified when an involuntary treatment order is made.
- The service will also advise the **Mental Health Tribunal** and the **Mental Health Advocacy Service (MHAS)** that the person has been made an involuntary patient. They will be contacted by a **mental health advocate** from the MHAS within 7 days of being made an involuntary patient if they are an adult, or within 24 hours if they are a child – see Section 13 [Mental Health Advocacy Service](#).

What are the criteria for an involuntary treatment order?

- A psychiatrist can only make an inpatient treatment order where he or she decides that:
 - The person has a mental illness that needs treatment; and
 - Because of the mental illness, there is a significant risk to the health and safety of the person, or the safety of another person; or there is a significant risk of serious harm to the person or another person; and
 - The person does not have the capacity (see the section below ‘What does “capacity” to make a treatment decision mean?’) to make a treatment decision; and
 - Receiving treatment in the community would not be sufficient; and
 - There is no less restrictive option available than making an inpatient treatment order.
- A psychiatrist can only make a CTO where he or she decides that:
 - A person has a mental illness that needs treatment; and
 - Because of the mental illness, there is a significant risk to the health and safety of the person, or the safety of another person; or there is a significant risk of serious harm to the person or another person; or there is a significant risk of the person suffering serious physical or mental deterioration; and
 - The person does not have the capacity to make a treatment decision (see the section below ‘What does “capacity” to make a treatment decision mean?’); and
 - Treatment in the community can reasonably be provided to the person; and
 - There are no options available that would be less restrictive than a CTO.
- The [Chief Psychiatrist’s Risk Assessment and Management Standard](#) describes risk in the following way:
 - Risk to self includes: self-harm, suicide and attempted suicide; repeated self-injury; self-neglect; physical deterioration including drug and alcohol misuse and medical conditions (including medical conditions secondary to eating disorders); quality of life issues including loss of dignity, reputation, social and financial status.
 - Risk to others includes: harassment; stalking or predatory intent; violence and aggression; property damage; public nuisance and reckless behaviour that endangers others.
 - Risk from others, especially considering vulnerable persons includes: physical, sexual or emotional harm or abuse by others and social or financial abuse or neglect by others.

“When I heard that I had been ‘put on forms’, it meant nothing to me but later I found out it meant I had become an involuntary patient. I had no idea how this had happened or what it meant, but under the new Mental Health Act 2014, all of this would be explained to me at the time.”

What does ‘capacity’ to make a treatment decision mean?

- Adults are considered to have capacity to make a treatment decision, unless they demonstrate that they do not have capacity.
- Children are assumed not to have capacity, unless they demonstrate that they do have capacity.
- Capacity to make a treatment decision may relate to the patient or to you or another person who is authorised by law to make a treatment decision on the patient’s behalf – see Section 6 [Treatment Options](#).
- For a person to have the required capacity to make a treatment decision, they need to be able to:
 - Understand information given to them about the treatment, other options and risks; and
 - Understand what is involved in making a treatment decision; and

- Understand the effect (consequences or outcomes) of the treatment decision such as side effects, or the consequences of refusing treatment altogether; and
 - Use or weigh up this information to make a decision; and
 - Freely communicate their decision in some way.
- Capacity to make a decision has to be specific to the proposed treatment. It is important that, if the person does not understand the information the psychiatrist is providing, or they are having trouble communicating, that they ask for help. For example, if English is not their first language, they come from a different cultural background, or are vision or hearing impaired, the psychiatrist must arrange support from a person who can help, such as an interpreter, a family member or someone from the person's community.
 - The patient may not have capacity to make decisions at certain times because, for example, they may be sedated, affected by drugs or alcohol, or very distressed.

How long does an inpatient treatment order last?

- An inpatient treatment order is made when the psychiatrist completes a legal form. The person will be given a copy of the form.
- The time period covered by an **initial inpatient treatment order** can be no longer than 21 days for an adult, or 14 days for a child.
- If the person is still in hospital shortly before the initial inpatient treatment order is going to end, their psychiatrist must examine them to decide whether or not they still need to be an involuntary inpatient.
- If they do still need to be an involuntary inpatient, the psychiatrist can place the person on a **continuation order**. The psychiatrist will complete another legal form. The person will be given a copy.
- The maximum time period for a continuation order can be no longer than 3 months for an adult, or 28 days for a child.
- There is no limit on the number of continuation orders that can be made.
- If the person is on an inpatient treatment order, they will not be able to leave the hospital until:
 - They are granted leave (see Section 10 [Leave from Hospital](#)); or
 - They are placed on a CTO (see Section 12 [Community Treatment Orders](#)); or
 - The inpatient treatment order expires (see Section 11 [Hospital Discharge](#)); or
 - The inpatient treatment order is revoked (cancelled) (see Section 11 [Hospital Discharge](#)).

How long does a community treatment order last?

- An **initial community treatment order** lasts 3 months.
- A **continuation order** also lasts 3 months.
- There is no limit on the number of continuation orders that can be made.
- If the person is on a CTO, they will need to comply with the requirements of the order until:
 - The CTO expires (see Section 12 [Community Treatment Orders](#)); or
 - The CTO is revoked (cancelled) (see Section 12 [Community Treatment Orders](#)); or
 - They are admitted to hospital as a voluntary inpatient.
- Alternatively, the person you care for may become more unwell and need to be placed on an inpatient treatment order – see Section 8 [Caring for Someone in Hospital](#).

What happens if the person I care for disagrees with the involuntary treatment order?

- The **Mental Health Tribunal** independently reviews every involuntary treatment order, both initially and on a periodic basis if it is continued – see Section 14 [Mental Health Tribunal](#) for how reviews are organised and conducted.
- You, the person you care for, another personal support person, or a mental health advocate, can request a review of involuntary status at any time. Even if no request is made, the Mental Health Tribunal will automatically conduct a review within 5 weeks for an adult, and within 10 days for a child.
- If the involuntary treatment order is extended, then it must be regularly reviewed. This will be at least every 3 months for an adult, and at least every 28 days for a child.

- The Mental Health Tribunal will inform you and other personal support people of any application for a review, or upcoming reviews.
- At the hearing, the person you care for may represent themselves, or they can be represented by someone else; for example, you, another personal support person, a mental health advocate, or a lawyer. A child can represent themselves at a review if they have the maturity and understanding to make reasonable decisions about matters relating to them. If the Mental Health Tribunal feels that it is not in the person's best interests to represent themselves, it can make an order that they be represented.
- When conducting a review of involuntary status, the Mental Health Tribunal must consider the wishes of the person, your views and the views of other personal support people, the person's medical record, what the treating team says, and whether all of the legal requirements for making an involuntary treatment order have been complied with.
- The Mental Health Tribunal can make recommendations to the person's psychiatrist about their treatment, support and discharge plan (although the psychiatrist is not required to follow these recommendations) – see Section 6 [Treatment Options](#), Section 7 [Electroconvulsive Therapy and Psychosurgery](#), and Section 11 [Hospital Discharge](#).
- Decisions of the Mental Health Tribunal can be reviewed by the State Administrative Tribunal and, after that, by the Supreme Court.

“It's really important to understand your rights and, now that the new legislation has come in, psychiatrists, other mental health workers and mental health advocates will have to explain them to you.”

6. Treatment Options

In this section:

- What kinds of treatment are there?
- Who decides what treatment is given to voluntary patients?
- Who decides what treatment is given to involuntary patients?
- What is emergency psychiatric treatment?
- What about non-psychiatric treatment?
- What happens if the person I care for disagrees with treatment being provided?

What kinds of treatment are there?

- A person who is admitted to hospital will usually be offered occupational therapy, psychotherapy or counselling. These may also be offered to an outpatient at a mental health service.
- A person who is admitted to hospital is also likely to be given some form of medication. Usually this will be oral medication. They may also be given medication via an injection, known as 'depot' medication.
- Other kinds of treatment include electroconvulsive therapy and psychosurgery – see Section 7 [Electroconvulsive Therapy and Psychosurgery](#).
- Whether the person you care for is a voluntary or an involuntary patient, their psychiatrist will decide on the treatment they think would be appropriate in the circumstances. A doctor will seek the person's consent, even if that consent is not needed.
- The person has the right to a clear explanation of the proposed treatment, any risks involved or alternatives available.
- Treatment and care for an involuntary patient is guided by a **treatment, support and discharge plan**. In making this plan and reviewing it as required, the service will involve you, the person, and other personal support people.
- If the person is of **Aboriginal or Torres Strait Islander descent**, their psychiatrist must, to the extent that is practical and appropriate in the circumstances, involve an Aboriginal or Torres Strait Islander mental health worker and significant members of their community (such as elders and traditional healers) in deciding on the appropriate treatment.
- If English is not the person's first language or they have a hearing impairment, you may wish to request the help of a free interpreter.

"Some people are afraid of being diagnosed with a mental illness because they think other people will treat them badly in future. Just remember that anyone can become mentally unwell at some point in their life and getting a diagnosis is the first step on the road to recovery."

Who decides what treatment is given to voluntary patients?

- A **voluntary patient** is a person receiving treatment or care for mental illness by a mental health service but who is not an involuntary patient or a mentally impaired accused patient.
- If the person you care for is a voluntary patient and has the **capacity** to decide on treatment, then treatment can only be provided with their consent (unless emergency psychiatric treatment is needed – see the section below 'What is emergency psychiatric treatment?').
- If the person is a voluntary patient who does not have the capacity to decide on treatment, then a doctor may rely on an **advance health directive** (if there is one); otherwise, someone else (such as a guardian) may be able to **consent to treatment on the person's behalf**.
- Whether consent is being sought from the person you care for, you, or another person, the doctor must do all of the following before seeking consent:
 - Provide information about the proposed treatment; and
 - Ensure that the person understands the information; and
 - Give the person enough time to think about whether they want to give consent; and
 - Give the person enough time to talk to others (such as a GP) about the treatment.

- If the doctor is seeking consent from the person you care for, they must communicate in a language and form of communication that the person is likely to understand. The same applies if the doctor is seeking consent from you or another personal support person. You may wish to ask for an **interpreter**.

“When I was in hospital, I don’t ever remember being asked what I thought about the treatment I was given. Even though I was unwell, I was capable of making decisions for myself. I would encourage everyone to take an active interest in their treatment and ask a lot of questions. After all, it’s your body, mind and life that are affected.”

Who decides what treatment is given to involuntary patients?

- A doctor will decide on what treatment needs to be provided.
- Treatment and care for involuntary patients must be given in accordance with the person’s **treatment, support and discharge plan**. This is prepared shortly after the person is made an involuntary patient, and reviewed regularly. It is prepared and reviewed with input from the person, you and other personal support people.
- Even where the person you care for is an involuntary patient, the doctor proposing treatment must still explain the proposed treatment, as is required for voluntary patients (as detailed above).
- If the person is an adult and has an advance health directive that contains relevant information, this will be taken into consideration.
- Once the doctor has understood the person’s wishes, he or she must take those wishes into account when deciding on the treatment that should be provided. For example, if the person you care for has stated that a particular medication has caused negative side effects for them in the past, the doctor proposing treatment will take this into account.
- Where a doctor makes a decision that goes against what the person wrote in an advance health directive, the decision and reasons for the decision must be reported to the person, to all personal support people, the Chief Psychiatrist, and the Mental Health Advocacy Service. (Definitions of all of these people and organisations are provided in the [Glossary of Terms](#) included in this handbook.)
- However, although all of the above processes must be followed, if the person is an involuntary patient, they may be given treatment for mental illness without the need for their consent.

“Looking back I can see why it was necessary to keep me in hospital against my wishes when I was at risk to myself, but you can feel quite powerless and distressed when you’re made an involuntary patient.”

What is emergency psychiatric treatment?

- **Emergency psychiatric treatment (EPT)** may be given to a person where their life is at risk, or to prevent them from behaving in a way that is likely to result in serious physical injury to themselves or another person.
- Emergency psychiatric treatment is usually in the form of oral medication or an injection of psychiatric medication (called a ‘depot’).
- Emergency psychiatric treatment can be provided without the need for consent. This applies to adults and children, whether voluntary or involuntary. Provision of emergency psychiatric treatment must be reported to the Chief Psychiatrist.

What about non-psychiatric treatment?

- Sometimes **mental illness may result in a physical condition**. For example, if a person has an eating disorder or has deliberately harmed themselves.
- If the person you care for is a voluntary patient and they have a physical condition that is a result of mental illness, they can be provided with treatment with their consent, based on: their consent given directly (if they have capacity); their wishes expressed in an advance health directive; or with the consent of someone else, such as a guardian (if the person does not have capacity).
- If the person you care for is an involuntary patient and they have a physical condition that is a result of mental illness, they can be provided with treatment without the need for consent.

- If the person has a physical condition that is not a result of mental illness, their treating team will decide whether they need urgent treatment or non-urgent treatment.
- A person can be given **urgent non-psychiatric treatment** if: they have a physical condition that needs urgent treatment; they are unable to consent to treatment; and nobody else is immediately available to consent on their behalf. If they are an involuntary patient or a mentally impaired accused patient in an authorised hospital, their psychiatrist must report the provision of the treatment in these circumstances to the Chief Psychiatrist.
- A person can be given **non-urgent non-psychiatric treatment** with their consent, based on: their consent given directly (if they are a voluntary patient and have capacity); or, where they have given consent in an advance health directive; or, with the consent of someone else, such as a guardian (if the person does not have capacity, and this applies whether they are a voluntary or involuntary patient).

“When my teenage son had an eating disorder, he had to receive urgent non-psychiatric treatment in the form of liquid food that was given to him via a tube into his stomach. This undoubtedly saved his life.”

What happens if the person I care for disagrees with treatment being provided?

- If the person you care for is an involuntary inpatient or an involuntary community patient, or if they are a mentally impaired accused patient in an authorised hospital, they are entitled to a **further opinion** regarding their treatment.
- A further opinion can be requested via the person’s psychiatrist or the Chief Psychiatrist (who will help with arrangements).
- The request can be made by the person, or a personal support person. However, if it is a personal support person who makes the request, the person being treated does not have to go ahead with this.
- Whoever is organising the further opinion should discuss the arrangements with the person.
- When a person asks for a further opinion, they should be clear as to why they are asking and what outcome they are seeking. For example, it might be that they want to stop taking a certain medication, or change to a different medication, or have the dosage changed.
- An independent psychiatrist will examine the person and decide whether the current treatment is appropriate. He or she will give a written report to the person and to their psychiatrist.
- While there is no guarantee that the independent psychiatrist will agree with the point of view of the person or the personal support person, their opinion will be independent of the person’s psychiatrist.
- There is no requirement that the person’s original psychiatrist accept the recommendations of the independent psychiatrist, but he or she has a duty to fully consider any alternative views raised by the independent psychiatrist.
- In the past, this ‘further opinion’ was referred to as a ‘second opinion’. Under the *Mental Health Act 2014*, if the person is unhappy with the further opinion, they can request an additional opinion. However, there is no guarantee that this will be given.
- The Chief Psychiatrist always has the power to override the decisions of the person’s own psychiatrist.
- If the person is a **voluntary patient**, they have a right to seek a further opinion, but they may need to arrange this for themselves (you can support them in doing this).

7. Electroconvulsive Therapy and Psychosurgery

In this section:

- What is electroconvulsive therapy and how is it performed?
- When can voluntary patients be given electroconvulsive therapy?
- When can involuntary patients be given electroconvulsive therapy?
- What is emergency electroconvulsive therapy?
- Why is psychosurgery and when can it be provided?
- What can I do if the person I care for does not want to receive electroconvulsive therapy?

What is electroconvulsive therapy and how is it performed?

- Electroconvulsive therapy (ECT) is a form of treatment that is usually used to help people with severe depression, bipolar disorder, and some psychotic illnesses.
- It may be recommended when symptoms are severe, where it has worked in the past and when other treatments are considered too risky or ineffective.
- Electroconvulsive therapy (ECT) involves a patient being given a general anaesthetic and a muscle relaxant, and then having a seizure induced.
- Treatment is usually given in 'courses'. An average course of ECT may involve around 3 treatments per week for 3 to 6 weeks.
- There is a clear body of scientific evidence that ECT is effective in improving depressive and psychotic symptoms.
- ECT is regarded medically as a very safe treatment, with no evidence of long-term damage to brain functions, such as reasoning and creativity.
- However, when a person wakes up from ECT they may feel confused. This is quite normal following a general anaesthetic. Some patients get a headache. Sometimes patients report short-term memory loss.

When can voluntary patients be given electroconvulsive therapy?

- If the person you care for is an **adult voluntary patient**, ECT can be given with their consent (if they have capacity to provide consent), in an advance health directive, or with the consent of somebody else, such as a guardian (if the person does not have capacity).
- If the person you care for is a **child voluntary patient**, ECT can only be given with their consent (if they have capacity to provide consent) or with the consent of their parent or guardian (if the child does not have capacity). Approval of the Mental Health Tribunal is also needed – see Section 14 [Mental Health Tribunal](#).
- A child can only be given ECT if they are at least 14 years old.
- Before anyone can consent to ECT, a description of the treatment, possible risks, and alternative treatments available, must be explained. The psychiatrist must leave the decision maker time to consider whether or not to consent.
- The person who provides consent has the right to withdraw consent at any time, even just before the treatment.

When can involuntary patients and mentally impaired accused patients be given electroconvulsive therapy?

- If the person you care for is an involuntary patient or mentally impaired accused patient, they can be given ECT with the approval of the Mental Health Tribunal – see Section 14 [Mental Health Tribunal](#).
- The same rule applies for adults and children, but a child can only be given ECT if they are at least 14 years old.
- Electroconvulsive therapy (ECT) may also be given where it is emergency ECT, without a requirement for the patient's consent.

What is emergency ECT?

- An involuntary patient or mentally impaired accused can be given emergency ECT, but only in limited circumstances.
- The circumstances in which emergency ECT can be given are where it is needed to save the person's life; or where there is an urgent need for ECT to prevent behaviour that will result in serious physical injury to the person or someone else. The approval of the Chief Psychiatrist is also needed.

What is psychosurgery and when can it be provided?

- Psychosurgery is a surgical procedure that has not been performed in WA since the 1970s.
- It is usually used to treat severe depression and obsessive-compulsive disorder. It is commonly used to treat physical conditions, particularly Parkinson's disease.
- It can only be provided with the consent of the patient themselves (either where they are a voluntary patient with capacity to consent, or where they have provided consent in an advance health directive). The approval of the Mental Health Tribunal is also needed – see Section 14 [Mental Health Tribunal](#).
- Psychosurgery can only be provided to a person who is at least 16 years old.

When can I do if the person I care for does not want to receive ECT?

- If the person you care for is an involuntary patient, you, another personal support person, or the person can ask for an independent **further opinion** from another psychiatrist – see Section 6 [Treatment Options](#).
- The Mental Health Tribunal is also there to safeguard the interests of people with mental illness – see Section 14 [Mental Health Tribunal](#) for more details on how reviews are organised and conducted.

8. Caring for Someone in Hospital

In this section:

- Why is the person I care for in hospital?
- Where will they stay?
- What will happen during admission?
- How will they be treated in hospital?
- How can I ensure they get the best treatment?
- Who can talk to them and visit them?
- Can they leave if they want to?

Why is the person I care for in hospital?

- If the person you care for is an **adult voluntary patient**, it means that the person (if they have capacity to consent) or someone else, such as their guardian (if they do not have capacity to consent), agreed that they should be admitted to hospital.
- If the person you care for is a **child voluntary patient**, it means that the child (if they have capacity) or their parent or guardian (if the child does not have capacity) has agreed that they should be admitted to hospital.
- If the person you care for is an **involuntary patient**, they have been admitted to hospital under the *Mental Health Act 2014* because the psychiatrist who examined them decided that:
 - They have a mental illness that needs treatment; and
 - Because of their mental illness, there is a significant risk to their health or safety, or the safety of another person; or there is a significant risk of serious harm to themselves or another person; and
 - They do not have the capacity to make a decision about their treatment; and
 - Treatment in the community cannot reasonably be provided to the person; and
 - There are no other treatment options available that would be less restrictive than making an **inpatient treatment order** (see Section 5 [Becoming an Involuntary Patient](#)).

“When my mum was assessed in the Emergency Department by a doctor and a psych liaison nurse, they suggested that she be admitted into a mental health unit because of the risk of harm to herself. She was a bit reluctant about going in but went along with the advice of the doctor and so was treated as a voluntary patient.”

Where will they stay?

- Whether the person you care for is a voluntary inpatient or an involuntary inpatient, they may be in either an authorised hospital or a general hospital.
- An authorised hospital is a hospital that is authorised to detain and treat involuntary patients. Authorised hospitals can still admit and treat voluntary patients.
- A general hospital is a hospital that is not an authorised hospital.
- The person you care for might not stay at the place where they were examined by a psychiatrist. For example, if they started off in an emergency department, they may be transferred to a mental health ward at the same hospital or a different hospital.
- The person can only be made an involuntary inpatient in a general hospital if they have a physical condition and a mental health condition, and both require treatment. This kind of order can only be made with the approval of the Chief Psychiatrist.
- **Mental health wards** in authorised hospitals treat a number of patients at once, so they will be staying with other people who are unwell where there are rules and routines that apply to everyone.
- Some wards are called locked wards (also known as ‘secure wards’). Others are called open wards. They can be placed in either; sometimes a voluntary patient may be in a locked ward, and sometimes an involuntary patient may be in an open ward. Some patients are transferred between locked wards and open wards, depending on how well or unwell they are.

- Whether the person is in a locked ward or an open ward, they are not allowed to leave the ward without permission.
- If the person you care for is a child, they should be admitted to a ward specifically for children. Sometimes this is not possible; for example, in a regional area. If a child is in an adult ward, the hospital must take extra steps to look after them (such as allocating them a room right outside the nurses' station) and they must write a report as to how they will be looked after. This report must be given to the child's parent or guardian and to the Chief Psychiatrist.
- It can be a difficult experience being admitted to a mental health ward, particularly if the person you care for has never been to one before and if they were brought there against their will. You should encourage them to discuss any fears or concerns they have with you and the hospital staff.

"The first time I was admitted to a psychiatric ward, I was terrified as I was unsure about what would happen during my admission. It gets easier though as you settle into the ward and become familiar with the routine and you realise it's not so scary after all."

What will happen during admission?

- When the person you care for arrives at the ward, staff will introduce themselves, provide them with information about the place and their rights, and show them around.
- During admission, staff have the right to search through their possessions. If they find a dangerous item, they can keep it locked away in the nurses' station and will only return it when they believe it is safe to do so. This may include things like prescription medication, alcohol, belts, razors, scissors, phone chargers and cables. Illegal items will be given to police or destroyed.
- Patients have a right to store personal possessions. However, staff might ask you or another personal support person to take certain items home, for example, expensive jewellery.
- Within 12 hours of admission, a doctor will come to see the person to offer them a physical examination. This will usually involve testing their heart rate and blood pressure, and asking about any physical health problems. The doctor may also want the person to have tests, such as a blood test.
- If the person is not able to be examined within the 12 hours (for example, where they are sedated or perhaps intoxicated), the doctor will come back regularly until the person is able to be examined.
- If the person is a voluntary patient, they can only be given a physical examination with their consent (if they have capacity to consent) or the consent of another person, such as a guardian (if the person does not have capacity to consent).
- If the person is an involuntary patient or a mentally impaired accused patient in an authorised hospital, they can be given a physical examination (which can include taking samples) even if they do not agree to it.
- Usually the person you care for will be assigned a **mental health nurse** as their main point of contact. Nurses are available at all times of the day and night to provide, treatment, care and support to the person you care for. You are also entitled to ask to speak with them at any time. The name of each patient's nurse for each shift will usually be put on a noticeboard near the nurses' station.
- The person you care for may or may not be given their own room. They may have to share bathroom and shower facilities with other patients too, but they can use them in private.
- They will be given a secure place to keep their possessions, but they are responsible for looking after them and most hospitals advise against keeping valuables at the hospital.
- You may not be allowed to enter the patient's room, but there are usually private areas available for when you visit.

How will they be treated in hospital?

- Everyone has a right to be treated with dignity and respect while in hospital. No one should be ill-treated or wilfully neglected.
- The person you care for will see a psychiatrist and a team of other staff such as mental health nurses, social workers, occupational therapists, and possibly psychologists.
- Mental health service staff must have regard to the Charter of Mental Health Care Principles – see Section 2 [Charter of Mental Health Care Principles](#).

How can I ensure they get the best treatment?

- There are several different categories of treatment – see Section 6 [Treatment Options](#) and Section 7 [Electroconvulsive Therapy and Psychosurgery](#).
- To provide the best treatment, the treating team will need to gather important information from the person you care for, from you, and from other personal support people.
- Make sure you tell the treating team about:
 - The person's medical history and any relevant family medical history.
 - Any medications they are already taking, including prescription or over-the-counter medications and complementary medicines.
 - Any change to their condition, or problems they are having with their treatment so far.
 - Any special needs they have, including dietary, cultural or religious needs.
 - Any concerns you have about their ability to manage their responsibilities, such as caring for other family members or pets, work commitments, payment of bills and rent and keeping appointments with other health care providers.
- The hospital staff and/or you can initiate a special meeting (often called a 'family meeting') if there are complex decisions that are best made with you, the person you care for, and other personal support people present. This allows all of the treating team to come together with the person and personal support people to discuss all aspects of the situation, before making any decisions or planning for the future.

"When Mum was admitted to a psychiatric ward, Dad and I sat in on part of the meeting when she was seen by the doctor. This allowed us to give our perspective on what had been going on that led to the admission, and gave us the opportunity to find out what treatment Mum would be receiving while in hospital."

Who can talk to them and visit them?

- Usually a patient can have as many visitors as they like, and they can make and receive phone calls.
- However, if they are an inpatient in an authorised hospital (voluntary, involuntary, or mentally impaired accused), a psychiatrist may restrict some visitors and phone calls in some situations.
- There are usually public and private rooms available for visits.
- When you visit, you may be able to speak with staff to provide input, such as your observations or anything else that the treating team needs to know.
- The person you care for may find it helpful to talk to other **patients** in the ward. Often, these people have been through similar experiences and may be able to give them advice and encouragement. However, the person you care for does not have to talk to them if they do not want to and some patients may prefer not to talk to other patients.
- You and the person you care for are not allowed to record conversations, make videos or take photos with your mobile phone in hospital because it could reveal confidential information about someone else. If you do, you will most likely be asked to delete the information.

Can they leave if they want to?

- If the person you care for is a **voluntary patient**, legally they can leave the hospital whenever they wish. However, leaving without permission may be against hospital policy.
- If the person is thinking about discharging themselves, you should encourage them to talk to staff first.
- If the person is a voluntary inpatient in an authorised hospital, then the person in charge of their ward can detain them for up to 6 hours to enable them to be assessed by a doctor or an authorised mental health practitioner.
- However, if the doctor or authorised mental health practitioner assesses the person and believes that they may be in need of involuntary treatment, he or she will refer them to a psychiatrist for examination. If the psychiatrist believes that the person should stay in hospital longer and that they meet the criteria for becoming an involuntary patient, they may be detained under the *Mental Health Act 2014* – see Section 5 [Becoming an Involuntary Patient](#).

- If the person you care for is an **involuntary patient**, they will not be allowed to decide when they want to leave, but staff will work with them and their personal support people to achieve that. The person can ask to take leave or be discharged from the hospital at any time and their psychiatrist has to consider any request. If they do leave without permission though, a hospital, community mental health worker, or the police will look for them and bring them back – see Section 10 [Leave from Hospital](#).

9. Seclusion and Bodily Restraint

In this section:

- What is meant by seclusion?
- What is meant by bodily restraint?
- How can seclusion and bodily restraint be used?

What is meant by seclusion?

- Seclusion means confining a person who is being provided with treatment or care at a hospital by leaving them at any time of the day or night alone in a room or area that they cannot leave.
- This definition of seclusion applies to any patient in an authorised hospital, whether they are voluntary, involuntary, or referred for examination.
- Seclusion does not mean asking someone to remain in an area where there is no physical barrier, or being stuck in a room because you are too frail, unwell or physically disabled to leave.
- Seclusion also does not include taking a voluntary time-out in a quiet area.

What is meant by bodily restraint?

- **Bodily restraint** is the physical or mechanical restriction of the movements of a person who is being provided with treatment or care at a hospital.
- There are two types of bodily restraint permitted:
 - **Physical restraint** means applying bodily force to the person's body to restrict the person's movement.
 - **Medical restraint** means using a device to restrict the person's movement, such as a belt, harness, manacle, sheet or strap. It does not include either the appropriate use of medical or surgical appliances or the appropriate use of furniture to restrict a person, such as cot sides or a chair fitted with a table.
- Bodily restraint does not mean the physical or mechanical restraint used by a police officer.
- Bodily restraint does not mean being supported physically to help a person do something because they are frail or disoriented.
- This definition of bodily restraint applies to any patient in an authorised hospital, whether they are voluntary, involuntary, or referred for examination.

How can seclusion and bodily restraint be used?

- The [Chief Psychiatrist's Standard on Seclusion and Restraint](#) says staff should agree on a Patient Safety Plan with the person you care for, you and other personal support people. This should be done as soon as possible after admission to hospital, in order to reduce the chances of the person becoming highly distressed or agitated, and to prevent a crisis.
- However, if a person is physically injuring themselves or another person, or persistently damaging property, they may be put in seclusion or restrained if there is no better alternative. It will not be used as a way to punish them.
- Bodily restraint may be used to provide a person with treatment, such as injected medication, where this is necessary. Staff do not need consent for this treatment, but will try to ask for it.
- Bodily restraint must not be used where it may involve significant risk to the person's health, for example if they have a heart condition or breathing difficulties.
- A person of any age, including a child, can be secluded or restrained.
- Staff will try to de-escalate the situation and calm the person down. They may offer medication, or the chance to go to a quiet room. If you are there at the time, they may ask you to help.
- If staff cannot manage this, they may seclude or restrain the person in a safe, dignified and respectful manner, but they will try to calm the person down and release them as soon as possible.
- Bodily restraint must use the least possible force, cause no pain and must not restrict breathing.
- Only a doctor or mental health practitioner can order seclusion or bodily restraint.

- Seclusion can last up to 2 hours. The time can be extended for further two-hour periods after a doctor has examined the person, if required. A nurse must check their mental and physical wellbeing at least every 15 minutes and a doctor will review them at least every 2 hours. Staff will offer support and reassurance.
- Bodily restraint can last for up to 30 minutes. The time can be extended for further 30-minute periods after a doctor has examined the person, if required. A nurse must observe their mental and physical wellbeing at all times and a doctor will review them at least every 30 minutes. Staff will offer support and reassurance.
- Within 6 hours of being released from seclusion or bodily restraint, doctor will examine the person to see whether their condition has changed due to being secluded or restrained.
- The person should also have a chance to talk to the staff member who ordered them to be secluded or restrained. This debrief should be documented and the person should be given copies of all the forms used to seclude or restrain them.
- At least one close family member, one carer, and the nominated person, are entitled to be informed of any instance of seclusion or bodily restraint.
- The Chief Psychiatrist be informed of any instances of seclusion and bodily restraint.

“I was treated under the Mental Health Act for anorexia nervosa because my physical health was at risk. However, because I was refusing to let them insert a nasogastric tube to provide me with nutrition, I had to be restrained for them to put it in. It was highly distressing at the time, but what helped was that the nurse did so in a compassionate manner, acknowledged that it would likely be quite traumatic for me and explained what they were going to do before carrying it out.”

10. Leave from Hospital

In this section:

- How can people get leave from hospital?
- What can I expect as a carer?
- Can leave be cancelled or extended?
- What happens when they return to hospital?
- What happens if things don't go according to plan?

How can people get leave from hospital?

- The person you care for can ask their psychiatrist for leave from the hospital, even if they are an involuntary patient. It is quite common for an involuntary patient to be granted leave from the hospital once they are getting better. Leave can last from a few hours to a few days.
- The person you care for may want leave because, as examples, they:
 - Have an important event they do not want to miss
 - Want to obtain treatment from another health professional, such as their GP or a dentist
 - Want to see whether they function and feel well enough when they are back at home.

At some point, the psychiatrist will want to see how well the person is doing by allowing them to have time with their family and friends and in the community, or to see how well they might cope at home or in new accommodation.

- Before leave can be granted, the psychiatrist must consult with the person and their personal support people about whether leave should be granted, and how to keep the person safe if they go on leave.
- As a personal support person, it is important that you are clear about whether you believe you can cope with looking after the person if they are granted leave.
- In deciding whether to grant leave, the psychiatrist will apply the guidelines in the [Chief Psychiatrist's Risk Assessment and Management Standard](#), which require them to consider a person's risk to themselves, risk to other people and the risk from other people while they are on leave – see Section 5 [Becoming an Involuntary Patient](#).
- If the person's psychiatrist does not want to grant them leave, he or she must explain the reasons. Either way, his or her decision to grant leave or not has to be written down, including the reasons for that decision. The person you care for is entitled to see a copy of that form.

“When our teenage son was transitioning from hospital back to home, it was really helpful that he take it in manageable chunks by coming home on leave for a few hours initially and then for a whole weekend. Given that he had an eating disorder, one of the main things we all needed to know was whether he could manage to eat at home.”

What can I expect as a carer?

- If the person you care for leaves hospital without permission, they will be considered absent without leave and if they do not return by their own choice when asked to do so, a staff member of the service, a police officer, or a transport officer, will look for them and bring them back to hospital. You may be able to help the person you care for agree to go back to hospital if they are finding it difficult to do so by themselves.
- Note that being granted leave does not mean that the person you care for is no longer an involuntary patient. They have to comply with any conditions of their leave, like taking medication, receiving certain treatment, staying at a certain place, and returning to hospital when required to do so.
- Make sure you see a copy of the form that describes the length and conditions of leave, and understand what it says before you leave with the person you care for. If you have difficulty, ask someone from the hospital to help you.
- If the person you care for goes on leave for a day or more, the hospital staff may pack up and store their belongings at the hospital so that someone else can use the room while they are away.

- When someone is on leave, a psychiatrist, someone from the hospital, or a community mental health worker may contact you from time to time to ask how everyone is doing.
- When granting leave, a psychiatrist must also consider whether it would be more appropriate to make the person you care for a voluntary patient, or put them on a CTO, or discharge them completely – see Section 12 [Community Treatment Orders](#) and Section 11 [Hospital Discharge](#).
- While the person you care for is on leave, another medical practitioner can write to their psychiatrist, saying that their involuntary treatment order is no longer necessary. Their psychiatrist at this point might agree and make a decision to discharge them.

“It can be a bit daunting, being responsible for the safety of the person you love when they are out on leave. It’s okay to speak up about this to someone from the hospital.”

Can leave be cancelled or extended?

- While the person you care for is on leave, their psychiatrist can:
 - Extend their leave, or
 - Change the conditions of their leave, or
 - Cancel their leave.
- If their psychiatrist extends their leave he or she must consider, at least every 21 days, whether the person you care for should become a voluntary patient, whether they should be put on a CTO, or whether they should be discharged completely – see Section 12 [Community Treatment Orders](#) and Section 11 [Hospital Discharge](#).
- If a psychiatrist cancels leave, for example because the person you care for has not complied with the conditions of leave (such as, receiving treatment), he or she will inform them by talking to them by phone and confirming in writing that they must return to the hospital. He or she may also ask for a community mental health worker to contact them on his or her behalf.
- You will be informed of any changes to the leave conditions of the person you care for, and if leave has been cancelled or extended, unless their psychiatrist believes it is not in their best interests for you to know.

What happens when they return to hospital?

- When the person you care for returns to hospital, staff will usually ask to search their bags and possessions to ensure that they are not bringing back anything that is harmful to them or anyone else.
- The person you care for might not be able to return to the same room that they were using before they went on leave, which is more likely if they have been away for some days.
- The psychiatrist will usually want to meet with the person you care for, and you, soon after they return, to discuss how their leave went and what the next steps are.

“Goodbyes can be hard when you take someone you care for back to hospital. There is no right way to handle everyone’s emotions, but I found that reminding yourself and the person you care for to look forward to the next time you will talk or meet certainly helps.”

What happens if things don’t go according to plan?

- If you or the person you care for feels unsafe in any way while they are on leave, you or they should contact the staff at the hospital they left from, a community mental health service, or their GP.
- In an emergency, phone one of the emergency contact numbers listed in the Community Services Directory on the [Mental Health Commission](#) website, or visit your local hospital’s emergency department with the person you care for and tell them that they are an involuntary patient on leave.
- If the person you care for does not return from leave when expected, a staff member from the hospital, the police, or a transport officer, can be sent to find them and take them back to the hospital using an **apprehension and return order**. You will be told if such an order is issued.
- However, before this happens every effort will be made to get the person you care for to return to hospital by him or herself, or with your help.

11. Hospital Discharge

In this section:

- What is discharge planning?
- What happens during discharge?

What is discharge planning?

- Discharge planning is a process that involves the person you care for, you and other personal support people, and any staff involved in the provision of care (for example, a community mental health nurse or a GP).
- The aim of discharge planning is to ensure a safe and smooth discharge from hospital, whether to home, a hostel or another location, and to manage the transfer of care either between or within services.
- A discharge plan documents what has happened while you were in hospital, any medications you need to take and any follow-up care or treatment after you leave hospital.
- The plan must be drawn up in line with standards published by the Chief Psychiatrist the [Physical Health Care Standard](#), the [Care Planning Standard](#) and the [Transfer of Care Standard](#). These standards state that hospital staff must provide the person you care for and their personal support people with information about the range of services available to support them in the community. If the person has multiple care plans, they should be merged wherever possible to ensure that care is coordinated across a range of services in a person-centred way.
- When the person you care for is discharged from hospital, they might:
 - Remain an involuntary patient and be placed a CTO (see Section 12 [Community Treatment Orders](#)); or
 - Be followed up by outpatient services and/or a community services team from the hospital; or
 - Be transferred (back) into custody if they are a mentally impaired accused patient on a custody order.
- A written copy of the discharge plan will be given to the person you care for, you and other personal support people, and everyone else involved in the person's care prior to discharge. The psychiatrist may need to provide the discharge plan to other services, such as a community mental health service, to ensure continuity of care.
- A copy should also be sent to the person's GP if they are going to be treated in the community. If they do not have a GP, a social worker can help locate a local service.
- **Questions** you may want to ask about the discharge plan (if the person you care for is going to be treated in the community) might be:
 - Who is going to be involved in preparing the discharge plan?
 - Can I have input into the plan?
 - What treatment(s) will the person I care for be taking?
 - What should I do if the person does not take their medication?
 - How will you ensure that there is regular communication between the person and other medical practitioners or service providers involved?
 - What symptoms should I watch out for that would indicate the person I care for is becoming unwell again?
 - What should I do if I think the person I care for is becoming unwell again?
 - Who should I contact in an emergency?
- For some ideas about community services that are available, refer to the Community Services Directory available on the [Mental Health Commission](#) website.

What happens during discharge?

- Make sure that you know the day and time the person you care for will be discharged. If you or another personal support person is not available to pick them up, the hospital should arrange for their transport home.
- There are **forms** that the hospital staff will need to fill out, and the person you care for should receive copies of these.
- Make sure the hospital has a record of your **contact details** and those of the person you care for.
- Make note of any follow-up **appointments** the person you care for has with their psychiatrist, psychologist, community mental health workers and/or GP.
- When the person you care for leaves hospital there are a number of practical things they will have to do, like packing up their **belongings** and emptying out their room. If the staff have kept any of their belongings in the nursing station, they will need to be reclaimed, by you or the person you care for.
- Note that the hospital has the right to dispose of anything that is left behind. If the person you care for does not claim their property within 6 months of discharge, the hospital can dispose of, or even sell, the items. However before this happens the hospital must give the owner at least one month's notice of their intention to dispose of items.
- Many people are discharged with a limited amount of medication from the hospital pharmacy and it can take some time for hospital staff to arrange this on the day. Make sure you and the person you care for understand all medication instructions. You both have a right to ask additional questions about the medication – see Section 6 [Treatment Options](#) for possible questions to ask.
- Hospital staff will also return any medication the person you care for brought with them to hospital.
- **Checklist:**
 - You know when the person you care for is going to be discharged
 - Transport home arranged
 - Received copies of forms
 - Hospital has my contact details
 - Follow up appointments arranged
 - Collected all their belongings
 - Have any medication they need.

“It’s best to allow a number of hours to support the person you care for through the discharge process as this process can take some time.”

12. Community Treatment Orders

In this section:

- Why is the person I care for on a community treatment order?
- What is a community treatment order?
- How does a community treatment order work?
- How long can a community treatment order last?
- What happens if the person I care for does not follow the community treatment order?
- What can I do if I think they should not be on a community treatment order?
- When can I request a further opinion?

Why is the person I care for on a community treatment order?

- If the person you care for is on a community treatment order (CTO), it means that a psychiatrist has examined them and believes that:
 - The person has a mental illness that requires treatment; and
 - Because of the mental illness, there is a significant risk to the person's health or safety, or the safety of another person; or there is a significant risk of serious harm to the person or another person; and
 - The person does not have the capacity to make a treatment decision; and
 - There are no options available that would be less restrictive than a CTO.
- An involuntary treatment order can apply to a person of any age. For further explanation, refer to Section 5 [Becoming an Involuntary Patient](#).
- If the psychiatrist believes the person you care for can be treated in the community, but they might not accept the treatment voluntarily, or because of their mental illness they are unable to consent (agree) to the treatment, then he or she can make a CTO. The order is made when the psychiatrist completes a legal form.
- A CTO can be a less restrictive alternative to involuntary admission to hospital, as the person you care for can remain living at home or another location in their community.
- However, in order for a CTO to work, the person has to be able to practically attend their appointments with their psychiatrist and other people involved in their treatment and care, so if they normally live in a remote place, this may not be the best option. For these reasons, their psychiatrist may instead make an **inpatient treatment order** that requires them to be treated in hospital – see Section 5 [Becoming an Involuntary Patient](#) and Section 8 [Caring for Someone in Hospital](#).
- You or another personal support person must be notified if the person you care for is made subject to a CTO.
- The person must also be visited or otherwise contacted by a **mental health advocate** within 7 days of becoming an involuntary patient if they are an adult, or 24 hours if they are a child – see Section 13 [Mental Health Advocacy Service](#).

What is a community treatment order?

- A CTO is a form that sets out the compulsory treatment and care to be provided in the community.
- The treatment that will be given will be based on the person's **treatment, support and discharge plan** – see Section 6 [Treatment Options](#).
- You will be involved in the making of the treatment, support and discharge plan, as will the person you care for, and other personal support people. You will also be given a copy of the plan.
- It is important that the person you care for is able to maintain a home, support themselves, care for their family and any pets, have a social life and build relationships, participate in their community, and generally have a meaningful life. Therefore, their treatment, support and discharge plan needs to take account of their personal circumstances. It is important that staff know:
 - Where the person is living and with whom.
 - Who else is caring for or otherwise supporting the person.

- If they are responsible for providing care for other people or pets.
 - Whether they are working (paid or unpaid), plus when and where they work.
 - Any other health issues that they need treatment for (such as diabetes, a substance addiction, etc.)
 - Who else is already giving them treatment (such as their GP, a psychologist or a specialist).
 - Any travel plans or other commitments (such as before and after school care, religious or cultural ceremonies, volunteering activities, etc.) that might interfere with their ability to attend appointments.
 - Anything else that is important to maintaining their health, wellbeing, safety and quality of life.
- Note: Permission can be given for a person on a CTO to travel interstate if arrangements can be made for their ongoing treatment and care in another state or territory.
 - Questions the person you care for or you might want to ask include:
 - What are the aims for their treatment and care?
 - Who will be responsible for their treatment and care?
 - What treatment do you recommend and why?
 - What are the risks and side effects of this treatment?
 - What are the potential benefits?
 - How effective is this treatment?
 - How long would it last?
 - How would we know whether it is working or not?
 - What will it cost?
 - Where can I get other information about this treatment?
 - What other treatment options are available?
 - What could happen if they refuse this treatment?
 - The person's treatment, support and discharge plan must be reviewed regularly in line with standards and guidelines published by the Chief Psychiatrist, including the [Physical Health Care Standard](#) and the [Care Planning Standard](#).
 - So that you are fully informed, know what to expect from treatment and care, and are able to help the person you care for meet the conditions of the CTO, the order should include:
 - The name of the psychiatrist (known as the **supervising psychiatrist**); and
 - The name of the treating practitioner (i.e., the doctor, or mental health practitioner (psychologist, mental health nurse, occupational therapist or social worker)) who is treating the person; and
 - A requirement to comply with all of the psychiatrist's directions about treatment; and
 - The date and time the CTO was made, when it comes into force and how long it lasts; and
 - A requirement that the person tell their psychiatrist of any change in address, or any travel plans (outside of WA) at least 7 days before departure (or, if they have to travel urgently, as soon as possible).
 - Their psychiatrist will explain to the person you care for, you and anyone else involved, the details of their treatment, support and discharge plan and the CTO. It is important that you ask questions if there is anything you do not understand.
 - Make sure the supervising psychiatrist and the treating practitioner have contact details for the person you care for, you and other personal support people, so they can make contact if required.

How does a community treatment order work?

- The supervising psychiatrist must inform the person you care for of when and where their first appointment will be, so that the person, you, or another personal support person, can make arrangements for the person to be there.
- While the CTO is in force, the supervising psychiatrist or treating practitioner must check on the person's progress at least every month.
- If the supervising psychiatrist does not see the person, then the treating practitioner who does must provide a written report to him or her. Nevertheless, the supervising psychiatrist must see the person at least once every 3 months to review their involuntary patient status.

- At their appointment, the person you care for should tell their supervising psychiatrist or treating practitioner about anything that is affecting their health, wellbeing, safety and quality of life and specifically how they are getting on with their treatment.
- At any time, the supervising psychiatrist can vary the terms of the CTO. They can change the treatment, support and discharge plan, who is treating the person, or where they are going to be treated. The supervising psychiatrist should discuss any changes with you, the person you care for, and other personal support people, as well as provide the legal forms to confirm this.

How long can a community treatment order last?

- A psychiatrist makes a CTO by filling out a legal form. This form will be given to the person you care for.
- The form will say when the CTO ends. It can last for only 3 months. However, it can be extended.
- The person will be examined every month.
- Sometimes it may be the supervising psychiatrist who conducts the examination. Other times it may be the treating practitioner. However, the supervising psychiatrist must conduct an examination at least every 3 months.
- During the examination the psychiatrist or practitioner must consider whether the person you care for still needs to be an involuntary patient.
- If the CTO is coming to an end, the person will be examined by their supervising psychiatrist. There are several different options:
 - If the person continues to meet all of the criteria for an involuntary treatment order at the end of that period and can still be treated in the community, the supervising psychiatrist can continue the CTO for up to 3 months using a **continuation order**; or
 - If the person continues to meet all the criteria for an involuntary treatment order, but can no longer be treated in the community, the supervising psychiatrist may suspend (pause) the CTO and consider making an inpatient treatment order (see Section 4 [Assessment, Referral and Examination](#) and Section 5 [Becoming an Involuntary Patient](#)); or
 - If the psychiatrist decides that the person you care for no longer meets all the criteria for an involuntary treatment order, he or she must **revoke (cancel) the CTO** and the person can either become a voluntary patient, or be discharged from the community mental health service.
- If the CTO expires without being extended or changed, then the CTO automatically ends and the person is no longer an involuntary patient.
- If the person's involuntary status changes, the supervising psychiatrist should discuss this with the person, you, and other personal support people, and give the person the legal form to confirm this.
- Even if there is no longer a need for involuntary treatment, to recover fully the person you care for may need ongoing treatment and care in the community as a voluntary patient.

What happens if the person I care for does not follow the community treatment order?

- Although a person on a CTO may be living at home or in a hostel, and is not a patient at a hospital, under the *Mental Health Act 2014*, they are still an involuntary patient and must comply with (follow) the treatment that has been prescribed.
- At the start of the CTO, the person you care for, you, and other personal support people should discuss with the supervising psychiatrist and/or treating practitioner what might happen if the person refuses to comply. He or she will make all reasonable efforts to help you understand and encourage the person you care for to follow the terms of the CTO.
- However, if they do not follow the terms of their CTO (for example, if they do not take the medication or attend a clinic as required), under the *Mental Health Act 2014* one or more of the following things can happen:
 - They can be issued with a **notice of breach** that tells them what they need to do differently and by when.
 - If this does not work, they can be given an **order to attend** that requires them to attend and possibly receive treatment at a particular time and place (for instance, at a community mental health service).

- The supervising psychiatrist must tell the person, and should also tell you and other personal support people, about any notice of breach, or order to attend. They will explain why this has happened, how to follow along with the order and what can happen if it is not followed.
- If the person you care for does not follow along with the notice of breach or order to attend, the supervising psychiatrist can do one of the following things:
 - Issue a **transport order** that tells the police or a transport officer to bring the person to a particular place, where they can be detained for up to 6 hours; or
 - Order that the person be admitted to hospital on an **inpatient treatment order** (see Section 5 [Becoming an Involuntary Patient](#)); or
 - Revoke (cancel) the CTO so that the person is no longer an involuntary patient.
- The supervising psychiatrist must tell the person – and should also tell you and other personal support people – about their decision and explain why this has happened and what will happen next, as well as provide the person you care for with the appropriate form to confirm this.
- If you, the person you care for, or another personal support person, objects to the person being on a CTO, or the terms of the CTO, this should be discussed with the supervising psychiatrist and/or treating practitioner. If still not satisfied, then you/they can request a further opinion – see below.

What can I do if I think they should not be on a community treatment order?

- The **Mental Health Tribunal** independently reviews every CTO, both initially and on a periodic basis if it is continued – see Section 14 [Mental Health Tribunal](#) for how reviews are organised and conducted.
- You, the person you care for, or another personal support person, may request a review of involuntary status at any time. However, even if nobody requests a review, the Mental Health Tribunal will conduct a mandatory review anyway; within 5 weeks for an adult or within 10 days for a child. If the CTO is extended, then it must be reviewed periodically – at least every 3 months for an adult or every 28 days for a child.
- A lawyer or a mental health advocate can also request a review – see Section 13 [Mental Health Advocacy Service](#).
- The person you care for may represent themselves at a Mental Health Tribunal Review, or be represented by another person, which could be a personal support person, a friend, a lawyer, or a mental health advocate. Children can represent themselves at reviews if the Mental Health Tribunal decides that they have the maturity and understanding to make reasonable decisions about matters relating to them. Children have the right to speak for themselves at a hearing even if they are unable to represent themselves.
- You and other personal support people will automatically be invited to the review, so long as the Mental Health Tribunal has your contact details. These are usually provided by the mental health service where the person you care for receives treatment, so make sure that you keep these details updated.
- When conducting a review of involuntary status, the Mental Health Tribunal must consider: the person’s current mental and physical health; any history of mental or physical illness; the treatment, support and discharge plan; the person’s wishes; your views and the views of other personal support people; input from the person’s lawyer or mental health advocate; plus anything else they think is relevant.
- The Mental Health Tribunal can also make recommendations to the person’s supervising psychiatrist about their treatment, support and discharge plan (see Section 6 [Treatment Options](#)), however the supervising psychiatrist is not obliged to follow these recommendations.
- If necessary, decisions made by the Mental Health Tribunal can be reviewed by the State Administrative Tribunal, and after that by the Supreme Court.

When can I request a further opinion?

- You, the person you care for, or another personal support person, may request a further opinion, which is the opinion of a psychiatrist who is independent from the supervising psychiatrist.
- For a patient on a CTO, a further opinion can be requested where the person who requests the further opinion:
 - disagrees with the diagnosis
 - is unhappy with the treatment plan; or
 - would like to challenge a continuation order.
- The request can be made verbally or in writing, to the supervising psychiatrist or the Chief Psychiatrist.
- If you or another personal support person requests a further opinion, but the person you care for does not want the further opinion, then a further opinion cannot be provided.
- For more detail on the process, see Section 6 [Treatment Options](#).
- In the past, a 'further opinion' was referred to as a 'second opinion'. Under the *Mental Health Act 2014*, you can ask for one or more additional opinions if you are not satisfied with the outcome of the further opinion, however there is no guarantee that this will be allowed. If the request is refused, the person you made the request to has to write down the reasons and give a copy to you.

13. Mental Health Advocacy Service

In this section:

- What is the Mental Health Advocacy Service and who can use it?
- What can a mental health advocate do to help the person I care for?
- How will the mental health advocate look after the needs of the person I care for?
- When can the person I care for see a mental health advocate?
- Can the person I care for make a complaint through a mental health advocate?

What is the Mental Health Advocacy Service and who can use it?

The Mental Health Advocacy Service (MHAS) is a free, confidential and independent service. An advocate is dedicated to ensuring that:

- The person you care for is informed about their rights
- Their rights are respected, and
- Their wishes are considered.

The following people can use the service:

- Involuntary inpatients
- Involuntary community patients
- Referred persons and people who are subject to an order for further examination
- Voluntary inpatients in an authorised hospital who are under an order for assessment
- Residents of private psychiatric hostels
- Mentally impaired accused in an authorised hospital, under a hospital order or a custody order
- Mentally impaired accused on a release order.

What can a mental health advocate do to help the person I care for?

The main role of an advocate is to:

- Support the person you care for to express their own wishes about their situation and what they want to happen.
- Advise them of their rights under the *Mental Health Act 2014*, their options and any possible consequences of their decisions.
- Consider and address issues that affect the person you care for and all other people who are receiving treatment, care and support at the place where they are staying.
- Promote the least restrictive environment and conditions that will help with their recovery.
- Ensure that their treatment and care is the best it can be for promoting their wellness and recovery.
- Respect the person you care for and all other parties and acknowledge the diverse obligations and opinions – this includes the obligations of personal support people, where the person has given permission for you/them to be involved.

The MHAS upholds all the principles of the Charter of Mental Health Care Principles – see Section 2 [Charter of Mental Health Care Principles](#) for more details.

In supporting the person you care for, a mental health advocate can also:

- Assist them find, or refer them to, other professionals or agencies that can address issues such as housing, employment, transport, income support, guardianship and the care of children.
- Give them information about various other services that may be able to assist with complex issues, such as drug and alcohol services or legal aid if there is a legal issue to deal with.
- Speak up for the person within the hospital or mental health service and externally with government and non-government agencies.
- Represent the person in different settings such as during reviews held by the Mental Health Tribunal – see Section 14 [Mental Health Tribunal](#).
- Assist the person in accessing their medical records.

- Listen to and act on any complaints they may have.
- Ensure they have access to interpreters, community representatives and any other person or organisation that may be helpful.
- If they are of Aboriginal or Torres Strait Islander descent, ensure that an Aboriginal or Torres Strait Islander mental health worker and significant members of their community (such as elders and traditional healers) are involved in their treatment and care.

How will the mental health advocate look after the needs of the person I care for?

A mental health advocate is someone who will look after the interests of the person you care for while they are in hospital or being treated on a community treatment order. They will represent their perspective only while they are involved with the mental health service. Their support will continue until the person is no longer an involuntary patient.

If the person you care for is a child (under 18 years) or youth (between 18 and 25 years) then the mental health advocate is likely to have qualifications, training or experience specific to children and young people.

If the person you care for has specific issues related to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices, Principle 6 of the [Charter of Mental Health Care Principles](#) applies. This principle states: “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.” A mental health advocate will be able to assist the person in ensuring this principle is followed.

If the person you care for is an Aboriginal or a Torres Strait Islander person, Principle 7 of the [Charter of Mental Health Care Principles](#) applies. This principle states: “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.” A mental health advocate will be able to assist the person you care for in ensuring this principle is followed.

If the person you care for is unable to express their wishes at different times while in hospital, a mental health advocate will make every effort to understand their preferences and represent them to ensure that their rights are upheld.

It may be a good idea for the person you care for to prepare an **advance health directive** that outlines their wishes. Advance health directives are legal documents in which an adult with capacity to make decisions can set out their decisions about future treatment. An advance health directive only comes into effect if there comes a time when the person is unable to make reasonable judgments.

When can the person I care for see a mental health advocate?

- A mental health advocate will come to visit or will make contact within 7 days of a person being admitted to hospital as an involuntary inpatient or becoming an involuntary community patient.
- If the person is a child a mental health advocate will visit or otherwise contact them within 24 hours.
- A mental health advocate can visit the person you care for at any time.
- The person you care for can also request a visit from a mental health advocate by contacting the MHAS themselves. You will find their contact details on the MHAS posters placed around the mental health service, or from the information they provided when they first contacted the person you care for. You can visit the [Mental Health Advocacy Service](#) website.
- The person you care for can also ask the mental health service to request a visit on their behalf. They should let their treating team know that they would like to talk to a mental health advocate. The service must then make contact with the MHAS within 24 hours to let them know that the person would like to speak with an advocate.

Can the person I care for make a complaint through a mental health advocate?

To make a complaint, the person you care for can contact a mental health advocate and register a complaint with them, or request a visit and speak to them in person. They will then assist the person to make a complaint and can help represent their views. The advocate can also make a complaint on the person's behalf if they do not want to complain for themselves.

The sorts of things a mental health advocate could assist with might be:

- The person would like to take leave but cannot reach agreement with the mental health service or their psychiatrist.
- The person is feeling very uncomfortable about their room on the ward and would like to be moved.
- The person would like to do some therapy or activities but have been told that they cannot.
- They need some additional support for drug and alcohol issues but cannot seem to get it.
- They feel that they have been treated badly by a staff member or another patient.

14. Mental Health Tribunal

In this section:

- What is the Mental Health Tribunal?
- Why is it called a Tribunal?
- Who is on the Mental Health Tribunal?
- What happens at a hearing or review?
- What can I do if I am unhappy with the Tribunal's decision?

What is the Mental Health Tribunal?

- The Mental Health Tribunal is a group of people who make decisions about whether a person should remain on an involuntary treatment order. They do this through conducting meetings, which are called 'hearings' or 'reviews'. They can also consider other issues to do with the person's involuntary treatment order.
- You may hear some people refer to 'reviews' while others say 'hearings'. They are actually the same thing.
- Hearings and reviews are informal and are closed to the public, so there is no need to worry about privacy issues. They are conducted in person; usually in meeting rooms at the place where the person you care for is staying or at a community mental health service (also called a 'community clinic'). For people in regional or remote areas, hearings can be conducted by videoconferencing. (Before the hearing the details of any videoconferencing arrangements will be provided to you, the person you care for, and other personal support people.)
- Hearings will be conducted by the Tribunal as soon as possible and some hearings must be conducted within certain timeframes (see table below).

Timeframes for mandatory reviews of involuntary treatment orders

	Adults	Children
Initial review	Within 5 weeks of involuntary treatment order being made	Within 10 days of involuntary treatment order being made
Periodic review	Within 3 months after initial review	Within 28 days after initial review
Subsequent periodic reviews	No more than 3 months apart	No more than 28 days apart

Why is it called a Tribunal?

The Tribunal is a legal body and is independent of the health services and the government. This does not mean that the hearing will run like a court hearing. It will be much less formal. A hearing is a way of protecting a person's rights and is concerned with making sure that the correct procedures were followed when a person is referred and made an involuntary patient. It is an opportunity for the person's best interests to be looked into by a third party, and for the person, their personal support people, and a mental health advocate to have input into the process and request further reviews if necessary.

Who is on the Mental Health Tribunal?

The Tribunal has a President and other members including psychiatrists, lawyers and community members.

If the person you care for is an adult, the Tribunal will be made up of:

- a member who is a lawyer;
- a member who is a psychiatrist; and
- a member of the general public who is not a lawyer, or a doctor, or a mental health practitioner working as a staff member at a mental health service or private psychiatric hostel.

If the person you care for is a child, the Tribunal will be made up of:

- a member who is a lawyer;
- a member who is a child and adolescent psychiatrist; or, if a child and adolescent psychiatrist is not available, then a member who is a psychiatrist; and
- a member of the general public who is not a lawyer, or a doctor, or a mental health practitioner working as a staff member at a mental health service or private psychiatric hostel.

What happens at a hearing or review?

- The hearing or review is a face-to-face meeting held where the person you care for is staying – usually at an authorised hospital or a community mental health service (also called a ‘community clinic’). Everyone who is invited to attend will be given advance notice of the date and time of the meeting.
- These meetings are held in private to protect privacy and confidentiality.
- If the person you care for is in a regional or remote area and videoconferencing is being used, the video is transmitted over a secure link. This means that the only people who can see or hear the meeting are the Tribunal and the people in the room with the person at the mental health service. If you or the person you care for has any issues with the sound or image quality at a videoconference hearing, you need to let the Tribunal know during the hearing and let the staff at the mental health service know too.
- At the meeting, you, the person you care for, and other personal support people, will have the opportunity to talk with the Tribunal members. You should try to actively participate and put your views across.
- The person you care for is entitled to know about the information the Tribunal members have been given, and usually they will have access to the same documents as the Tribunal members.
- You, the person you care for, and other personal support people who attend can speak, but are not required to.
- The person you care for can also ask a mental health advocate or a lawyer to speak up for them at the meeting.
- Further, you and other personal support people are allowed to have a lawyer.
- During the hearing or review any special needs that the person has must be taken into account, such as wheelchair access, an interpreter, support of a community member or any other requirements.

What can I do if I am unhappy about the Tribunal’s decision?

If you are a person with sufficient interest and are unhappy with the decision made by the Mental Health Tribunal you may apply to the State Administrative Tribunal for a review of the decision.

15. Chief Psychiatrist

In this section:

- What does the Chief Psychiatrist do?
- Can the Chief Psychiatrist review the treatment of the person I care for?
- What reports does the Chief Psychiatrist receive?

What does the Chief Psychiatrist do?

- The Chief Psychiatrist has overall responsibility for the treatment and care of people experiencing mental illness who come within the scope of the *Mental Health Act 2014*.
- The Chief Psychiatrist publishes standards and guidelines for the treatment and care that is provided by mental health services.
- The Chief Psychiatrist deals with reports from services about serious matters such as possible staff misconduct, and any serious risks to the welfare of patients while they are in hospital.
- The Chief Psychiatrist can visit an authorised hospital at any time, and may visit any other mental health service if it is suspected that proper standards of treatment and care are not being maintained.

Can the Chief Psychiatrist review the treatment of the person I care for?

- The Chief Psychiatrist can consider the treatment being given to the person you care for, and can direct their psychiatrist to change the treatment.
- The first step is for the person you care for, you, or another personal support person, to seek a further opinion – see Section 6 [Treatment Options](#).

What reports does the Chief Psychiatrist receive?

Where the person in charge of a hospital becomes aware of a **notifiable incident**, he or she must report this to the Chief Psychiatrist.

A notifiable incident could be any of the following:

- The death of a patient
- A serious medication error
- Unlawful sexual contact between patients in hospital
- Unlawful sexual contact between a staff member and a patient
- Unreasonable use of force on a person by a staff member
- Any other incident connected with the treatment or care of a person that has had, or is likely to have, a serious adverse effect on the person.

16. Compliments, Complaints and Feedback

In this section:

- What kinds of things can feedback be given about?
- What can be done to avoid making a complaint?
- How can a complaint be made?
- Who can make a complaint?
- How long will it take to resolve a complaint?
- What sort of complaints are of interest to the Health and Disability Services Complaints Office?

What kinds of things can feedback be given about?

Feedback can include compliments, suggestions, complaints, or any information about a clinician or a mental health service.

- **Compliments:** Everyone loves a compliment and you can certainly provide compliments if you believe that you or the person you care for have been treated well by a person within a service or if you are happy with the service generally. You may also have a specific example of something that really helped you while you were involved with the service. For example, you could write a letter to a service, about a particular nurse who really listened to you or the person you care for. You could express how this was helpful and how it made a difference for you and the recovery of the person you care for.
- **Suggestions:** Suggestions include all general comments about how the service could improve. You can provide feedback or suggestions at any time to staff at the mental health service.
- **Complaints:** You also have a right to make a complaint if you believe that you have not been treated well by a mental health service. It is a good idea to make a complaint as soon as possible in case you may be able to solve the problem with the service straight away.
- If you make a complaint on behalf of the person you care for, you must take reasonable steps to resolve the issue with the service. An example of taking reasonable steps to resolve the issue would be to discuss the issue with the service and see if things can be changed.
- Keep in mind that making a complaint can give a service the opportunity to change the way that they do things and actually improve the service, which can be a good thing for everyone.

What can be done to avoid making a complaint?

Good communication can make things a lot easier for everyone. Sometimes things can go wrong because communication may not be so great. To help improve communication and prevent problems, here are some things to consider:

- Ask questions if you are not quite sure about something.
- It is okay to take your time when talking or asking questions.
- Ask for explanations of certain terms or language used (and refer to the [Glossary of Terms](#) at the end of this handbook).
- Be open and honest with staff.
- Do not be afraid to ask if you can make notes while you are speaking with staff.
- If you or the person you care for require an interpreter, it is important that you request one.

How can a complaint be made?

- The mental health service will have an **internal complaints procedure** in place so that people can make complaints and to ensure the service has an organised way of dealing with complaints that must be followed.
- Up-to-date copies of the complaints procedure are freely available at the mental health service. If you cannot find one, ask someone who works at the service, as they must provide you with one.
- A complaint can be made verbally or in writing.

Who can make a complaint?

- As a carer, family member or personal support person, you can personally make a complaint about how you have been treated.
- The person you care for can also make a complaint and in doing so can seek help from you, a mental health advocate, or their lawyer.

How long will it take to resolve a complaint?

- Complaints must be dealt with by any service as soon as possible.
- If your complaint is not resolved by the service, if a response is taking an unreasonable amount of time, or if you are unhappy with the outcome, then you may wish to make a complaint to the [Health and Disability Services Complaints Office](#) (HaDSCO). However, HaDSCO can only accept complaints about things that occurred less than 2 years before the day that the complaint is made unless, in the Director's opinion, you have shown good reason for the delay.

What sort of complaints are of interest to the Health and Disability Services Complaints Office?

The Health and Disability Services Complaints Office accepts complaints where you think that the service did any of the following:

- Acted unreasonably in not providing a mental health service.
- Acted unreasonably by providing a mental health service.
- Acted unreasonably in the manner of providing a mental health service.
- Acted unreasonably by delaying, denying or restricting access to records kept by the service provider.
- Acted unreasonably in disclosing records or confidential information.
- Failed to comply with the [Charter of Mental Health Care Principles](#).
- Failed to comply with the Carers Charter.
- Not properly investigating the complaint or not causing it to be properly investigated.
- Not taking proper action or not causing proper action to be taken in relation to the complaint.
- Acted unreasonably by charging an excessive fee or acted unreasonably with respect to a fee.

17. Glossary of Terms

In this 'Glossary of Terms' you will find an explanation of terms you may come across in mental health services. Much of the content has been taken from [Carers WA's Prepare to Care](#) resource, the Mental Health Association of NSW, the [Mental Health Coordinating Council](#), the WA Mental Health Commission's report [Mental Health 2020](#), or the [Mental Health Act 2014](#) itself. The terms included here are broader than the ones mentioned in the handbook.

Note: words in blue text refer to other terms contained within this glossary.

A

Aboriginal or Torres Strait Islander people: According to the High Court of Australia (1983), a person of *Aboriginal or Torres Strait Islander* descent identifies as an *Aboriginal or Torres Strait Islander* person and is accepted as such by the community in which he or she lives.

Acute: A person experiencing severe distress associated with the onset of, or increased signs/symptoms of, psychiatric problems. These are characterised by severe symptoms that have the potential to be prolonged or cause risk to the person or to others.

Addiction: The inability to control a psychological or physiological dependence on a substance or activity that leads to [self-harm](#).

Adult: Legally, an adult is a person who has reached 18 years of age.

Admission: The admission, entry or receiving of a patient into a mental health service, whether the patient is admitted as an [inpatient](#) or an [outpatient](#).

Advance health directive: Written instructions under common law that apply to health care professionals about the amount and type of medical care and treatment a person wants. It usually contains information about where they do or do not wish to be cared for and by whom, or what treatment they want or do not want. However, an advance health directive can express wishes about any aspect of a person's life or affairs. They are used when a person is too unwell to state these wishes for themselves.

Advocate/advocacy: An advocate is someone who works on behalf of the person you care for and at their direction (advocacy). Under the *Mental Health Act 2014*, it is mandatory for [involuntary patients](#) and some other people to be contacted by a [mental health advocate](#) from the [Mental Health Advocacy Service](#).

Anaesthetic: A medication given to patients who are undergoing [electroconvulsive therapy](#) or [psychosurgery](#) by a specialist anaesthetist in order to make them unconscious. The anaesthetist also takes care of them during and after the procedure.

Antidepressant medication: A form of medication intended to help reduce the symptoms of depression. Antidepressants may also be helpful in the treatment of anxiety disorders, such as generalised anxiety disorder, obsessive-compulsive disorder, social anxiety disorder, eating disorders and post-traumatic stress disorder. People with depression and anxiety disorders may have an imbalance in certain natural chemicals in the brain. Antidepressant medications can help the brain to restore its usual chemical balance and so reduce symptoms. It can take up to six weeks after the first dose of medication before it has a noticeable effect.

Antipsychotic medication: This is a form of medication helpful to people with schizophrenia and some forms of bipolar disorder. It is able to reduce, or sometimes eliminate, the distressing and disabling symptoms of psychosis, such as paranoia, confused thinking, delusions and hallucinations. People with psychotic illnesses may have an imbalance in certain natural chemicals in the brain, especially dopamine. Antipsychotic medications help the brain to restore its usual chemical balance and so reduce symptoms. People should begin to feel better within six weeks of starting to take antipsychotic medication.

Area Health Service: These agencies are responsible for providing public health services on behalf of the WA government. There are currently four Area Health Services: North Metropolitan, South Metropolitan, WA Country, and Child and Adolescent (state wide).

Authorised hospital: This is a public or private hospital in WA that is authorised to detain and treat involuntary patients.

Authorised mental health practitioner: This means a person with at least three years' experience in the management of people with a mental illness, and may include a psychologist, a mental health nurse, an occupational therapist or a social worker, whom the [Chief Psychiatrist](#) has decided has the relevant qualifications, training and experience to administer the *Mental Health Act 2014*.

B

Bodily restraint: This is the physical or mechanical restriction of the movements of a person who is being provided with treatment or care at an [authorised hospital](#).

C

Capacity: A legal term meaning the extent to which someone is able to make decisions about their treatment and personal welfare. These may be small decisions, such as whether to take a mild painkiller for a headache, or what treatment to have for mental illness. A person may lack capacity in some areas of their life, but still be able to make other decisions. An [adult](#) is assumed to have capacity unless it is established that they lack capacity, whereas a [child](#) is assumed to not have capacity unless they can demonstrate otherwise. To demonstrate capacity, a person has to have the ability to understand, remember and use the information given to them.

Care coordination: Care coordination provides a locally based approach to supporting people with mental health issues and their families to navigate, plan and coordinate access to the services and supports needed to live a good life.

Carer: This is a term defined under the [Carers Recognition Act 2004 Section 5](#) that can apply to family members, friends and even neighbours who provide ongoing support and assistance (without being paid) to people who have a mental health illness. You may hear support workers and other staff working in the mental health sector use the term 'carer' when talking about themselves, but under the [Carers Recognition Act 2004](#) someone who provides a service on contract or while doing voluntary community service is not considered to be a carer.

Catatonic: This is a state of apparent unresponsiveness where a person can remain speechless and motionless, and refuse to eat or drink for an extended period of time even though they are apparently awake. It can be associated with post-traumatic stress disorder, bipolar disorder, and depression.

Charter of Mental Health Principles: The *Mental Health Act 2014* is built around 15 principles described in a Charter of Mental Health Care Principles. Mental health services, including private psychiatric hostels, have to follow these principles when providing treatment, care and support to people experiencing a mental illness, and when dealing with their carers, families and other support people.

Chief Mental Health Advocate: This person is appointed by the Minister for Mental Health to run the [Mental Health Advocacy Service](#).

Chief Psychiatrist: A psychiatrist appointed who is responsible for the overall treatment and care of all mental health patients (including in private psychiatric hospitals). The Chief Psychiatrist always has the power to override the decisions of a patient's psychiatrist with respect to the treatment being provided to an [involuntary patient](#) or [mentally impaired accused patient](#) in an [authorised hospital](#). His or her responsibilities include publishing standards and guidelines for the treatment and care provided by mental health services, and ensuring compliance.

Child: Under the *Mental Health Act 2014*, a child is a person who is under 18 years of age.

Child and Adolescent Mental Health Service (CAMHS): This service provides mental health programs to infants, children and young people under the age of 18 who are experiencing significant mental health issues, and their families. This includes services offered in the community and in a hospital setting.

Chronic: A prolonged mental or physical illness or disability.

Close family member: Under the *Mental Health Act 2014*, this is a family member who is not also the person's primary carer, or their nominated person, but who nevertheless provides ongoing care or assistance to the person. If a person identifies as an [Aboriginal or Torres Strait Islander](#) person, then a close family member includes any person recognised this way under customary law or tradition.

Cognitive behavioural therapy (CBT): A short-term goal oriented psychological treatment that stresses the importance of thoughts in controlling behaviour and mood. Cognitive behavioural therapy helps people discover how their feelings, thoughts and behaviour can get stuck in unhelpful patterns. They are encouraged to try new, more positive ways of thinking and acting. Therapy usually includes tasks to try between sessions. Cognitive behavioural therapy is a well-established treatment for depression and most anxiety disorders. It can also be an effective part of treatment for other conditions, including post-traumatic stress disorder, eating disorders, bipolar disorder and schizophrenia.

Community mental health service: Comprises a team of psychiatrists, psychologists, mental health nurses, social workers and occupational therapists, but does not include private medical practitioners or other health professionals. They are able to conduct assessments or examinations under the *Mental Health Act 2014* or provide care and treatment in the community for people of all ages. It does not include doctors or other health professionals in private practice.

Community treatment order (CTO): A [psychiatrist](#) who makes someone an [involuntary patient](#) may offer that person compulsory treatment and care in the community instead of being admitted to hospital under an [inpatient treatment order](#). A CTO can apply to a person of any age. It must be in force for as short a time as possible, be reviewed regularly and be revoked (cancelled) if the person no longer meets one or more of the criteria for an [involuntary treatment order](#).

Comorbidity: The co-occurrence of two or more disorders (for example, a person having an anxiety disorder with depression), or a mental illness combined with substance abuse.

Confidentiality: A set of rules or a promise that limits access or places restrictions on certain types of information being shared. Under the *Mental Health Act 2014*, nobody is allowed to directly or indirectly record, disclose (reveal) or use any information they obtain about a person while providing them with a mental health service.

Consultant psychiatrist: The consultant psychiatrist is the most experienced psychiatrist on the team.

Consumer: Any person who identifies as having a current or past lived experience of psychological or emotional issues, distress or problems, irrespective of whether they have a diagnosed [mental illness](#) and/or received treatment. It is most commonly used when referring to a person utilising, or who has utilised, a mental health service. Other ways people may choose to describe themselves include 'peer', 'survivor', 'person with a [lived experience](#)' and 'expert by experience'.

Continuation order: A form filled out by a psychiatrist that recommends the continuation of an [involuntary treatment order](#) – either an [inpatient treatment order](#), or a [community treatment order](#).

Counsellor: Someone who is a [health professional](#) that provides supportive listening and emotional support to individuals dealing with difficulties of varied nature, as well as providing support to their families.

Culturally and linguistically diverse (CaLD): This is a term applied to people of diverse ethnic origin who identify with one or more non-Australian cultures and/or speak in language(s) other than English. They may include migrants, immigrants or refugees born overseas, or children of these people who were born in Australia. Sometimes, such people are referred to as 'multicultural' or 'transcultural'. The public mental health service for CaLD communities is called the WA Transcultural Mental Health Service.

D

Depression: Clinical depression is an illness that significantly affects the way someone feels, causing a persistent low mood. Depression is often accompanied by a range of other physical and psychological symptoms (including feeling extremely sad or tearful; disturbances to normal sleep patterns; loss of interest and motivation; feeling worthless or guilty; loss of pleasure in activities; anxiety; changes in appetite or weight; loss of sexual interest; physical aches and pains; and impaired thinking or

concentration) that can interfere with the way a person is able to function in their everyday life. Every year, around 6% of all adult Australians are affected by a depressive illness. Children and teenagers can also be affected by depression.

Depot: Medication that is injected rather than taken orally.

Detention order: A form filled out by a [medical practitioner](#) or [authorised mental health practitioner](#) to detain (hold) a person in order to take them safely to an [authorised hospital](#) or another place where a [psychiatric examination](#) can take place. Detention can also be used if a person is already in hospital as a voluntary patient but are trying to leave against medical advice. Then the person in charge of the ward can detain them and refer them to be examined by a [psychiatrist](#).

Diagnosis: The determination that the set of symptoms or problems of a person indicates a particular disorder which is described in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). This is a manual produced by the American Psychiatric Association to define and classify mental and personality disorders.

Discharge: This means the discharge or exit of the patient from a mental health service, whether the patient was admitted as an inpatient or outpatient.

Discharge planning: Discharge planning is a process that involves the patient, close family members, carers, nominated persons, guardians or enduring guardians and any staff involved in the patient's care. The aim of discharge planning is to ensure a safe and smooth discharge from hospital, whether to home, a hostel or another location.

Doctor (medical practitioner): Doctors, also known as medical practitioners, diagnose, treat and assist in the prevention of human physical and mental illness, disease and injury and promote good human health. They are involved in a wide range of activities including consultations, attending emergencies, performing operations and arranging medical investigations. In caring for patients, medical practitioners work with many other health professionals.

E

Early intervention: Responding early in life and/or early in the course of a mental disorder or illness, or early in an episode of illness, to reduce the risk of escalation, have a positive impact on the pattern of illness and minimise the harmful impact on individuals, their families and the wider community.

Electroconvulsive therapy (ECT): This treatment involves the application of an electric current to specific areas of a person's head to produce a generalised seizure. It is administered under general anaesthetic together with a muscle-relaxing agent. It is often recommended in the treatment of severe depression, bipolar disorder or acute psychosis when symptoms are severe and other treatments are considered too risky or ineffective.

Enduring guardian: A person can appoint an enduring guardian, at a time when the person is well, to make certain decisions on their behalf if they become unwell.

Enduring power of guardianship: A legal document that authorises a person of a patient's choice to be their [enduring guardian](#).

Emergency psychiatric treatment: Treatment may be given to a person without their informed consent where their life is at risk, or to prevent them from behaving in a way that is likely to result in serious physical injury to that person or another person.

F

Family meeting: Family meetings are quite common in hospitals, often being used to inform or educate families, gather information from families, make decisions, resolve any possible conflict in families; and plan for the future. This gives everyone involved, including the patient, time to prepare, to consider the issues, any questions they have and how they might respond should certain situations arise. It is helpful to know who will be present: various staff that are involved in a patient's care will be present. This is an opportunity for everyone to gather information as well as present their point of view.

Family therapy: This therapy aims to support families and other carers where one or more members of the family have a mental illness, by fostering calm and constructive family relationships. Family therapy sessions typically focus on education about mental illness, solving problems encountered as a result of the illness, and improving communication and relationships where these are strained or stressful. This form of therapy can reduce relapse rates for people with mental illness while also supporting everyone involved.

Forensic patient: A person who has been arrested for committing a crime but found to be of unsound mind or unfit for trial under the [Criminal Law \(Mentally Impaired Accused\) Act 1996](#). These people are referred to as [mentally impaired accused patients](#) under the *Mental Health Act 2014*.

Forensic mental health service: Refers to mental health services that principally provide assessment, treatment and care of people with a mental health problem and/or mental illness who are in the criminal justice system, or who have been found not guilty of an offence because of mental impairment. Forensic mental health services are provided in a range of settings, including prisons, hospitals and the community.

Forms: When staff refer to 'forms' they are meaning the mandatory forms that they have to complete to enter information and record clinical decisions for the health information network and a person's medical record. The information contained in these forms is confidential. Sometimes, staff refer to people being 'put on forms', or 'being formed' which means that they have been deemed an [involuntary patient](#) under the *Mental Health Act 2014*.

Further opinion: The independent opinion of a psychiatrist other than a patient's treating psychiatrist, regarding the treatment being offered to the patient.

G

General hospital: A hospital in which patients with many different types of ailments or illnesses are given care and treatment. It does not include an [authorised hospital](#), maternity home or nursing home.

General practitioner (GP): General practitioners or GPs diagnose and treat physical and mental illnesses, disorders and injuries. They recommend preventative action and refer patients to specialist doctors, other health care workers, and social, welfare and support workers.

Guardian: A guardian can be appointed to make personal, lifestyle and treatment decisions in the best interests of an adult who is not capable of making reasoned decisions for themselves because of a mental illness. They can also be the legal guardian of a child.

Guardianship: The State Administrative Tribunal can appoint a person as a guardian under the [Guardianship and Administration Act 1990](#) for a person who does not have decision making capacity.

H

Health and Disability Services Complaints Office (HaDSCO): This is an independent body that provides a service to resolve complaints relating to health or disability services in WA. This service is free and available to all consumers and providers of health or disability services. The Health and Disability Services Complaints Office also reviews and reports on the causes of complaints, undertakes investigations, suggests service improvements and advises service providers about how to better resolve complaints.

Health professional: A person who is a medical practitioner, nurse, [occupational therapist \(OT\)](#), [psychologist](#) or [social worker](#) or an Aboriginal or Torres Strait Islander mental health worker.

I

Informed consent: This is a legal term meaning that a person with mental [capacity](#) has given permission for a particular medical treatment. Consent should only be given after a full disclosure and discussion of treatment risks, possible side effects, perceived benefits and alternative options. The person must be given sufficient time to consider the information given and to obtain other advice if they want to, which may include a [further opinion](#). Failure to resist treatment is not informed consent.

Inpatient: Someone receiving treatment while staying within the hospital setting.

Inpatient treatment order: An order allowing a patient to be detained in hospital and provided with treatment for mental illness without a need for consent.

Involuntary patient: An involuntary patient is someone who is placed on an [involuntary treatment order](#).

Involuntary treatment order: An involuntary treatment order can be an [inpatient treatment order](#) that requires a person to be admitted to an [authorised hospital](#) or a [community treatment order](#) that means the person must receive treatment in the community.

L

Lawyer: A lawyer can provide advice on how the *Mental Health Act 2014* applies to a situation, a person's rights under the Act, how to access medical records and how to deal with the [Mental Health Tribunal](#). The [Mental Health Law Centre \(WA\)](#) provides free and confidential legal services to people who are involuntary patients under the *Mental Health Act 2014* and may also be able to assist in other legal matters related to criminal law, guardianship and administration, family law, employment and discrimination law, and freedom of information, amongst other things.

Lived experience: A term commonly used to describe the current or past lived experience (of mental health [consumers](#) and [carers](#)) of dealing with psychological or emotional issues, distress or problems, irrespective of whether this was related to a diagnosed mental illness and/or involved treatment.

M

Medical practitioner (doctor): Doctors, also known as medical practitioners, diagnose, treat and assist in the prevention of human physical and mental illness, disease and injury and promote good human health. A psychiatrist is a kind of medical practitioner.

Mental disorder (mental illness): Clinically, a recognised and diagnosable disorder that significantly interferes with an individual's thoughts, emotions or social abilities. The diagnosis is generally made when a specific set of symptoms meet the criteria in the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Mental health: A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his/her community.

Mental health advocate: An employee of the [Mental Health Advocacy Service](#).

Mental Health Advocacy Service (MHAS): This service is established to ensure that all people are informed of their rights, their rights are respected and their wishes known. The MHAS is allowed to inspect facilities and advocate on behalf of people referred for examination by a psychiatrist, involuntary patients, hostel residents and mentally impaired accused. It replaces the Council of Official Visitors that existed under the *Mental Health Act 1996*.

Mental Health Commission: A government department that provides mental health policy advice to the WA government and purchases mental health services on behalf of the State.

Mental health consumer: Any person who identifies as having a current or past lived experience of psychological or emotional issues, distress or problems, irrespective of whether they have a diagnosed [mental illness](#) and/or have received treatment. Most commonly used when referring to a person utilising, or who has utilised, a mental health service. Other ways people may choose to describe themselves include 'peer', 'survivor', 'person with a [lived experience](#)' and 'expert by experience'.

Mental health nurse: A specialised type of nurse who cares for people with mental illness. The term 'psychiatric nurse' is also used.

Mental health practitioner: Under the *Mental Health Act 2014*, this means a person with at least three years' experience in the management of people with a mental illness and may include a [psychologist](#), [mental health nurse](#), [occupational therapist \(OT\)](#) or [social worker](#).

Mental health service: Refers to hospital or community based services in which the main function is to provide clinical treatment, rehabilitation or support targeted at people affected by mental illness. Mental

health services are provided by organisations operating in both the government and non-government sectors. Such organisations may exclusively provide a mental health service or a broader range of health or human services.

Mental Health Tribunal: A quasi-judicial oversight body (that is, it has some legal powers) responsible for reviewing involuntary treatment orders and other matters relating to the administration of the *Mental Health Act 2014*. It replaces the Mental Health Review Board that existed under the *Mental Health Act 1996* and is independent of the mental health services, and the government. A lawyer, an independent psychiatrist and a community member will usually make up the Mental Health Tribunal.

Mental illness: Clinically, a recognised and diagnosable illness that significantly interferes with an individual's thoughts, emotions or social abilities. The diagnosis is generally made when a specific set of symptoms meet the criteria in the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Mentally impaired accused patient: These are people found unfit to stand trial or are acquitted on the grounds of unsoundness of mind, but may still be detained on a custody order under the [Criminal Law \(Mentally Impaired Accused\) Act 1996 Section 23](#). Sometimes these people are referred to as [forensic patients](#). They can be sent to an [authorised hospital](#) (such as the Frankland Centre at Graylands Hospital in Perth) as an [involuntary patient](#) if they have a treatable mental illness.

Mentally Impaired Accused Review Board: This the body defined under the [Criminal Law \(Mentally Impaired Accused\) Act 1996 Section 41](#) to supervise [mentally impaired accused patients](#). It comprises the chairperson and community members from the Prisoners Review Board, a psychiatrist and a psychologist.

Metropolitan area: This is an area of WA that is not serviced by the WA Country Health Service.

N

Nominated person: An adult, such as a friend, who has been formally nominated (named) in writing by a person to receive information and be involved in decisions about their treatment and care. Any person, even a child, may propose someone to be their nominated person, but they must understand the impact of making the nomination. They can name only one person at a time. The person who made the nomination can revoke (stop) it at any time, in any way they choose.

Neurosurgeon: This is a specialist surgeon who has been trained in surgery of the spine and brain. They can perform [psychosurgery](#) and are involved in approvals for psychosurgery by the [Mental Health Tribunal](#).

Non-metropolitan area: This is an area of WA that is serviced by the WA Country Health Service. Also known as a regional, remote or rural area.

O

Occupational therapist (OT): A person who assesses someone's levels of independence, cognitive skills and safety, and encourages activities that promote health and [wellbeing](#). This helps people to participate fully in activities of daily life. Mental health OTs provide education sessions on stress management, community engagement and disease management, amongst other things.

Office of Mental Health (OMH): An office within the Department of Health that promotes improvement within the WA's public mental health services.

Outpatient: Someone receiving treatment during visits to a community mental health service or a private practitioner such as a private psychiatrist.

P

Parent: The person who has parental responsibility for a child as defined in the [Family Court Act 1997 Section 68](#).

Paranoia: The general terms for delusions of persecution, grandiosity or both, found in several mental health conditions.

Peer support: Social, emotional and/or practical support provided between one or more people who have a similar or shared [lived experience](#) of mental health problems, and who recognise each other as peers. These experiences provide the conditions for fostering trust, equality, respect and understanding. This can be offered professionally (through a [peer support worker](#)), or informally (such as through friendships and support groups).

Peer support worker: Someone with a lived experience of mental illness or disorder, who is living well and is able to support others experiencing mental health problems in facilitating their own recovery.

Person-centred: An approach to providing a service, which aims to provide respect for, and a partnership with, people receiving [mental health services](#). It is a collaborative effort between [consumers](#), [family members](#), [carers](#), friends and [mental health practitioners](#).

Personal support person: Under the *Mental Health Act 2014*, this means: the guardian or enduring guardian of an adult; the parent or guardian of a child; a [close family member](#); a [carer](#), or a [nominated person](#).

Prevention: Strategies to maintain positive [mental health](#) through addressing factors which may lead to mental health problems or illnesses ahead of time. These strategies can be aimed at increasing protective factors, decreasing risk factors or both, as long as the goal is to maintain or enhance [mental health](#) and [wellbeing](#).

Private hospital: A hospital owned and funded by a private organisation that charges a fee for medical care.

Psychiatrist: Psychiatrists are doctors with specialist training in psychiatry that enables them to diagnose, assess, treat and prevent human mental, emotional and behavioural disorders. They are able to prescribe medication.

Psychiatric treatment: Treatments include medication, [electroconvulsive therapy](#), [psychosurgery](#), and [emergency psychiatric treatment](#). The most common form of psychiatric treatment is oral or injected medication.

Psychologist (clinical): A clinical psychologist is a [health professional](#) who engages in therapy or counselling as treatment for mental health problems with the aim of reducing psychological distress and improving and promoting psychological wellbeing. They work with people with a range of mental health and physical problems – which might include anxiety and depression, adjustment to physical illness, neurological disorders, addictive behaviours, childhood behaviour disorders, or personal and family relationships.

Psychosis: This is a sign of mental illness in which thinking and emotion are so impaired that the individual is unable to distinguish what is real – there is a loss of contact with reality. Symptoms can include confused thinking, delusions and hallucinations.

Psychosurgery: This includes a surgical procedure performed by a [neurosurgeon](#) known as deep brain stimulation (DBS) whereby electrodes are inserted into a person's brain to alter their thoughts, emotions or behaviour. Deep brain stimulation is used to treat conditions such as Parkinson's disease and Tourette's syndrome and may be used to treat some mental illnesses, including major depression and obsessive-compulsive disorder.

Public hospital: A hospital owned and funded by the WA government that provides medical care free of charge.

R

Recovery: Many definitions of recovery from mental illness have been put forward and there is no one that fits everyone's situation. In general, recovery is described as a personal, unique journey involving changing attitudes, values, feelings, goals, skills and/or roles that is oriented towards rediscovering a state of [mental wellbeing](#) that enables a person to stay in the community, out of hospital and live a satisfying, hopeful and contributing life.

Recovery-oriented service: The intention is that services are delivered in a way that supports each person's individual recovery. This practice promotes a partnership between people accessing mental health services and professionals who provide those services, whereby people with lived experience are considered experts on their lives and experiences, while the professionals are considered experts on available interventions and services.

Referral: Referral can have two meanings in mental health. One is where a doctor, such as a GP, refers a person to a specialist. This may be a mental health specialist, such as a private psychologist. This is similar to a referral to a specialist in general health, such as a cardiologist. The other meaning of referral is the one used under the *Mental Health Act 2014*. This means an order made by a doctor or an authorised mental health practitioner for a person to be examined by a psychiatrist (to decide whether they need to be an involuntary patient).

Registrar: A registrar has completed a medical degree. They have some extra experience in their specialty area of mental health but work under the instructions of a psychiatrist.

Respite care: Respite provides temporary care of a person in order to offer relief for the family, friend or regular carer. Respite care may be provided in the home of the person receiving care or providing care, or may involve a short stay somewhere else.

Resilience: Capacities within a person that promote positive outcomes, such as [mental health](#) and [wellbeing](#), and provide protection from factors that might otherwise place that person at risk of adverse health outcomes such as stress and adversity.

Risk factors: Those characteristics that make it more likely that an individual will develop a disorder.

S

Safe: This is a word commonly used in the question, 'Are you safe?' to people who are, or have been showing signs of thinking about harming themselves ([self-harm](#)) or ending their own life ([suicide](#)). If you think someone is at risk of deliberately trying to end his or her life, [Lifeline](#) recommends asking the more direct question, 'Are you thinking about suicide?'

Seclusion: Seclusion means confining a person who is being provided with treatment or care at an authorised hospital by leaving them (at any time of the day or night) alone in a room or area that they cannot leave.

Sedative: This is a medication used to reduce a person's anxiety or help them to sleep. The most common sedatives used for mental health patients are benzodiazepines.

Self-esteem: This is characterised as the perception an individual has of themselves and how their self-belief affects their social and emotional wellbeing.

Self-harm: A deliberate injury to one's own body.

Self-help groups: A self-help group is a place where members are encouraged to improve their wellbeing through certain activities and the application of new skills learnt within the group. Self-help groups may also draw on, or offer a bridge to, professional assistance.

Service provider: This term is used to describe a person or agency that delivers health care or social services. Providers can be individuals (doctors, nurses, social workers, and others) or facilities (hospitals), or agencies (respite care, hostels, community support), or businesses that sell services or equipment.

Social worker: A [health professional](#) who provides support to people and their families to deal with personal and social problems. Social workers may counsel individuals or families through a crisis that might occur because of death, illness, relationship breakdown, finances or other reasons. They provide patients and families or carers with practical support, counselling, and information on services to assist them and emotional support.

Stigma: A mark or label that sets a person apart. Stigma can create negative attitudes and prejudice, which can lead to negative actions, prejudice and discrimination.

Supervising psychiatrist: The [psychiatrist](#) who is overseeing someone who is on a [community treatment order](#).

Support group: A support group is a place where a group of people with some common interest meet to provide emotional support and exchange information and past experiences.

T

Traditional healer: The role of traditional healers is recognised in the *Mental Health Act 2014*. A traditional healer is defined as a person of Aboriginal or Torres Strait Islander descent who uses traditional (including spiritual) methods of healing, and is recognised by the community as a traditional healer. The Act requires assessment and examination of a person of Aboriginal or Torres Strait Islander descent to be conducted in collaboration with Aboriginal or Torres Strait Islander mental health workers and significant members of the person's community, including elders and traditional healers. The same collaboration is required in relation to the provision of treatment.

Transport officer: A person who is trained and employed by or through mental health services, who has some powers under the *Mental Health Act 2014* to apprehend, detain and transport people to hospital or another specified place.

Transport order: A form filled out to order the police or a [transport officer](#) to take a person safely to another place, such as an [authorised hospital](#), [general hospital](#) or other place.

Treating practitioner: Usually refers to the medical practitioner or mental health practitioner who provides treatment and care to an involuntary community patient.

Treating psychiatrist: The [psychiatrist](#) who is overseeing someone who is on an inpatient treatment order or is a voluntary inpatient.

Treatment: Psychiatric, medical, psychological or psychosocial interventions intended to help a person's mental illness. Medical treatment can only be provided where the medical problem is caused by mental illness; for example, an eating disorder.

Treatment, support and discharge plan: Governs the treatment, care and support that is to be provided to a patient, and makes plans for when the patient is discharged. Every [involuntary patient](#) and [mentally impaired accused patient](#) must have a treatment, support and discharge plan. This is prepared with input from the patient and their personal support people.

Triage nurse: The triage nurse in an emergency department allocates triage categories to each patient based on an assessment of their presenting conditions, with Triage 1 being the most urgent and Triage 5 being the least urgent. There are also mental health triage nurses at some hospitals that will respond to questions by phone or in person from a person experiencing mental illness, or their family member or carer. Their role is to prioritise the mental health service type, need and urgency based on their assessment of risk, need and dysfunction. They may request a service or make a referral to an appropriate service.

V

Voluntary patient: Under the *Mental Health Act 2014*, a voluntary patient is someone to whom treatment is being given, or going to be given, by a [mental health service](#), who is neither an [involuntary patient](#) nor a [mentally impaired accused patient](#). It means that they must be able provide [informed consent](#) to their treatment; or, if they are unable to provide informed consent, then someone else (such as a guardian) may be able to make a decision on their behalf.

W

Wellbeing: The state of being and maintaining a balance of physical, mental, emotional and spiritual health.

18. List of Approved Forms

Below is a list of the legal forms used by clinicians under the *Mental Health Act 2014*.

Group	Form Number	Form title
1. Referrals	1A	Referral for examination by psychiatrist
	1B	Variation of referral
2. Voluntary inpatient	2	Order to detain voluntary inpatient in authorised hospital for assessment
3. Detention	3A	Detention order
	3B	Continuation of detention
	3C	Continuation of detention to enable a further examination by a psychiatrist
	3D	Order authorising reception and detention in an authorised hospital for further examination
	3E	Order that person cannot continue to be detained
4. Transport and Transfer	4A	Transport order
	4B	Extension of transport order
	4C	Transfer order
	4D	Interstate transfer order
	4E	Interstate transfer approval order
5. Community treatment order	5A	Community treatment order
	5B	Continuation of community treatment order
	5C	Variation of terms of community treatment order
	5D	Request made by a supervising psychiatrist for a practitioner to conduct the monthly examination of a patient
	5E	Notice and record of breach of community treatment order
	5F	Order to attend
6. Inpatient treatment order	6A	Inpatient treatment order in authorised hospital
	6B	Inpatient treatment order in general hospital
	6C	Continuation of inpatient treatment order
	6D	Confirmation of inpatient treatment order
7. Leave & Absence without leave	7A	Grant of leave to involuntary inpatient
	7B	Extension and/or variation of grant of leave
	7C	Cancellation of grant of leave
	7D	Apprehension and return order

Group	Form Number	Form title (continued)
8. Search and seizure	8A	Record of search and seizure
	8B	Record of dealing with seized article
9. Urgent treatment	9A	Record of emergency psychiatric treatment
	9B	Report to chief psychiatrist about provision of urgent non-psychiatric treatment
10. Bodily restraint	10A	Record of oral authorisation of bodily restraint
	10B	Written bodily restraint order
	10C	Record of informing medical practitioner and treating psychiatrist of bodily restraint
	10D	Record of observations made of restrained person
	10E	Record of examination of restrained person
	10F	Variation of bodily restraint order
	10G	Revocation or expiry of bodily restraint order
	10H	Review of bodily restraint order by psychiatrist
	10I	Record of post-bodily restraint examination
11. Seclusion	11A	Record of oral authorisation of seclusion
	11B	Written seclusion order
	11C	Record of informing medical practitioner and treating psychiatrist of seclusion
	11D	Record of observations made of secluded person
	11E	Record of examination of secluded person
	11F	Revocation or expiry of seclusion
	11G	Record of post-seclusion examination
12. Communication and information sharing	12A	Nomination of nominated person
	12B	Record of refusal of patient's request to access document
	12C	Restriction on freedom of communication
13. Reporting	13	Statistics about ECT