MENTAL HEALTH REVIEW BOARD

Western Australia

Annual Report 2001

MENTAL HEALTH REVIEW BOARD

ANNUAL REPORT 2001

To the Hon. Bob Kucera, MLA
Minister for Health

Dear Minister

I am pleased to submit to you this fourth Annual Report of the Mental Health Review Board (the Board). This report provides information about the Board and details the activities of the Board for the year ending 30 June 2001. (All references in the report to year refer to the 2000/2001 financial year).

Although the *Mental Health Act 1996* (the Act) does not require the Board to produce an Annual Report, the Board has always done so in the interests of accountability and openness. It is for this reason that this Annual Report has been prepared, though the Government's policy in relation to Annual Reports (to publish them only when required and then in an economical manner) has been carefully considered and implemented.

This year has seen a consolidation of the Board's activities. Highlights of the year include a continuation of the work of the Board within the existing budgetary framework and resources, the completion of an increased number of reviews, and the continuation of the Board's educational programme.

This report provides statistical information about the work undertaken by the Board in accordance with its statutory obligations. It also gives case study examples of reviews undertaken. The Board well recognises that especially within the mental health sector, statistics are much less important than each individual patient that the Board reviews. The Board maintains as its focus the people for whom it was created and seeks to maximise respect and dignity given to each involuntary patient who is reviewed by the Board.

The Board has benefited significantly during the year from assistance provided to it, either directly or indirectly, by consumers and consumer organisations, clinicians, service provider administrative personnel, representatives from professional associations and others. On behalf of the Board, I thank all those persons and agencies for the critical role that they continue to play in enabling the Board to fulfil its statutory functions.

Yours sincerely

Neville Barber
PRESIDENT

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2000-2001 IN SUMMARY – 1

The Board has completed its third full year of operation and continues to provide those patients on an involuntary order under the Act (whether on a Community Treatment Order (CTO) or involuntary detention order) with an informal and timely review of their involuntary status.

Some of the Board's achievements during the year are as follows:

Reviews

The Board completed 909 reviews at over 30 different venues across Western Australia, this represented a 4% increase from the previous financial year. Section 6 of this report provides further statistical information about the reviews conducted by the Board this year.

Seminar Series

The Board continued it 'twilight seminars'. The purpose of these seminars is to provide a forum to discuss matters of interest relating to mental health and this raise the profile of mental health and informed opinion in the area. Invitations are sent to consumer and carer organisations, mental health service providers and Board members. Feedback to date has been very positive.

Revised Handbook

In 2000 the Board produced a policy book, Handbook 2000. This year an updated version of the Handbook was undertaken. Consumer groups, service providers and Board members were extended the opportunity to offer feedback that was considered in preparing the revised edition.

Education series

The Board continued with its successful educational series. The President provided information about the Board and its statutory purpose at a number of tertiary educational centres, mental health service provider venues, and non-government organisations during the course of the year.

Attendance at conferences

The President attended and presented at the Australian and New Zealand Association of Psychiatrists, Psychologists and Lawyers Conference in Auckland, New Zealand, in August 2000, and the Second International Conference on Therapeutic Jurisprudence conference in Cincinatti, Ohio in May 2001. The President also attended the annual national meeting of Presidents and members of Mental Health Review Boards and Tribunals in Canberra in May 2001.

PURPOSE AND FUNCTIONS OF THE BOARD –2

The Board is a review body established under Part 6 of the Act and its primary purpose is to review persons made involuntary patients under the Act in accordance with the Act.

Involuntary patients are those people who have been placed by a psychiatrist on an involuntary order under the Act. There are two types of involuntary orders that a psychiatrist may make. One is for a person to be detained in an authorised hospital as an involuntary patient. The other is for the person to be placed on a CTO, an involuntary order that requires the patient to comply with the treatment plan specified in the order but otherwise enables the patient to live in the community: *section 66*.

Section 126 of the Act provides that the Governor, on the recommendation of the Minister (for Health), appoint a President and other members of the Board. The section also provides that the membership of the Board is to comprise the number of persons the Minister thinks is appropriate and is to include psychiatrists, lawyers, and persons who are neither medical nor legal practitioners (referred to as "community members").

When conducting reviews the Board is always comprised of three persons, that is, a psychiatrist, a lawyer, and a community member: *section 129*.

Role of the Board

The Board's primary statutory role is to review involuntary patients, in accordance with the Act. In conducting reviews, the Board reviews the decision of a psychiatrist to order or maintain the involuntary status of a patient and has to decide whether or not the involuntary order should continue to have effect.

In making a determination upon a review, the Board applies the same legislative criteria as the psychiatrist when he or she makes a person an involuntary patient under the Act (primarily considering sections 4 and 26 of the Act). The Board is also to have regard primarily to the psychiatric condition of the person concerned and is to consider the medical and psychiatric history and the social circumstances of the person: *section 137*.

Types of Review

The Board may conduct reviews in three different situations:

1. in conformity with legislative timeframes;
   - initial period review (as soon as practicable, within eight weeks of commencement of involuntary order): *section 138(1)*
   - periodic review (not later than six months after the initial review and every six months after, if involuntary status continues): *section 139*
2. in response to a request by a patient (or other person who has concern for the patient): *section 142*
3. when the Board itself considers a further review is appropriate: *section 144*.

Other functions and duties of the Board

- The Board is required to enquire into any complaint made to it concerning any failure to recognise the rights given by the Act to an involuntary patient or any other matter to do with the administration of the Act: *section 146*.
- The Minister for Health may direct the Board to inquire into any matter to do with the administration of the Act: *section 147*. In the year, there was no direction from the Minister to conduct an inqury.
- The Chief Psychiatrist may report to the Board on matters concerning the medical care or welfare of involuntary patients: *section 10(d)*.

MEMBERSHIP OF THE BOARD – 3

At 30 June 2001, the Board consisted of 30 members, as follows:

President

Mr Neville Barber

Lawyer Members	Expiry Date
Mr Henry Christie	12 November 2002
Mr Tony Fowke	12 November 2001
Ms Hannah Leslie	12 November 2002
Ms Anne Seghezzi	12 November 2001
Mr Stephen Walker	12 November 2001
Mr Colin Watt	12 November 2002

Community Members

Ms Kerri Boase-Jelinek	12 November 2001
Mr John Casson	12 November 2001
Dr Christine Choo	12 November 2002
Professor David Hawks	12 November 2002
Ms Lynne McGuigan	12 November 2002
Ms Michelle Scott	12 November 2001
Mr Craig Somerville	12 November 2002
Reverend Richard Williams	12 November 2002

Psychiatrist Members

Dr Ann Bell	12 November 2002
Dr Peter Burvill	2 November 2002
Dr Hugh Cook	12 November 2001
Dr Aaron Groves	12 November 2001
Dr Steven Patchett	12 November 2002
Dr John Penman	12 November 2001
Dr Nada Raich	12 November 2002
Dr Mark Rooney	12 November 2002
Dr Martin Sawday	12 November 2002
Dr Patricia Shalala	12 November 2001
Dr Jonathon Spear	12 November 2002
Dr John Spencer	12 November 2001
Dr Prudence Stone	12 November 2001
Dr Felice Watt	12 November 2001
Dr Andy Zorbas	12 November 2001

The terms of appointment for Dr David Castle and Dr Alan Woods, psychiatrist members and Ms Margaret Jordan, legal member expired on 12 November 2000. The President thanks these persons for the contribution they made to the Board during their time as members.

ADMINISTRATION OF THE BOARD – 4

At 30 June 2001, the Board's administrative staff members were as follows:

President	Mr Neville Barber
A/Registrar	Ms Sue Lewis
A/Executive Officer	Mrs Jane Hall-Payn
Personal Assistant	(Vacant)

Scheduling

The Board has a comprehensive computer program, known as the Case Tracking System (CTS) that enables it to maintain accurate details of all patients on involuntary orders. When a person is admitted to an authorised hospital as a detained involuntary patient or placed on a CTO the Board is forwarded a copy of the relevant order. This information is registered on the CTS and the Board's administrative staff draw upon this information to schedule reviews and to produce a variety of reports.

The Board's policy is to schedule requested reviews as soon as practicable and preferably within 14 days of receipt. However this is dependent on the number of reviews to be scheduled and, to ensure compliance with the statutory obligations under the Act, precedence will be given to periodical reviews if scheduling space is limited.

Notice of Review

After a review is scheduled a 'Notice of Review', providing details such as date, time and venue accompanied by an explanatory letter is forwarded to the following people:

- the patient;
- the applicant (if the applicant is not the patient);
- the supervising psychiatrist;
- the patient's representative (if applicable);
- the clinical nurse specialist (if patient is detained in hospital);
- the responsible practitioner (if patient is on a CTO); and
- medical records/liaison staff.

If the patient is detained in an authorised hospital then a staff member is required to hand deliver this letter and sign the attached *Service of Notice* and place this on the patient's file. If the patient is on a CTO then the letter is sent in a plain envelope via registered mail addressed to the place of residence listed on the CTO and the Board receives confirmation of receipt of this notification.

The Board's pamphlet is always provided to the patient when notice of the review is given. The pamphlet gives information about the Board, how to apply for a review, how to prepare for a review and what happens at a review.

Venues and Teleconferencing

The Board is required to provide appropriate access to involuntary patients' state-wide, as patients may be on a CTO anywhere in the State. For those patients in rural areas the Board utilises teleconferencing technology to conduct reviews and the patient is asked to attend his or her local clinic or hospital for the review. During the year, reviews were conducted using audio-visual means in 61 reviews, at venues as diverse as Karratha, Albany, Esperance and Halls Creek. The Board provides information to participants in teleconference reviews about the process for those reviews. Teleconference reviews proceed in a manner consistent with other reviews that the Board conducts.

Representation/Advice

The Board encourages each involuntary patient to be represented and to that end informs each involuntary patient scheduled for a review by letter and pamphlet of their right to have legal representation or the support of an Official Visitor at their review. An involuntary patient may be represented at review by a legal practitioner or, with leave of the Board, any other person.

Mental Health Law Centre

In almost all cases of legal representation, the Mental Health Law Centre (MHLC) provided that representation. In total, the MHLC represented patients in 129 reviews (14.2%). Of that number, 24

reviews (18.6%) were adjourned (in most instances to allow the representative sufficient time to access the patient records and prepare). The involuntary status of patients represented was maintained in 99 reviews (94.3%) and involuntary status was discharged in the remaining 6 (5.7%).

Council of Official Visitors

The Council is provided with statutory authority to assist involuntary patients with the making and presentation of an application or appeal before the Board: *section 188(g)*. Official Visitors attended reviews in this capacity in 34 reviews (3.7%) during the year. This was an increase on the total of 12 (1.4%) in the previous year.

As part of the orientation and training of new Council members they may arrange with the Board to be present at reviews in an observer capacity. Six members of the Council attended reviews in this capacity during the year.

These statistics reveal that more than 80% of patients attended a review with neither a legal representative nor an official support person, despite the existence of the MHLC and the Council, and even though the Board provides notice to each patient of the contact details for these advocacy agencies on every occasion a review is scheduled. A useful research project may be to determine why there is not a greater utilisation of the assistance available to patients who are to be reviewed.

Interpreters

The Board accepts that even though a person may speak some English, this does not mean that the person understands everything that takes place at a review. In these circumstances the Board will utilise the services of an interpreter.

The Board relies upon others, primarily mental health service providers, for information on when an interpreter is required. Once advised that an interpreter is required, the Board arranges for a qualified and independent interpreter to attend the review.

Interpreters were required for seven reviews this year; with the languages spoken being, Arabic, Burmese, Korean, Macedonian, Persian, and Somalian (twice).

Patients or relatives are also able to make use of the services of the Translating & Interpreting Service by way of a three-way conference call with staff at the Board if they require clarification or explanation on the review process or instructions on how to request a review. The cost of this service is met by the Board as required under the principles of the Commonwealth's *Charter of Public Service in a Culturally Diverse Society*.

Observers

On 30 occasions, and with the specific permission of the patient, observers were present at reviews during the year.

Expenditure Statement

For the period of operation from 1 July 2000 to 30 June 2001 the Board incurred operating expenditure of $718,300.

This was $46,300 less than the total expenditure of the previous financial year, 1999-2000 (although the Board did incur the cost of moving premises with its associated costs within the allocated budget during this period).

Board members were paid a total of $260,679 in remuneration which included fees for review days, training and administrative expenses. These fees are part of the operating expenditure of the Board.

The Board has continued to meet the increasing demands placed upon it due to the increasing numbers of reviews scheduled and completed within its budget allocation each year since commencement.

THE PROCESS OF REVIEW – 5

What happens at a Review

In the metropolitan area, it is Board policy to attend the relevant authorised hospital or mental health clinic. Reviews are conducted in a room allocated by the service provider at the hospital or clinic that is adequate to accommodate the Board members, patient, patient's representative, family or support person and, members of the treating team.

Each review is conducted using an informal, non-adversarial approach, having regard to the requirements of the Act.

Prior to the review, the members of the Board may review relevant parts of the medical files applicable to the patient. Generally of greater importance is the report that has been requested and prepared by treating psychiatrist in relation to the patient prior to the commencement of the review. It is the Board's clear preference for the reports provided to it to also be made available to the patient and/or discussed with the patient prior to the review as this both shortens and improves the review itself.

The review commences with introductions and an explanation of the purpose and process of the review. In most instances the patient and treating team member will be present from the commencement of the review. The Board provides the patient the opportunity to state the outcome they would like from the review.

After the short introductory phase, the treating or supervising psychiatrist or other member of the treating team provides further comment, where necessary, on the report, the patient's progress and treatment plan, and the need for continuing involuntary status. Board members, and/or the patient/patient's representative may question the treating team member on issues arising from the report or more generally. Although it is preferable where possible for the psychiatrist to personally attend the review, the Board accepts that this is not always practical and therefore accepts that in some instances the necessary information may be provided by telephone or by other members of the treating team.

The patient is given the opportunity to respond to the issues raised by the treating team member and may introduce information personally or by calling other persons. Board members are able to speak personally with the patient about his or her views, whether or not the patient is represented.

Once all relevant information has been provided, the member of the treating team and the patient may make final submissions or comments. The Board then adjourns and considers the information and makes its decision. The Board then invites the patient back and advises the patient of the decision reached as well as providing a copy of the decision sheet. Where the patient is represented, a copy of the decision sheet is also generally provided to the patient's representative.

Each patient is informed of his or her review by letter, which includes a 'Notice of Review'. Provided that the Board is satisfied that the patient has received the Notice of Review, the review may proceed and be concluded in the absence of the patient. *Schedule 2.1(2)* In these instances the Board will inform the patient of the decision by post.

Powers of the Board at a Review

The Board's decision whether to continue or discharge the involuntary status is based on reviewing whether the patient has a mental illness as defined in the Act and whether the criteria of the Act for involuntary status have been satisfied and continue to be satisfied.

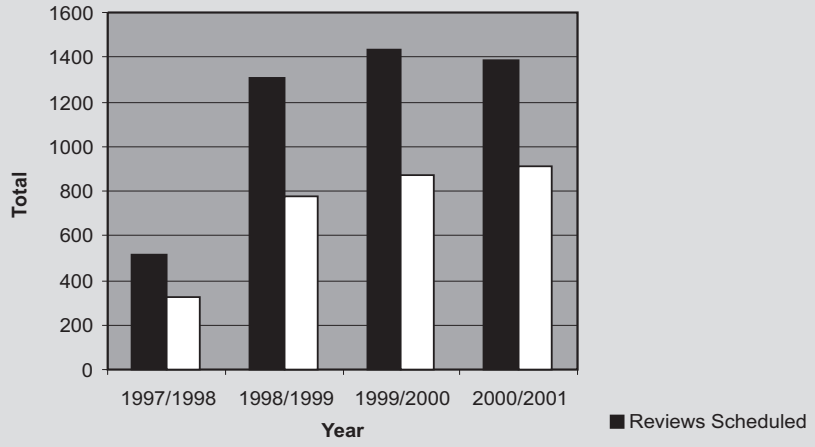
At a review the Board may decide to:

- Maintain the involuntary order: *section 145(1);*
- Discharge the patient from involuntary status: *section 145(2)(a);*
- Order that a CTO be made (provided that it is satisfied that requirements for the making of such an order have been established): *section 145(2)(b);* or
- Vary the terms of a CTO: *section 145(2)(c).*

STATISTICAL INFORMATION – 6

The Board conducts both periodic and requested reviews for patients either in an authorised hospital on a detained involuntary order or living in the community on a Community Treatment Order, the majority of reviews scheduled and completed are of a periodic nature. The significant variance in the number of reviews scheduled to the number completed can be attributed to the fact that the patient has been discharged (in this one-two week timeframe) from his/her involuntary order by the treating psychiatrist. The following charts and graphs give an indication of the number and category of reviews both scheduled and completed over this financial year.

Comparison of Scheduled to Completed Reviews



Note: 1997/98 figure is for a 7-month period from the Board's commencement through to 30 June 1998

Table 1

Comparison in Review Numbers				
Reviews	**1998/99**	**1999/00**	**2000/01**	**Variance 1998/99 and 2000/01**
Total Scheduled	1304	1436	1389	6.5%
Total Completed	773	873	909	17.6%
Requested				
CTO *(Scheduled)*	42	47	61	45.2%
CTO *(Completed)*	35	40	38	8.6%
Involuntary Detained *(Scheduled)*	320	304	306	-4.4%
Involuntary Detained *(Completed)*	164	155	151	-7.9%
Periodic				
CTO *(Scheduled)*	282	447	453	60.6%
CTO *(Completed)*	226	325	374	65.5%
Involuntary Detained *(Scheduled)*	660	638	569	-13.8%
Involuntary Detained *(Completed)*	348	353	346	-0.6%

Table 2

Requested Reviews

An application for review may be made by the involuntary patient, an official visitor, or any other person, such as the patient's representative, advocate or carer, who the Board is satisfied has a genuine concern for the patient. *section 142(2)*.

Although the Act provides that requests for reviews are to be in writing, there is no prescribed form to request a review. A request can therefore be made by letter to the Board or by using the 'Application Form' that is attached to the pamphlet *Information on the Review Process* available at all mental health services, (reply paid envelopes are also provided to all mental health services). It assists the Board to determine priorities for review if full information about the reason for the request is provided. In some circumstances, for example, where the Board is required by the Act to conduct a periodic review, a review scheduled as a result of a request may be continued even if the person seeking the review subsequently withdraws the request for a review.

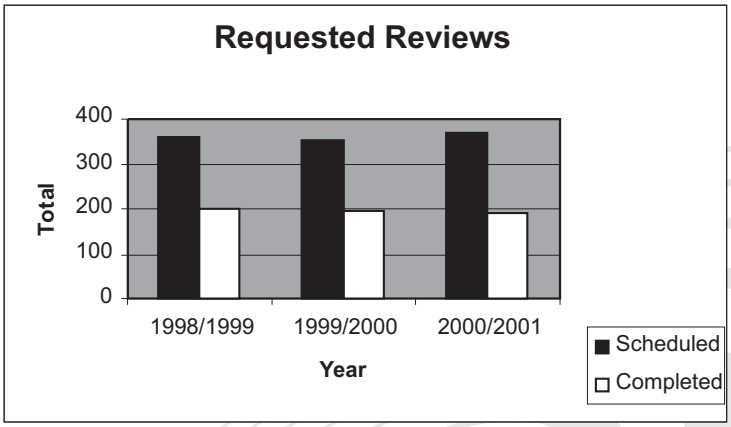


Table 3

REQUESTED REVIEW PROCESS

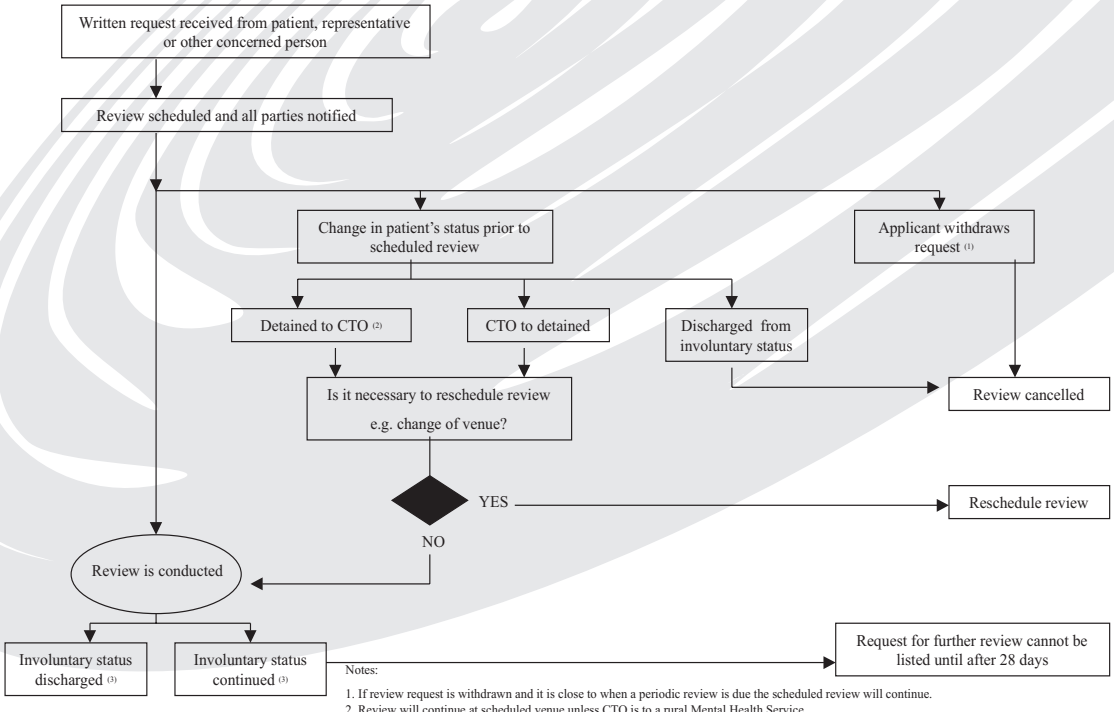


Table 4

Periodic Reviews

A periodic review is a mandatory review to be undertaken by the Board even if the patient does not request a review, and must be held by the Board within eight weeks of a patient becoming an involuntary patient provided that the patient remains involuntary: *sections 138 & 142*. Although the status of a patient may be changed by a psychiatrist from detained status to a CTO, an initial review is still required within eight weeks of the patient first becoming involuntary.

If a patient continues as an involuntary patient for a longer period, either detained in hospital or on a CTO, periodic reviews will occur every six months: *section 139*.

PERIODIC REVIEW PROCESS

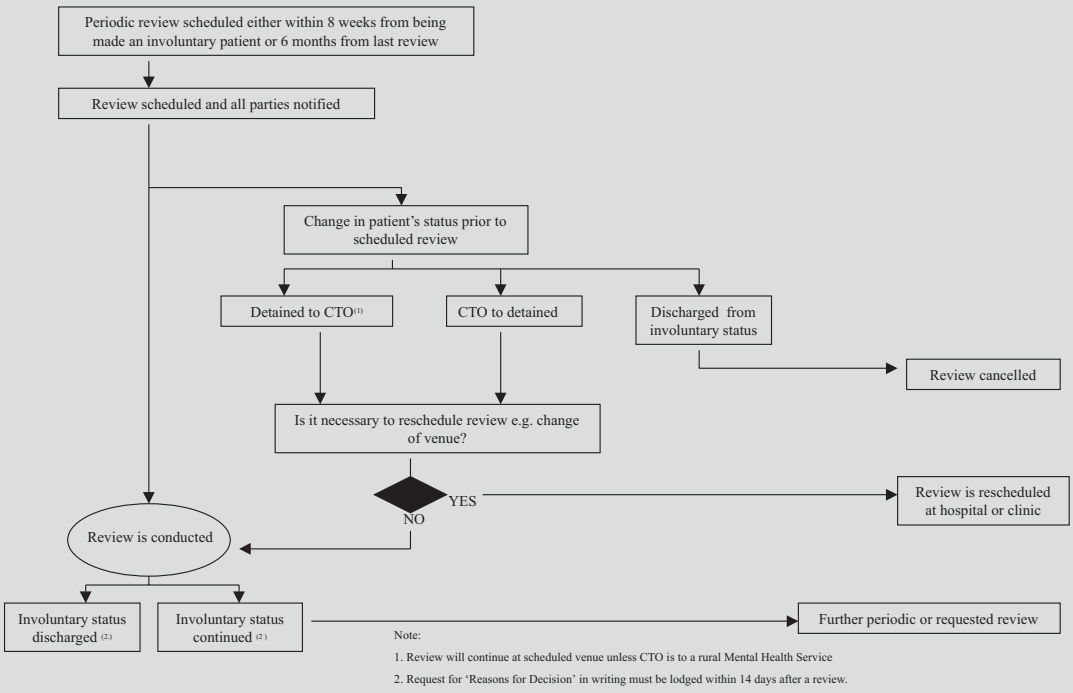


Table 5

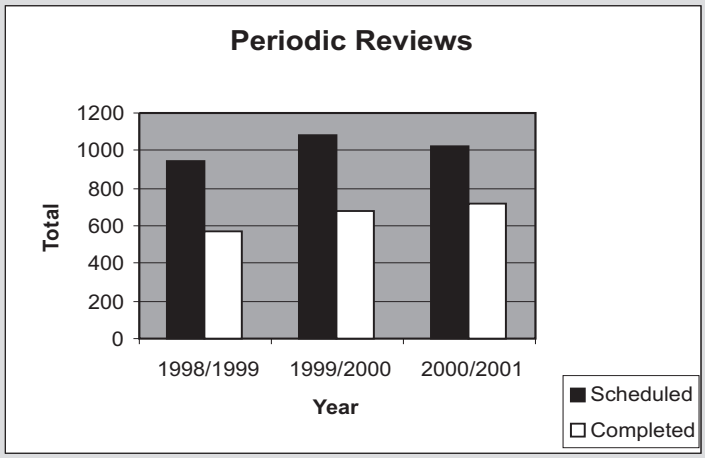


Table 6

Outcome of Reviews

Table 7 demonstrates the number of patients discharged from involuntary status by the decision of the Board at review. For 31 patients (3.4%), the Board made such an order. Of these persons, 22 were on CTOs and 9 were on involuntary detained orders. An additional 369 patients (26.5%) were discharged from their order after the review had been scheduled but before it was completed. Frequently, patients are discharged from involuntary status in the 48 hours prior to the review.

Table 8 provides a comparison of the number of persons discharged by the Board since commencement in November 1997. For further discussion of this issue, see section 8.

However, as demonstrated in Table 9, the greater proportion of patients placed on an involuntary detained order are discharged by the treating psychiatrist within the first 28 days of the order. This proportion has increased marginally since the Board commenced. This result would appear to indicate that the Act has been useful in requiring the treating team to regularly evaluate the statutory criteria to ensure that involuntary status continues to be justified for each individual patient.

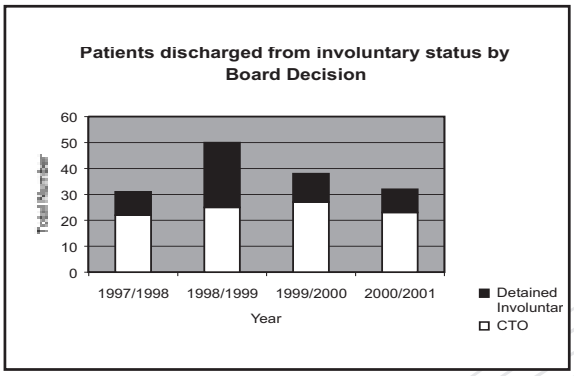
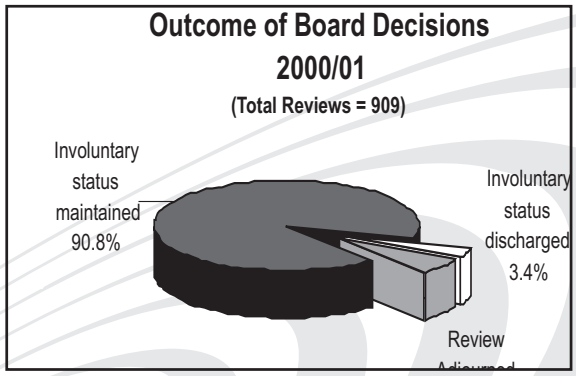


Table 7



Note: 1997/98 figure is for a 7-month period from the Board's commencement through to 30 June 1998

Table 8

Involuntary Orders discharged within 28 days

	1997/98	1998/99	1999/00	2000/01
Number of involuntary detained orders	1298	2250	2303	2360
Number of involuntary detained orders discharged within 28 days	795	1427	1498	1561
% of involuntary detained orders discharged within 28 days	**61%**	**63%**	**65%**	**66%**

Note: 1997/98 figure is for a 7-month period from the Board's commencement through to 30 June 1998

Table 9

Reasons for Decision

Any party to a review is entitled to request and be provided with reasons for the Board's decision: *Item 15, Schedule 2 of the Act*. This request is to be received within 14 days of the review being held. It is Board policy for the legal member (who presides at the review) to prepare the draft reasons. When the draft version has been completed a copy is sent to the other members who sat at the review for comment and feedback and thereafter the final version is sealed and sent to the parties involved with the review. Board policy requires that reasons are provided within 21 days of request. During the year, reasons were requested on 53 occasions (5.8%). Section 9 of this report provides some illustrative examples of reviews conducted and reasons prepared.

Emergency Psychiatric Treatment (section 115)

The Board receives notification of the use of emergency psychiatric treatment as required by *section 115*. Emergency psychiatric treatment means psychiatric treatment that it is necessary to give to a person -

(a) to save the person's life; or

(b) to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person: *section 113*.

During the year the Board received notification of 171 occasions of the use of emergency psychiatric treatment.

Seclusion (section 120)

Seclusion means sole confinement in a room that it is not within the control of the person confined to leave: *section 116*. The Board receives notifications of seclusion in authorised hospitals. During the year the Board received notification of the use of seclusion on 757 occasions in relation to involuntary patients. Some of these notifications related to the use of seclusion on more than one occasion with the same patient.

Mechanical Bodily Restraint (section 124)

Mechanical bodily restraint, in relation to a person, means restraint preventing the free movement of the person's body or a limb by mechanical means, other than by the use of a medical or surgical appliance for the proper treatment of physical disease or injury: *section 121*. The Board receives notification of the use of mechanical bodily restraint. During the year the Board received notification of 18 occasions of the use of mechanical bodily restraint.

Complaints (section 146)

As earlier indicated, the Board has an obligation to inquire into any complaint made to it concerning

(a) any failure to recognise the rights given by the Act to an involuntary patient; or

(b) any other matter to do with the administration of the Act.

During the year, the Board received three complaints. Two inquiries were completed within the year. The third complaint, in relation to restriction or denial of entitlements (Division 2 of Part 7 of the Act), was investigated but not completed in the year.

Complaint 1

The patient's legal representative submitted a complaint concerning a client's change of status under the Act.

The facts

The patient self presented to an authorised hospital. Some days later, the patient was referred for examination by a psychiatrist and was made an involuntary patient. Before the patient was made an involuntary patient, he recollected being advised that he was an involuntary patient and was given medication for his mental illness against his will.

The inquiry

The relevant authorised hospital was provided with details of the complaint and subsequently provided a letter addressing the issues raised. With the response,

there general agreement between the parties about the facts giving rise to the dispute. The hospital also (a) recognised some incidents of incorrect process; (b) gave an assurance that it acted in what it perceived to be the client's best interests; and (c) had undertaken clarification of its processes with its staff since the complaint was made. On the available information it was concluded that the complaint had been adequately addressed and the matter was closed.

The complaint highlighted difficulties associated with the application of sections 29 and 30 of the Act to the situation where a person is already in an authorised hospital. It is evident that section 30 of the Act requires amendment as it currently provides considerable difficulties of interpretation.

Complaint 2

The patient's legal representative submitted a complaint regarding the form of referral for examination that was followed in relation to the patient's admission to hospital.

The facts

In essence, this complaint raised for consideration similar issues to that raised in complaint 1, namely the appropriate interpretation of section 30 of the Act. The complaint was that a patient voluntarily at hospital had been referred for examination for involuntary status using a form 1 (under section 29 of the Act) instead of using a form 2 (under section 30 of the Act). On this occasion, the patient was in any event examined by a psychiatrist within the time limit prescribed by section 30 (six hours).

The inquiry

In response to the complaint, the Board wrote to the service provider and subsequently received a reply in which, by and large, the factual issues were agreed.

The complaint again highlighted difficulties associated with the application of sections 29 and 30 of the Act to the situation where a person is already in an authorised hospital. As already indicated, it is evident that section 30 requires amendment to clarify the process for admission to involuntary status of a person who is already voluntarily at the hospital.

In this and earlier Annual Reports, the Board has listed a number of areas of the Act that could be reviewed. These include sections 160-161 (access to information); criteria for involuntary status (section 26); the timing of mandatory reviews when a person's status has been changed from detained to CTO (section 138). To this list is now added section 30 of the Act. The Board notes that the Government will be establishing a review of the Act in the near future.

Supreme Court Appeal

As mentioned in last year's Report, an appeal was heard on 25 May 2000. The decision of his Honour Templeman J. in that matter was provided in writing in August 2000. The decision is known as EO v Mental Health Board and can be found at (2000) WASC 203.

EO v Mental Health Review Board

Facts: EO was a man who had since 1989 suffered from a mental illness. He had had a number of admissions to hospital, on one prior occasion involuntarily. On this occasion, EO was made an involuntary detained patient and then put onto a CTO. The Board reviewed the CTO on a periodic basis and ordered that the CTO continue.

EO appealed against the decision of the Board on 4 grounds:

(1) that the Board failed to accord procedural fairness to EO;
(2) the Board failed to consider section 26 (1)(c) of the Act;
(3) the Board failed to consider section 26 (1)(d) of the Act;
(4) the CTO was void for uncertainty.

Held: His Honour held firstly that the Act provided an absolute right, subject to some exceptions, of inspection and provision of copies of documents. As, on the evidence before him, EO had not received all relevant documents in accordance with this right, had the CTO remained in force at the time of the appeal, his Honour would have quashed the decision and remitted it to the Board. Secondly, he held that the Board's concern about the patient's consent to treatment could not be elevated to a finding that the patient had refused to consent. Thirdly, his Honour concluded that with respect to section 26(1)(d) the Board had not made it clear whether it had taken the evidence of a less restrictive option into account. (In relation to these two matters, had the CTO been in existence, his Honour would have remitted the matter

back to the Board for further consideration.) Fourthly, his Honour concluded that the terms of the particular CTO were defective and did not comply with section 68 of the Act. His Honour also made the point that a CTO, like an involuntary admission to hospital, should be strictly construed because, although a CTO does not itself result in the detention or continued detention of an involuntary patient, it may lead to that result.

Following the judgment in EO, the Chief Psychiatrist issued information to service providers about the terms of CTOs, access to information, and an unrelated matter.

Board Seminars

During the year, the Board continued its tertiary education programme. It also continued and expanded its seminar series. The following seminars were held during the year:

1. The *Guardianship & Administration Act* explored with reference to boundaries with the *Mental Health Act*

   Pamela Eldred, Deputy President Guardianship and Administration Board

   Julie Roberts, Public Advocate

   Hannah Leslie, Member of the Board and the Guardianship Board

2. *Confronting Ethics*, presenters: Ms Maria Harries & Professor Bob Ewin, UWA
3. *The Impact of Mental Illness on Families* – Kate Mevik

All seminars were well attended and provided interesting discussion of the issues raised.

Board Handbook

In May 2000 the Board published for the first time a Handbook detailing the Board's policy and procedure guidelines, Handbook 2000. This was also the first time in Australia that a mental health review board/ tribunal had attempted to provide its policies in this way and the initiative was progressed to provide openness to interested persons about the Board's processes.

As foreshadowed in the foreword to that edition of the Handbook, it was never the intention that Handbook 2000 be 'cast in stone' and inviolable. Thus, this year, an updated version of the Handbook was undertaken. The opportunity to offer feedback to be considered in the revised version was extended to consumer groups, service providers and Board members.

Education Series

A number of educational seminars were provided during the course of the year. The seminars presented included the following:

Edith Cowan University	–	Nursing
Curtin University	–	Occupational Therapy Nursing
Murdoch University	–	Psychology
Metropolitan Mental Health Service	–	Psychiatric Emergency Training Program
University of Western Australia	–	Social Work

The seminars covered the basic premise and structure of the Act, consideration of the Board within a human rights framework, and provided information about the legal and ethical tensions under which the Board operates. The feedback received from the attendees of the seminars was consistently positive.

Therapeutic Jurisprudence Conference, Cincinatti, Ohio

Attendance and presentation at the Therapeutic Jurisprudence conference in Ohio enabled the President to gain direct knowledge of the emerging field of therapeutic jurisprudence. This new field of social science was created in the area of mental health and is now being considered in other broader contexts. Its basic premise is that the law has to have regard to the context in which it is being applied.

In the US, civil commitment proceedings are judicial (court based) rather than quasi-judicial (tribunal based). During the visit to the United States, civil

commitment proceedings were observed in two States. In California, an involuntary patient had two separate hearings on the one day. The first was for involuntary status. This hearing was before a Hearings Officer and the standard of proof was balance of probabilities. The hospital and patient was represented by advocates. In the particular case, the Hearings Officer was satisfied that the person met the criteria and involuntary status was maintained. The patient's father and brothers were present but were not invited to contribute to the review.

In the afternoon of the same day, there was another hearing for the same patient occurred. This hearing was to determine an application to treat the patient even though she objected to that treatment. This hearing was before a judge (who attended with a sheriff and bailiff) and both the hospital and patient were represented by attorneys. The patient's father and brothers remained at the hospital but were not invited to attend the review, as their views were deemed irrelevant to the outcome.

Based on the different standard of proof (clear and convincing evidence) the judge was not satisfied that the criteria were satisfied and ordered that the application for treatment be dismissed. Therefore, the result was that the patient found to satisfy the criteria for involuntary status in the morning was not found to satisfy the (stricter) criteria for involuntary treatment the same day. Accordingly, the patient was discharged from the hospital against medical advice the same day, again without consultation with the patient's family.

The reviews observed in Ohio were notable for their short duration (less than 7 minutes average) and lack of an adversarial approach inconsistent with the legislation under which they were conducted. Generally, what is clear is that as a matter of practice, the procedural safeguards in the legislation in the US states observed are observed more in their breach than in fact. It is also clear that the system is highly individualistic in nature. Finally, it is apparent that the due process safeguards are relevant only to a small proportion of those persons who have a mental illness. For a significant proportion of persons in the US with mental health, the real issue is not protection of human rights in legislative terms, but protection of human rights by the availability of a mental health service that they can access. In other words, for many indigent persons suffering mental illness in the US, not having any access to the available mental health services is more critical than the degree of protection provided by legislation.

The UK mental health review system observed in the same trip is closer to the system operational in Western Australia. The UK Tribunal is distinguished by its unusual constitution with the tribunal medical member both assessing a patient and then participating in a decision about that patient's status. In contrast, in Western Australia, the medical member (psychiatrist member), like all members, receives information from both the treating team and the patient and then makes a decision on that information without conducting an assessment of the patient during the course of the review.

In WA, the majority of involuntary patients (approximately 65%) are taken off that status by their psychiatrist within the first 28 days of the order. Of those that remain involuntary, a significant proportion are discharged from involuntary status between the scheduling of a review and its actual date, between 7 to 14 days later. Of the patients for whom reviews are completed by the Board, the rate of discharge of involuntary orders in Western Australia has declined since the Act commenced and is now similar to most other jurisdictions. In the first months following the introduction of the Act, the rate of discharge was 10%. It has since steadily decreased and is now about 3-4%. The procedure of review in WA is more flexible in WA than in the US, as the Act requires the Board to act according to equity, good conscience and the substantial merits of the case. Therefore, there is for example scope for the attendance of carers and relative to provide the Board with information. In WA, though there is no mandated legal representation, all patients are advised of their right to legal representation and the agency (the Mental Health Law Centre) that has been established to provide that representation.

The pressures on the WA mental health system are probably similar to the pressures on the mental health systems elsewhere.

REASONS FOR DECISION – 9
CASE STUDIES

The Board provides written reasons for decision on request to any party to a review. The request is to be in writing and should be received by the Board within 14 days of the review.

This section includes a selection of reasons that have been completed this year. Identifying information has been changed to protect the identity of the patients and other persons involved.

As indicated earlier, the Board has to consider in a review the same criteria that a psychiatrist considers when making a person an involuntary patient. The criteria are found in section 4 (definition of mental illness) and section 26 (criteria for involuntary status). In summary, section 26 requires that an involuntary order be made only if:

(1) (a) *the person has a mental illness requiring treatment;*

(b) *the treatment can be provided through detention in an authorised hospital or through a CTO and is required:*

(i) *to protect the health or safety of that person or any other;*

(ii) *to protect the person from self-inflicted harm;*

(iii) *to prevent the person doing serious damage to any property;*

(c) *the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment;*

(d) *the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.*

Bearing these criteria in mind, in addition to section 137 which requires the Board to have regard primarily to the psychiatric condition of the person concerned and to consider the medical and social circumstances of the person, the following case studies are presented.

Case 1 – Mr A

Issues:

- different decisions with the one patient
- least restrictive alternative
- consent to treatment

Background: Some of the relevant criteria that the Board is to consider when reviewing a patient's involuntary status include sections:

- 26(1)(c) which states a person should only be an involuntary patient if the person has refused or, due to the nature of their mental illness, is unable to consent to treatment; and
- 26(1)(d) which states that the person should only be an involuntary patient if treatment cannot be provided in a way that would involve less restriction of freedom of movement and choice than would result in the person being an involuntary patient.

Mr A was a 25 year old male, admitted to an authorised hospital with a known history of bipolar affective disorder and three previous admissions to that hospital over the past 6 years. The report stated that the patient had a history of poor compliance with medication with aggressive and threatening behaviour when in the manic phase of his illness.

Mr A had been admitted to hospital after the Police apprehended him for walking down a highway with a jumper over his head. He applied for a review about 9 days after his admission, seeking voluntary status.

The report provided by the treating doctor for the review indicated that on admission to hospital (almost a month before the review), the patient was hypervigilant and restless being agitated and reluctant to be interviewed. He had marked thought disorder with rhyming and clang associations. He was unable to concentrate for any period of time.

The report stated that the patient required management on a secure ward and was commenced on a mood stabiliser, and antipsychotic. He was slow to improve. In the week preceding the review, the patient showed improvement though he continued

to have elevated mood, grandiose delusions and very limited insight. The report concluded that the patient "(had) very limited insight into his condition… He remains unwell and would be likely to discharge himself from hospital and become non-compliant with medication if not an involuntary patient. His mental state has not yet settled to the point where management on an open ward would be suitable."

At the review, the Board heard from the author of the report (who confirmed its contents) and from the patient. The patient told the Board that he fully intended to continue to take the medication and intended to stay with his parents if released. He asked the Board to trust him.

First Decision: The Board decided to discharge Mr A from involuntary status. The Board decided that whilst he had a mental illness that required treatment he appeared to have full insight into his illness and had expressed his willingness to continue the medication prescribed and that keeping him in hospital as an involuntary patient was not the least restrictive option.

Post Decision Situation: Two weeks later, Mr A was again admitted on an involuntary order. The report provided at the review stated that following his discharge by the Board the patient had left the hospital, ceased his medication and again became quite manic requiring re-admission. Although his mental state had improved since readmission (two weeks before the review) the previous weekend the patient had absconded to a country town having to be returned by Royal Flying Doctor Service.

At the subsequent review, the patient stated that he wanted to be a voluntary patient and be transferred to an open ward. He said that he was now taking the medication.

Second Decision: The Board decided to maintain the patient's involuntary detained status. The Board concluded that the patient has a mental illness requiring treatment, that there were risks to himself and others when he was unwell, and that he could not be relied upon to take the necessary medication in the absence of an involuntary order.

Commentary: This case provides an example of the difficult decisions that the Board is sometimes required to make. The principal issue in this matter was the patient's capacity to consent to treatment and the extent to which the Board can or should place reliance upon a patient's statement that they will take the treatment required for their mental illness. Clearly, this is a matter about which the Board is required to make a qualitative decision.

Case 2 – Ms B

Issues:

- consent to treatment

Background: The Board received a telephone call from a consumer advocate seeking an urgent review for an involuntary patient. Subsequent enquiries indicated that the person concerned was not in fact an involuntary patient at that time but had been transferred to an authorised hospital the previous day for assessment. Later that same day, Ms B was placed on an involuntary order.

Ms B was married, and worked as a teacher in a private school. During her brief stay at the other hospital, Ms B had formed a relationship with a fellow patient.

There was some altercation between the patient's friend and the patient's husband at the authorised hospital. Ms B was thereafter restricted from having access with her new friend, under section 169 of the Act.

At the repeated requests of her consumer advocate, and a request by Ms B, and following discussions with her legal representative, an early review was scheduled, five days after the involuntary order was completed.

The report provided at the review indicated that this was the patient's first episode of bipolar affective disorder. The report stated that the patient's initial symptoms began approximately six weeks ago and included elevated mood, delusions of multiple pregnancies, over spending, increased libido, and poor sleep. The concern was that the patient had only received 2-3 weeks treatment and that her judgment was likely to remain impaired. It was conceded that the patient was in the resolution phase of her mental illness.

Although family members were present, the Board decided it was not necessary to hear from them. Ms B was represented at the review by a legal practitioner.

Decision: The Board discharged the patient from involuntary status. The issue at the review was the patient's capacity to consent to treatment. The Board concluded that the patient consented to treatment and therefore that it was not necessary to hear from the patient's relatives. Following her discharge, Ms B left the hospital and the metropolitan area. She subsequently wrote to the Board a month after her discharge. She stated that she had been placed on the involuntary order as a result of the relationship that she had commenced with another patient. She had only known this man for a period of two days and yet had completely rejected her husband of several years.

In retrospect the former patient stated that she was now able to see that her actions had been illness driven, she had made some very out of character decisions and had totally rejected her family and friends. She stated that the Board had made the decision to release her based on the fact that she had told the Board that she consented to treatment. However, she felt that she was still very unwell at the time. The patient wrote to the Board in an endeavour to encourage members to think very carefully about decisions they made in the future. She felt that if the right decision had been made in her case a lot of serious damage could have been prevented and that in this instance the decision made was not in her best interest.

Commentary: This case highlights some of the significant tensions faced by the Board, which is regularly requested to discharge people from involuntary status. Sometimes, as in this matter, the patient and patient advocates make strenuous representations seeking early discharge. In this instance, the Board made a decision consistent with the decision sought by the patient, her advocate and her legal representative. Soon after, however, the Board was criticised for making the decision it did. This matter exemplifies some of the ethical and legal tensions evident in the area of mental health.

Case 3 – Ms C

Issues:

- mental illness requiring treatment
- protection of health or safety
- consent to treatment

Background: Ms C had been suffering from anorexia nervosa for more than three years. All attempts at voluntary treatment over the past three years had failed to achieve the restoration of normal body weight for Ms C and on two occasions Ms C was near death. According, her psychiatrist made Ms C an involuntary patient to provide for her ongoing treatment. The review conducted was an initial periodic review of her involuntary detained order. Ms C was represented at the review by a legal practitioner. Her mother and sister also attended the review.

In the reports supplied by her treating team at the review the following details were outlined: the patient's refusal to comply with care plans aimed at establishing a realistic weight had led to severe, life-threatening medical complications in the past. Ms C had admitted to the treating psychiatrist that she had deliberately failed to comply with the care plans and that she did not wish to take any regular diet and stated that she saw her ideal weight as somewhat less than was recommended by the treating team.

Ms C's low weight was of such concern that it was considered safer for her to be managed in a unit attached to a general hospital, rather than a stand alone psychiatric unit. This would allow greater medical care, she had been placed on leave from the authorised hospital to a general hospital.

Her weight gain initially was minimal due to Ms C refusing to cooperate with the feeding regime. Initially it had been difficult to engage Ms C in any focussed conversation. This was considered to be a consequence of Ms C's emaciated state. The psychiatrist considered that Ms C's impairment of judgement and behaviour was of such a degree as to imperil her life, and it had become necessary to use involuntary treatment as the least restrictive alternative to effect treatment for what was described as a life-threatening condition.

Ms C provided a submission to the Board where she outlined in detail her disagreement with the involuntary order, which she stated infringed her rights and freedom of choice. She was of the view that she should be able to choose alternative services rather than being placed on an involuntary order. She acknowledged that the treatment given under the order had resulted in a significant increase in weight. However, Ms C was of the view that this result was at considerable cost to her feelings of pride, self-respect and enthusiasm.

Decision: The Board decided to maintain the patient's involuntary detained status. The Board concluded that the patient had a mental illness requiring treatment, and that there were considerable risks to her due to her mental illness that had been documented over time and which were not in dispute. Although the Board was mindful of the patient's well articulated views about what she perceived to be the extreme infringement of her rights, it had to balance those views with the requirements of section 26. The Board concluded that the patient satisfied the criteria of the Act for involuntary status and accordingly continued the involuntary order.

Commentary: This matter illustrates the obligation of the Board to balance, within the legislative framework, sometimes contrary or competing interests. In this instance, the Board was presented with clear evidence in support of the patient having a serious mental illness. The Board was also presented with a well-articulated viewpoint from the person concerned that she should be given the respect and dignity of voluntary status and that her weight loss came with the negative adverse consequences of feelings to her pride, autonomy, self-respect and enthusiasm. On this occasion, it was clear that the criteria were satisfied and therefore the Board could not rely upon the issue of respect and dignity as being sufficient to discharge the patient from involuntary status, though it accepted the importance of those issues for the patient.

Case 4 – Mr D

Issues:

- mental illness requiring treatment
- consent to treatment
- risk to self and others

Background: Mr D had requested a review of his detained involuntary status. He had been reviewed by the Board on four previous occasions, two whilst on an involuntary detained order and two when on a CTO. The Board had maintained the order on both occasions when he was reviewed as an involuntary detained patient and had discharged the order on both occasions when he was reviewed on a CTO.

The report provided to the Board at this review stated that Mr D has a long history of paranoid schizophrenia, and that though he had been tried on various anti-psychotic medications none had resulted in a complete remission of Mr D's symptoms. Non-compliance has resulted in severe psychotic relapses with re-admission to hospital. When unwell he presented with persecutory and grandiose delusions. When unwell, the patient believes his father to be Satan and had threatened to kill him. Mr D remained insightless and believed that the only medication that worked for him was herbal remedy. The treatment plan was to continue treatment, namely depot anti-psychotic that the psychiatrist felt was unlikely to resolve his symptoms but was likely to reduce the risk of him acting on them by diminishing the intensity of his psychosis.

Mr D's legal representative submitted that although Mr D's file had references to him threatening people he had not in fact acted on those threats. In this submission, Mr D accepted that he had a mental illness but disagreed that he suffered from schizophrenia, instead believing that he suffered from post-traumatic stress. Mr D felt that the more his medication increased the worse he becomes.

On this occasion, Mr D had been voluntarily admitted to hospital with a severe psychotic relapse. He had requested a review two weeks after he was placed on an involuntary detained order. A few days before the review, the patient was discharged to a CTO. However, the day before the review Mr D returned to the hospital and agreed to stay there voluntarily, after an incident where the patient had visited several television stations to inform them that he was aware of the perpetrator of a major crime. Thus, the CTO continued and it was the CTO that the Board reviewed.

Mr D's legal representative submitted that the patient did not satisfy the legislative criteria, that his reputation was more at risk by involuntary status than anything else, and that the patient was not a risk to himself or others.

Decision: Based on the information supplied, the Board concluded that the patient did suffer from a mental illness and that he required treatment to protect the health and safety of both himself and others. The Board accepted that that there had been occasions in the past when the patient was aroused and unwell, and noted that community mental health staff had intervened to ensure his admission to hospital before the patient had had opportunity to act on his beliefs when unwell.

In relation to medication, the Board found that the patient accepted medication when provided to him in hospital but, in the light of his history, could not be relied upon to continue to take the medication required on a voluntary basis. Therefore, the Board concluded that at the time of review the necessary treatment could not be provided in a less restrictive manner and ordered that the CTO be continued.

Commentary: This case raises the issues of capacity to consent to treatment and risk to self or others. The patient appears to be a person who functions well when treated, but places himself and others at significant risk when unwell.

THE KELLIE CASTLE AWARD – 10

Kellie Castle was an employee of the Mental Health Review Board who died unexpectedly in April 2000. She was a highly talented writer and poet who also suffered depression. In order to acknowledge her contribution and to provide a positive focus for mental health issues it was decided in consultation with Kellie's parents to offer to year 10 students throughout the state the opportunity to participate in a poetry competition.

The Board received almost sixty entries from Year 10 students throughout Western Australia for the award, honouring Kellie and promoting positive mental health. The winning entry was written by Danielle Deitos from Kearnan College, Manjimup. Danielle was presented with her prize at the launch of Mental Health Week. Danielle received a book voucher to the value of $200 and the Parents & Citizens Committee of her school received $500. Both awards were funded by Mr and Mrs Castle. Although initially it was proposed that this would be an annual reward the benefactors of the Award subsequently decided not to proceed with the award at present. Below is Danielle's winning poem, "The Grey Cell".

The Grey Cell

I saw one like me the other day,
At the supermarket,
One that resembled me before the recovery.

I could see her pale, pasty complexion,
Gaunt face,
Empty gouges where her eyes should have been.

I understand.

I know what personal terror she has encompassed herself in,
The blackness,
No,
Blackness is death and I am alive,
But I was dead,
To the world I was deceased,
But in my mind the turmoil raged,
Sadness at the emptiness and complete hopelessness I felt,
Inside the prison of my mind it was grey, a grey mist that I was wrapped inside,
Alarmingly comforting,
The grey, padded cell walls that I could indulge in my self pity,
But for what crime?
What horrors did I complete to endure such madness?

You poor girl.

Those sad eyes floating on that unfeeling, emotionless face,
Depression had wrapped its soft, supple fingers about her mind,
She had surrendered to its beckoning,
Beckoning,
She looked at me, no smile, just self pity and confusion.

You slipped into the grey haziness too, didn't you?

Her frail body does not come to the measures to the delicacy of her mind,

Strings of cobwebs holding up the main frame behind that painridden face,
She is unable to express her feelings,
Yet all she does is express her emotions,
Confusion has enveloped her,

Yet all she can think of is the pain,
Tearing at her logic,
Unable to haul herself out of the strange comfort the grey allows her to feel,
She walked away from me,
Clutching a plastic bag filled with white bottles,
Bottles whose contents would plunge her deep in the blackness.

No, it doesn't have to be this way!

I tapped her slumped, saddened shoulder,
Her glazed, emotionless eyes met mine,
We drank coffee, her head hung low,
Defeated,
Ironic,
While I try to prevent the eternal sleep, we drink the liquid of the insomniac,
Salty tears forming a lake of pain on the café benchtop,
We confided our fears,
Shared our dreams,
When we parted her expression had changed,
A small, satisfied glow about that haunting face.

You will survive.

I walked down the street,
A paved journey,
A trash can caught my eye,
Inside…..
A plastic bag filled with white bottles,
The sun had defeated the blackness…..

Danielle Deitos

CONTACT INFORMATION AND DETAILS – 11

Information available:

Brochure - Information on the Review Process

Annual Report

Handbook

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