*Mental Health and Related Services Act 1998*

Section 34

# Form 9

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| Under section 34 of the *Mental Health and Related Services Act 1998*, a medical practitioner, an authorised psychiatric practitioner or designated mental health practitioner must make a recommendation for psychiatric examination of a person if, after assessing them, the practitioner is satisfied that they fulfil the criteria for involuntary admission on the grounds of mental illness or mental disturbance. Refer to **Approved Procedure 6 – Involuntary Admission and Treatment** for further information.  Under s160 ‘Documents relating to examination, admission and treatment’, s160(1) states ‘A person must not sign a relevant document relating to another person unless: (a) the person has seen, and personally examined, the other person; or (b) the signing of the document is (i) in accordance with approved procedures; or (ii) otherwise permitted under this Act. The effect of s160(1)(b)(ii) and Approved Procedures 20 and 26 is that an APP or DMO can sign a Recommendation for Psychiatric Examination on the basis of information conveyed to them by remote health centre staff where there is some urgency required in order to expedite transfer of a patient to an ATF. Refer to **Approved Procedure 20 - Delegations, Appointments and Declaration of Facilities and Agencies Procedure** and to **Approved Procedure 26 - Use of Interactive Tele/Video Conferencing for Assessment and Review** for further information. |

|  | | | | | | | ***Complete person details or affix patient label in box below:*** | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full name of person:** | | | | | | |  | | |  | | | | | | | | | | | |  |
| **Also known as** | | | | | | |  | | |  | | | | | | | | | | | |  |
| **Date of birth:** | | | | | | |  | | | / / | | | | | | | | | | | |  |
| **HRN:** | | | | | | |  | | |  | | | | | | | | | | | |  |
| **Sex:** | | | | | | |  | | | Male  Female  Non-binary  Not specified | | | | | | | | | | | |  |
| **Address:** | | | | | | | | |  | | | | | | | | | | | | | |
| The abovementioned person was assessed at *(time)*:       hours, on *(date)*:    / /  Or  Information about the above mentioned person was provided to me at *(time)*:       hours, on *(date)*:    / /    by remote health centre staff member *(name &title)* Criteria for psychiatric examination I am satisfied that the person *(select appropriate statement)* | | | | | | | | | | | | | | | | | | | | | | |
| has a mental illness and requires treatment that is available at an approved treatment facility and without treatment, they are likely to cause serious harm to themselves or others or suffer serious mental or physical deterioration.  OR | | | | | | | | | | | | | | | | | | | | | | |
| does not fulfil the criteria for having a mental illness or complex cognitive impairment, however their behaviour is, or within the preceding 48 hours has been, so irrational as to lead to the conclusion that:   * + The person is experiencing or exhibiting a severe impairment of or deviation from their customary or everyday ability to reason and function in a socially acceptable and culturally appropriate manner;   AND   * + The person is behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that justify a determination that the person requires psychiatric assessment, treatment and care that is available at an approved treatment facility.   AND   * + Unless the person receives treatment and care at an approved treatment facility, they are likely to cause serious harm to themselves, others or will represent a substantial danger to the general community or suffer serious mental or physical deterioration. | | | | | | | | | | | | | | | | | | | | | | |
| I am also satisfied that the person is not capable of giving informed consent to the treatment and care or has unreasonably refused to consent to the treatment and care and there is no less restrictive means of ensuring that they receive the treatment and care. Request and authorisation Under the provisions of section of 34(1) of the *Mental Health and Related Services Act 1998*, I therefore make a recommendation for psychiatric examination and authorise the following person/entity/agency: *(select appropriate)*    To:  Control the person and take them to an approved treatment facility for psychiatric examination and if the person cannot be taken immediately to an approved treatment facility, to hold the person at a hospital or other place where they can be safely held until it becomes practicable to do so.  Detain the person at an approved treatment facility for up to 24 hours.  Furthermore, without approval of the Tribunal, treatment may be administered where it is immediately necessary to:   * prevent the person causing serious harm to themselves or someone else; * prevent behaviour of the person likely to cause serious harm to the person or someone else; * prevent further physical or mental deterioration of the person; or * relieve acute symptomatology. | | | | | | | | | | | | | | | | | | | | | | |
| Consideration of police assistance Having considered the least restrictive options available, I have determined that *(select appropriate)*:  Police assistance is not required; or  There is no other safe alternative under the circumstances and as such, I authorise a police officer to exercise, or to assist someone else exercising the powers under section 34(3)(a) to control the abovementioned person and take them to an approved treatment facility for psychiatric examination.  *Note: Any action or assistance provided by police under this authority will be at the direction/guidance of the assessing practitioner.* | | | | | | | | | | | | | | | | | | | | | | |
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| **Name of recommending practitioner:** | | | |  | | | | | | | | | **Signature:** | | |  | | | | | | |
| **Practitioner is:** | A medical practitioner  An authorised psychiatric practitioner  A designated mental health practitioner | | | | | | | | | | | | | | | | | | | | | |
| **Work location:** |  | | | | | | | | | | | | | | **Date:** | | | /   / | | | | |
| Revocation of recommendation for psychiatric examination and written report *(to be completed by a practitioner only when required)* *Select appropriate statement for revocation of recommendation for psychiatric examination*  **Where further assessment has been undertaken by the recommending practitioner:**  I have conducted a further assessment of the above mentioned person and I am no longer satisfied that they fulfil the criteria for involuntary admission on the grounds of mental illness or mental disturbance. I therefore revoke the above recommendation for psychiatric examination.  **Where further assessment has been undertaken by practitioner, other than recommending practitioner:**  I have conducted an assessment of the above mentioned person and I am not satisfied that the person fulfils the criteria for involuntary admission on the grounds of mental illness or mental disturbance. I therefore revoke the above recommendation for psychiatric examination on behalf of the initiating practitioner. Reason for revocation I wish to advise the Tribunal that the recommendation for psychiatric examination has been revoked for the following reasons: | | | | | | | | | | | | | | | | | | | | | | |
| **Name of practitioner:** | | |  | | | | | | | | | **Signature:** | | | |  | | | | | | |
| **Practitioner is:** | | A medical practitioner  An authorised psychiatric practitioner  A designated mental health practitioner | | | | | | | | | | | | | | | | | | | | |
| **Work location:** | |  | | | | | | | | | | | | | **Date:** | | | /   / | | | | |
| Emergency treatment without Tribunal approval notification *(to be completed only when required)* I wish to advise the:   * Person-in-charge (PIC) of the approved treatment facility (ATF); * Authorised psychiatric practitioner (APP) ; and * Tribunal   that the following emergency treatment was administered to the above mentioned person *(provide details on name, dosages, times and dates administered. Attach additional documentation, if required)*: | | | | | | | | | | | | | | | | | | | | | | |
| This treatment was to:  Prevent the person causing serious harm to himself/herself or someone else  Prevent behaviour of the person that is likely to cause serious harm to himself/herself or someone else  Prevent further physical or mental deterioration of the person  Relieve acute symptomatology  Support Emergency Management/Transfer  **AND**  Approval of the Tribunal to administer the treatment was not obtained as to delay the treatment to obtain Tribunal approval would have caused a deleterious effect on the person’s health.  Treatment was approved by the following medical practitioner:  *(full name)*:       at *(time)*:       hours, on *(date)*:    / / | | | | | | | | | | | | | | | | | | | | | | |
| **Name of person administering treatment:** | | | | | | | | **Signature** | | | | | | | | | | | **Date:** | | | |
|  | | | | | | | |  | | | | | | | | | | | /   / | | | |
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| Delay in taking a person to an approved treatment facility *(the person in charge of the approved treatment facility is required to forward this report to the Tribunal)* I wish to advise the Tribunal of a delay in taking the abovementioned person to an approved treatment facility for psychiatric examination. During this period the person was detained:  At *(location):*       from *(time)*:       hours, on *(date)*:    /   /  until *(time)*:       hours, on *(date)*:    /   /  for the following reasons: | | | | | | | | | | | | | | | | | | | | | | | |
| During this time, the following treatment was administered to the person *(complete if appropriate)*: | | | | | | | | | | | | | | | | | | | | | | | |
| This treatment was administered for the following reasons: | | | | | | | | | | | | | | | | | | | | | | | |
| This treatment was approved by the following authorised psychiatric practitioner:  *(full name)*:       at *(time)*:       hours, on *(date)*:    / / | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of person in charge** | | | | |  | | | | | | | | | **Signature** | | |  | | | | | | |
| **Name of approved treatment facility** | | | | | |  | | | | | | | | | | | **Date:** | | | | /   / | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| Outcome acknowledgement *(and release of police from providing assistance)* A psychiatric examination of the abovementioned person occurred:  at *(location):*        at *(time)*:       hours, on *(date)*:    /   /  The person was:  Accepted  Not accepted  for further treatment.  Assessment decision details have been documented in **Form 10 – Psychiatric examination outcome (including involuntary admission)**  Police were released from assisting in this matter at *(time)*:        hours, on *(date)*:    /   / | | | | | | | | | | | | | | | | | | | | | | |
| **Name of authorised psychiatric practitioner:** | | | | | | | | | | | **Signature** | | | | | | | | | **Date:** | | | |
|  | | | | | | | | | | |  | | | | | | | | | /   / | | | |

**Form Requirements**

**Practitioner**

Send copy to PIC and the APP of the ATF

**Approved Treatment Facility**

Send copy to Tribunal *(where there has been a delay in transfer to an ATF, emergency treatment without Tribunal approval or a revocation of recommendation for psychiatric examination)*

Form to be placed on clinical file