Mental Health Review Board

Annual Report 2002

MENTAL
HEALTH
REVIEW
BOARD

Western Australia

To the Hon. Bob Kucera, MLA
Minister for Health

Dear Minister

I am pleased to submit to you this fifth 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 2002. (All references in the report to year refer to the mentioned 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. In line with the Government's request, this Annual Report is available only upon its newly established website.

This year has seen a further increase in demand for the Board's services. Through careful planning and close monitoring, the Board has been able to meet the increase in demand for services within a stable budget whilst not compromising the standard of the reviews it conducts.

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.

As before, 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. This is despite increasing pressures on many organisations due to financial and other constraints. On behalf of the Board, I thank all those persons and agencies for the key role that they continue to play in enabling the Board to fulfil its statutory functions.

During the year, the State Administrative Tribunal Report was published. This Report proposes the alignment of the Board with the new Tribunal. Should this proposal proceed, it will be essential that 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.

Yours sincerely

Neville Barber
PRESIDENT

CONTENT

1. 2001-2002 IN SUMMARY

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

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

Reviews

The Board scheduled 1365 reviews at over 30 different venues across Western Australia. Of the 1365 scheduled reviews, 958 were completed. Section 6 of this Report provides further statistical information about the reviews conducted by the Board this year.

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.

Launch of the Board's web site

During the year, the Board's web site was launched as a resource available to all interested persons. The web site includes information about the Board, its *Handbook*, and a selection of Reasons for Decision, as well as an application for review.

Attendances at conferences

The President attended the Guardianship and Administration National Conference in Melbourne in October 2001. In November 2001, the President attended and presented at the Australian and New Zealand Association of Psychiatrists, Psychologists and Lawyers Conference in Melbourne.

One Day Conference

The Board sponsored a one-day conference on 30 November 2001, entitled Mental Health Law: Past, Present and Future.
The Board was very pleased with the response to the conference. In total, over 120 people registered and attended the conference.

The keynote speaker for the conference was Associate Professor Alfred Allan, who gave a stimulating and challenging address on whether mental health legislation should continue to exist.

Other speakers at the conference included:

- Mr Lloyd Marsh;

- Ms Elaine Smith;
- Mr Stuart Flynn;
- Dr Sandy Tait;
- Ms Kathryn Shain; and
- Mr Patrick Mugliston.

Ms Maria Harries subsequently facilitated an interactive session in which groups reflected on the presentations. Feedback received from delegates indicated that the conference was regarded very positively.

Review of the *Mental Health Act 1996*

At the Board's One-Day Conference held on 30 November 2001, the Minister announced the appointment of Professor D'Arcy Holman to chair the review of the Act. The Act specifically requires that the functioning of the Board be considered in the review and the Board looks forward to working with all other agencies and individuals to further the review.

2. PURPOSE AND FUNCTIONS OF THE BOARD

Much of the material in the ensuing sections of this Annual Report is based upon or replicates material in previous Reports. In this way, ease of comparison with earlier Reports is maximised. Statistical updates are provided, where appropriate.

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 Community Treatment Order (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

(a) 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*.

(b) 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.

(c) The Chief Psychiatrist may report to the Board on matters concerning the medical care or welfare of involuntary patients: *section 10(d)*.

3. MEMBERSHIP OF BOARD

At 30 June 2002, the Board consisted of 26 members, as follows:

President
Mr Neville Barber

Lawyer Members	**Expiry Date**
Mr Henry Christie	12 November 2002
Mr Tony Fowke	12 November 2004
Ms Hannah Leslie	12 November 2002
Ms Anne Seghezzi	12 November 2003
Mr Colin Watt	12 November 2002
Community Members	
Ms Kerri Boase-Jelinek	12 November 2003
Mr John Casson	12 November 2004
Dr Christine Choo	12 November 2002
Professor David Hawks	12 November 2002
Ms Lynne McGuigan	12 November 2002
Mr Craig Somerville	12 November 2002
Reverend Richard Williams	12 November 2002
Psychiatrist Members	
Dr Ann Bell	12 November 2002
Dr Peter Burvill	12 November 2002
Dr Hugh Cook	12 November 2004
Dr Steven Patchett	12 November 2002
Dr John Penman	12 November 2004
Dr Nada Raich	12 November 2002
Dr Mark Rooney	12 November 2002
Dr Martin Sawday	12 November 2002
Dr Patricia Shalala	12 November 2003
Dr Jonathon Spear	12 November 2002
Dr Prudence Stone	12 November 2003
Dr Felice Watt	12 November 2004
Dr Andy Zorbas	12 November 2003

The terms of appointment for Ms Michelle Scott, Dr Aaron Groves, and Dr John Spencer expired on 12 November 2001. In addition, Mr Walker resigned from the Board in October 2001. The President thanks these persons for the contribution they made to the Board during their time as members.

4. ADMINISTRATION OF THE BOARD

At 30 June 2002, 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	(Temporarily filled)

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 draws upon this information to schedule reviews and to produce a variety of reports. During the year, the Board updated and improved the CTS to ensure that the programme continues to meet its increasing requirements.

As noted in the Board's Handbook, 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. Further details of the Board's policies are available in the Handbook.

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 47 reviews, at venues as diverse as Broome, Kalgoorlie, Esperance and Meekatharra. 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 83 reviews (8.7%). This was a decrease in the total of 129 (14.2%) from the previous year. Of that number, 14 reviews (1.5%) 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 60 reviews (87%) and involuntary status was discharged in the remaining 9 (13%).

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 44 reviews (4.6%) during the year. This was an increase in the total of 34 (3.7%) from 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. Four members of the Council attended reviews in this capacity during the year.

These statistics reveal that less than 15% of patients attended a review with either a legal representative or an official support person, even though the Board advises each involuntary patient of the availability of persons from those agencies to assist them at their review.

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 will also arrange for an interpreter when a person significant to the patient requires an interpreter and attends the review.

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 ten reviews this year; with the languages spoken being Polish, Vietnamese, Thai, Italian, Mandarin. Also, on one occasion an interpreter from the Deaf Interpreting Service was required.

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 33 occasions during the year, and with the permission of the patient in each instance, observers were present at reviews.

Expenditure Statement

For the period of operation from 1 July 2001 to 30 June 2002 the Board incurred operating expenditure of $761,768.

Board members were paid a total of $252,925 in remuneration which included fees for review days, training and administrative expenses. These fees are part of the operating expenditure of the Board.

5. THE PROCESS OF REVIEW

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 view relevant parts of the medical files applicable to the patient. Generally of greater importance is the report that has been requested and prepared 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.

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:

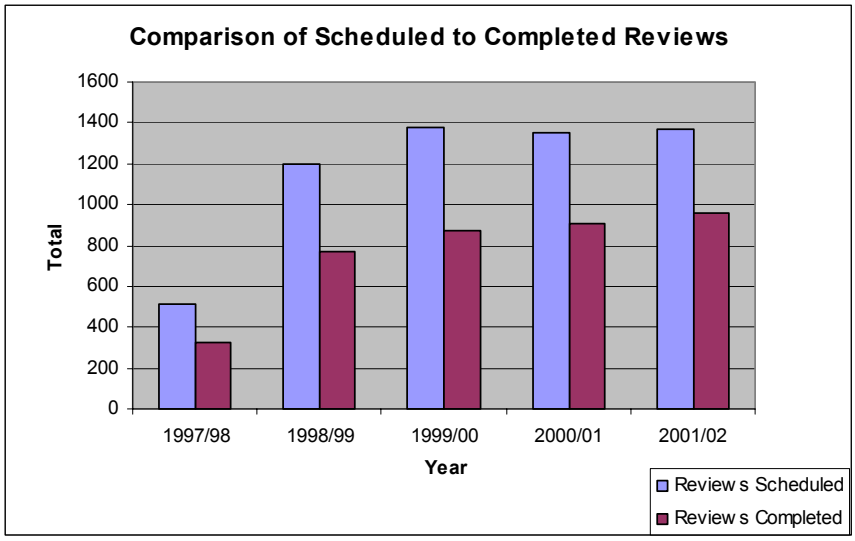
- Maintain the involuntary order: *section 145(1);*
- Discharge the patient from involuntary status: *section 145(2)(a);*
- Order that a CTO be made (provided that it is satisfied that requirements for the making of such an order have been established): *section 145(2)(b);* or
- Vary the terms of a CTO: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

6. STATISTICAL INFORMATION

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 CTO. The majority of reviews scheduled and completed are of a periodic nature. The significant variance between the number of reviews scheduled and completed can be attributed to the patient being discharged from involuntary status following scheduling but prior to the review. Tables 1 and 2 indicate the number and category of reviews both scheduled and completed since commencement of the Act and Board.

Table 1: demonstrates the increase in reviews completed in each year of the Board's operation.

Table 1.



1. 1997/98 figure is for a 7-month period from the Board's commencement through to 30 June 1998
2. Due to enhancements to the CTS, the number of reviews recorded as 'scheduled' for previous years has altered.

Table 2: confirms that a total of 958 reviews were completed during the year, an increase since inception of 23.9%.

Table 2.

Comparison in Review Numbers					
Reviews	**1998/99**	**1999/00**	**2000/01**	**2001/02**	**Variance 1998/99 and 2001/02**
Total Scheduled	1196	1379	1354	1365	14.1%
Total Completed	773	874	910	958	23.9%
Requested					
CTO *(Scheduled)*	41	44	58	38	-7.3%
CTO *(Completed)*	32	39	39	23	-28.1%
Involuntary Detained *(Scheduled)*	275	298	303	229	-16.7%
Involuntary Detained *(Completed)*	149	156	150	110	-26.2%
Periodic					
CTO *(Scheduled)*	263	423	439	546	107.6%
CTO *(Completed)*	234	325	374	463	97.9%
Involuntary Detained *(Scheduled)*	617	614	554	552	-10.5%
Involuntary Detained *(Completed)*	358	354	347	362	1.1%

Requested Reviews

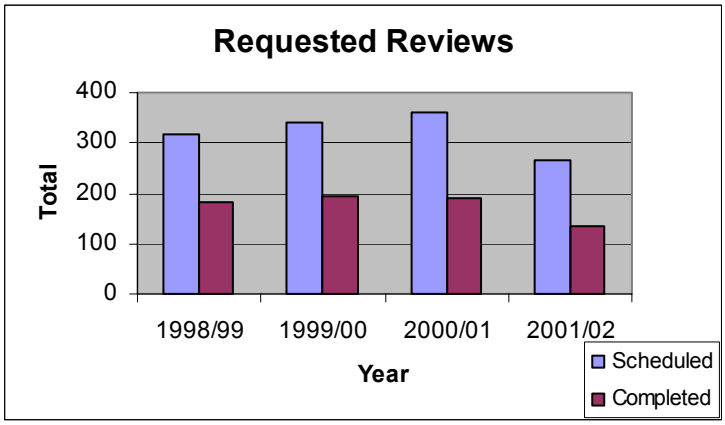
An application for review may be made by the involuntary patient, an official visitor, or any other person, such as the patient's representative, advocate or carer, whom the Board is satisfied has a genuine concern for the patient. *section 142(2).*

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: demonstrates the reduction in requested reviews scheduled and completed during the year. This decrease was counterbalanced by an increase in periodic reviews (see Table 4).

Table 3.



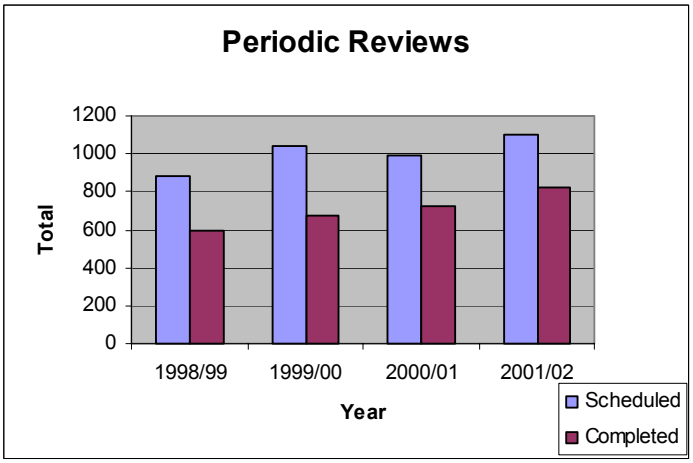
Periodic Reviews

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.*

Table 4: demonstrates that the number of periodic reviews scheduled and completed during the year increased.

Table 4.



Outcome of reviews

Table 5: demonstrates the number of patients discharged from involuntary status by the decision of the Board at review. For 26 patients (3%), the Board made such an order. Of these persons, 15 were on CTOs and 11 were on involuntary detained orders. An additional 338 patients (25%) were discharged from their involuntary 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 6: provides a comparison of the number of persons discharged by the Board since commencement in November 1997. The figures reveal a decrease in the number of persons discharged from involuntary status by the Board. This is an expected result based upon psychiatrists becoming more familiar with the requirements for involuntary status.

Table 5.

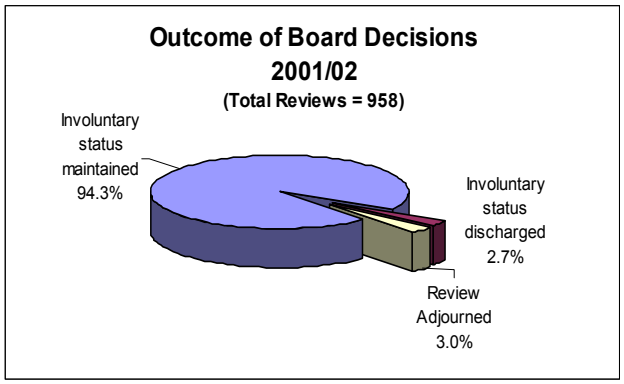
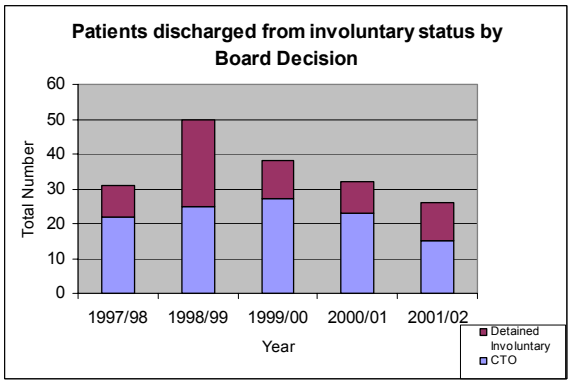


Table 6.



Patient Attendance at Reviews

The Act allows the Board to proceed with a review even though a party to the review does not attend. The review process is clearly more satisfactory when attended by the patient. The Board encourages the patient to attend reviews, and in addition advises the patient that they may bring a relative, friend or carer to the review. Those who did not attend the review are informed of the Board's decision by post.

Table 7: reveals that the number of persons who attend reviews has remained relatively constant in the last three years, with a slight decrease from the first year of the Board's operation.

Table 7.

Patient Attendance at Reviews	1998/99	1999/00	2000/01	2001/02
Total Reviews	773	874	910	958
Total Detained Involuntary Reviews	507	510	497	472
Patient Attended	469	466	427	421
	92.5%	**91.4%**	**85.9%**	**89.2%**
Patient Absent	38	44	70	51
	7.5%	**8.6%**	**14.1%**	**10.8%**
Community Treatment Order Reviews	266	364	413	486
Patient Attended	169	197	221	253
	63.5%	**54.1%**	**53.5%**	**52.1%**
Patient Absent	97	167	192	233
	36.5%	**45.9%**	**46.5%**	**47.9%**
Total Patient Attendance	638	663	648	674
	82.5%	**75.9%**	**71.2%**	**70.4%**

Patients discharged by psychiatrists

Table 8: demonstrates that the majority 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 8.

Involuntary Orders discharged within 28 days	1998/99	1999/00	2000/01	2001/02
Number of involuntary detained orders	2250	2304	2360	2390
Number of involuntary detained orders discharged within 28 days	1428	1497	1561	1551
% of involuntary detained orders discharged within 28 days	**63.5%**	**65%**	**66%**	**64.9%**

7. OTHER STATUTORY REQUIREMENTS

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 41 occasions (4.3%). Section 9 of this report provides some illustrative examples of reviews conducted and reasons prepared.

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 888 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 45 notification of occasions of the use of mechanical bodily restraint for involuntary patients.

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 eight occasions of the use of emergency psychiatric treatment for involuntary patients.

Section 146 Complaints

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 one complaint and completed its investigation into a complaint submitted the previous financial year.

Complaint One (received during the previous year; inquiry completed in this year)

The patient's legal representative submitted a complaint about restrictions on her client's rights to make and receive phone calls, specifically to her legal representative.

The Issues
An involuntary detained patient was restricted in the telephone calls she could make. Complaint was made both about the content and specificity of the restrictions.

The Inquiry
The relevant authorised hospital was provided with a copy of the complaint and subsequently provided its response.

The Board considered the complaint, the response and the legislative framework.

By written response, the legal representative was advised as follows:

- In response to the first issue (the suggestion that the restriction order was defective in that it was not signed by a psychiatrist): the Act requires that a psychiatrist makes the order for restriction and that a record of the order and each review of it is to be made in the case notes of the patient's file. The Act does not require that the psychiatrist write the record in the patient's notes or sign the order. However, it is clearly desirable that there are procedures in place that maximise the chances of complying with the Act or decrease the potential for dispute.

- In response to the second issue (that the initial order was not sufficiently specific): general principles indicate that an order should be clear and unambiguous when perused by another person not party to its writing. In this instance, there was some ambiguity on the form as to whether there is to be a restriction to the use of a telephone or denial of access to a telephone. Therefore, it was agreed that the form could be amended to make the order clearer.

- In response to the third issue (the monitoring of calls to the legal practitioner): at a factual level, the service provider stated that it was not possible for any one to listen-in on a patient's conversations on the public phones at the authorised hospital but confirmed that it is possible for a staff member to terminate a call.

  The service provider stated that the author of the remarks on the order intended to convey that the telephone calls to another agency were of concern (in relation to possible adverse effects the calls may have on the outcome of decisions relating to the patient's son). The explanations provided by the service provider were accepted.

- In response to the fourth issue (that the service provider should have drawn the orders of restriction to the attention of the Board): this was established and confirmed with the service provider.

Following this inquiry, a letter was sent to the Chief Psychiatrist about the need for review of the forms for restriction or denial, with a view to making the forms clearer.

Complaint Two

The issues
A complaint was received from a legal practitioner about the forms provided, or not provided, to the patient in accordance with the Act.

The complaint raised the following issues:

- It was stated that the patient had not received a copy of the Form 1 (Referral for Assessment). Though it was acknowledged that the Act does not require a copy of this form to be provided to the patient, it was suggested that the proper administration of the Act required that the person be provided with the form.

- It was stated that the patient had not received a copy of the Form 3 (Transport Order) as required by the Act.

The Inquiry
In response to the complaint, the Board conducted an Inquiry by writing to the relevant authorised hospital and receiving and considering its response.

By written response, the legal representative was advised as follows:

In response to the raised issues, it was not possible to establish with certainty the course of events at the time of the patient's admission to hospital. However, the Board noted the issues raised by the authorised hospital in relation to the provision of copy of orders. These issues included:

- The difficulties of obtaining copies of the forms for patients;

- Concern about who is responsible for provision of the Transport Order to the patient (while the Act identifies the referrer as being responsible for supplying the patient with a copy of the form, the instructions on the form identify the Police Officer as the person responsible for providing a copy to the patient;

- The Act does not articulate when the Transport Order is to be provided to the patient.

The mentioned issues can be considered in the review of the Act.

Supreme Court appeal

No Supreme Court appeals were heard during the year.

8. OTHER ACHIEVEMENTS AND ISSUES

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. "*Managing Comorbidity*" Treating drug abuse and mental illness – which comes first and what to do?
   Dr Alan Quigley: *Director, Next Step Specialist Drug & Alcohol Services*
   Ms Serena Ryan: *Registered Psychologist, Coordinator of the Joint Services Development Unit*

2. Mental Health Law Conference: The Past, Present and Future
   Keynote Presentation was given by Dr Alfred Allan
   Other presentations were given by:
   Mr Lloyd Marsh: *West Australian Association for Mental Health (WAAMH)*
   Ms Elaine Smith: *Association of Relatives and Friends of the Mentally Ill (ARAFMI)*
   Mr Stuart Flynn: *Council of Official Visitors*
   Dr Sandy Tait: *Consultant Psychiatrist*
   Ms Kathryn Shain: *Mental Health Law Centre*
   Mr Patrick Mugliston: *Lawyer*

3. The Drug Court – grappling with legal and ethical issues
   Ms Julie Wager, SM: *Presiding Magistrate, Drug Court*

Board Web site

The Board has established a website with assistance from the Department of Health. The address of the Website is www.mhrbwa.org.au.

The web site not only includes information about the Board (including its Handbook and previous Annual Reports) but also incorporates an application form for review and links to other topical sites. In addition, the web site allows users to directly email the Board with any comments or questions that they may have.

Board Handbook

In July 2001, the revised and updated Handbook was published in hard copy. More recently, the Handbook has been put on the Board's website.

Education Series

A number of education sessions were provided during the course of the year. The sessions 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
- Marr Mooditj Foundation Inc.
- GP Education Australia

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

Addressing issues raised by other agencies

The Board received public feedback from other agencies during the year. In particular, the Mental Health Law Centre and the Council of Official Visitors made comments about the Board in their respective Annual Reports. In some instances, because there had been no discussion with the Board about the issues raised, those Annual Reports contained inaccurate material.

State Administrative Tribunal Report

The State Administrative Tribunal Taskforce Report was published in July 2002.

This Report discusses the establishment of a State Administrative Tribunal, to cover the functions of many current Tribunals and Boards. The Report recognises the very special jurisdiction that each of these Boards has and specifically does not propose that the substance of the relevant legislation be altered in any way. The Report proposes the continuation of the Board and the Guardianship Board, on the basis of the specialised role and the expertise built up by these two Boards. However, the Report also proposes that the two Boards be aligned with the State Administrative Tribunal to achieve administrative advantage to the overall Tribunal structure.

The recommendations of the Report, and its recognition of the sensitive jurisdiction in which the Board operates, are encouraging to the Board.

9. REASONS FOR DECISION – CASE STUDIES

The Board does not automatically provide written reasons for decision for every determination that it makes. Any party to a review is entitled to request and be provided with reasons for the Board's decision. The request is to be in writing and should be received within 14 days of the review being completed.

This section includes a selection of reasons that have been completed this year, with identifying information changed to ensure anonymity.

As earlier indicated, 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*:**
- the need for treatment
- risk
- living circumstances

Background:
Mr A was made an involuntary hospital patient. Mr A requested a review and was represented at that review by a lawyer and supported by an Official Visitor.

The Board heard that the patient was a single man diagnosed with manic episode and polysubstance abuse. Prior to his admission to hospital, the patient had been arguing with family members and had been charged with a minor criminal offence. The patient was sleeping very little and reported increased energy.

The doctor told the Board that the patient did not accept that he had a mental illness. Though the patient had improved since admission, he remained restless and demanding and not able to

sleep. The patient's doctor stated that the patient had refused medication and did not appreciate that he had a serious mental illness. She was doubtful that the patient would continue treatment as a voluntary patient. The patient's lawyer submitted that though the patient did not completely accept that he had a mental illness requiring treatment, he was willing to cooperate with treatment.

Key issues for the Board were: the patient's need for treatment (there being a clear distinction between the doctor's views and those of the patient about this; risk (again there was a clear distinction, though the information about risk was not somewhat equivocal) and the patient's social circumstances (the patient lived on his own in a small country town).

Decision:
The Board unanimously concluded that the patient had a mental illness requiring treatment. The majority concluded that the risks of harm were not sufficiently established to warrant continued involuntary status. The minority view was that on the only available medical evidence, the patient required further treatment and that there was a risk of further deterioration and relapse if the patient was not treated.

Given the majority conclusion, the patient was discharged from involuntary status. However, the minority opinion in relation to consent to treatment was that treatment could only be ensured by continuing the patient's involuntary status.

Commentary:
This case highlights the frequently difficult nature of the decisions that the Board has to make. Though it is rare for the Board to have majority/minority decisions, the issue in particular of determining the extent to which a patient is capable of consenting to treatment is often complex and finely balanced.

Case 2 – Mr B

Issues:
- diagnosis
- consent to treatment

Background:
Mr B was placed on a Community Treatment Order and subsequently had a periodic review. He was represented by a lawyer at his review.

Mr B had a diagnosis of bipolar disorder. The concern of Mr B's doctor was that, without the CTO in place, the patient would reduce or cease his medication, thus leading to a further relapse of his illness and further period of hospitalisation.

The medical information was that Mr B had been diagnosed with his mental illness some years earlier and that attempts to treat the patient on a voluntary basis had failed. The patient had been involuntarily admitted to hospital just a month prior to his review and had ceased medication prior to that admission.

The patient told the Board that he was now compliant with medication and consented to treatment.

Decision:
The Board concluded that the patient had a mental illness (this was not in dispute) and required treatment for his illness. However, the Board accepted that the patient recognised the

benefits of medication (albeit at a dosage less than recommended by his doctor) and that Mr B was capable of consenting to treatment. The Board discharged the CTO.

***Commentary*:**
This matter was an instance in which the Board accepted the patient's statements regarding his intentions to continue treatment in the light of his psychiatrist's acceptance that the patient would continue treatment, albeit at a dosage of medication less than recommended by the psychiatrist.

Case 3 – Ms C

***Issues*:**
- Understanding of mental illness
- Consent to treatment
- Submissions not supported by information available to the Board

Background:
Ms C had a number of earlier involuntary orders. On this occasion, she was admitted to hospital. She requested a review and was represented at that review by a lawyer.

The doctor stated that Ms C had a diagnosis of paranoid schizophrenia for which she required treatment. The Board was advised by the doctor that the patient had told the doctor that she did not have a mental illness and did not require treatment. Indeed, at the review itself, the patient stated that there was nothing wrong with her and that she did not need treatment.

The patient's lawyer submitted that the patient would consent to treatment if she were discharged by the Board. The lawyer also asked a number of questions about the patient's husband, from whom she was temporarily separated, apparently with a view to suggesting that the patient's husband was involved in the decision to have his wife hospitalised. Though there was information before the Board that when the patient became unwell, her husband removed himself and their children, there was no information before the Board that the patient's husband had deliberately set out to have his wife hospitalised.

Decision:
The Board concluded that the patient had a mental illness and accepted the information provided by the treating team. The Board also accepted that the patient's mental illness required treatment as without treatment she was a risk to herself and others. As the patient did not accept that she had an illness, the Board concluded that she was unable to consent to treatment and, further, that she could not be relied upon to accept the necessary treatment for her mental illness on a voluntary basis.

***Commentary*:**
This matter was an instance in which the submissions provided by the Board were not supported by information available to the Board.

Case 4 - Mr D

Issues:

- Acceptance of mental illness
- Consent to treatment
- Submissions not supported by information available to Board

Background:

The patient had been in prison for a serious assault on his former girlfriend. During his term of imprisonment, he had been transferred to hospital for treatment. The patient was released from prison on parole and then placed on a CTO. The CTO had been revoked as the patient was not taking the prescribed medication. The patient applied for a review of his involuntary (hospital) status. Prior to the review, he was again discharged to a CTO.

At the review, the patient was represented by a lawyer. The medical information before the Board was that the patient had a diagnosis of paranoid schizophrenia and needed treatment with medication.

The patient told the Board that he would take the medication but did not see the need to do so and that, if he had a choice, he would cease medication. The patient said that he was 'not at all' unwell.

The submissions provided by the patient's lawyer were in essence that the patient had the capacity to consent to treatment for a mental illness that he now did not have. A further submission seemed to be that the patient was no longer a risk or that, if he was, the risk had been considered by the Parole Board.

Decision:

The Board continued the patient's CTO. The information provided by the doctor and case manager about the patient's mental illness and risk was preferred by the Board. It was consistent with earlier available information. On the basis of the information before it, including the patient's statements that he had ceased taking his medication some eight months prior to admission to hospital, that he did not see the need for medication as he did not believe he had a mental illness, that he felt better without medication, and that if he had a choice not to be on medication he would not take it, the Board concluded that the patient was refusing treatment. The Board also concluded that the patient was unable to give informed consent to treatment because he did not accept that he had a mental illness. There was no information before the Board to support the submissions that the patient's mental illness was transitory or that he would continue to have prescribed treatment.

Commentary:

This matter also highlights the distinction that the Board sometimes observes between what it is told by an advocate and what the patient him or herself tells the Board. In this instance, the patient was emphatic that he did not have a mental illness, and also quite clear that he did not want treatment. Accordingly, there was little if any information to support the submission that the patient would continue to accept treatment for a mental illness that he said that he did not have.

10. INFORMATION AVAILABLE AND BOARD CONTACT DETAILS

Information available on the Board's website:

1. **Brochure - Information on the Review Process**
2. **Annual Report**
3. **Handbook**

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