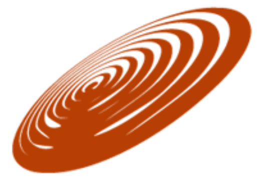

MENTAL
HEALTH
REVIEW
BOARD
Western Australia

Annual Report 2003

To the Hon. Jim McGinty MLA
Minister for Health

Dear Minister

I am pleased to submit to you this sixth 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 2003. (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 primarily upon its established website (www.mhrbwa.org.au).

This year has again seen an increase in demand for the Board's services, something the Board has experienced in each year of its existence. Through careful planning and close monitoring, the Board has been able to meet the increase in demand for services within a modest 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 always, 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.

With the anticipated implementation of the State Administrative Tribunal in the forthcoming year, this report may cover the last full year of the Board's separate operations.

Though the Board operates in a highly complex environment, in which there are many tensions and difficulties, and has therefore and inevitably always been the subject of comment and criticism, I have no doubt that the Board has performed its difficult role in its short life always with the interests of mental health consumers foremost in mind. It is to be hoped that the proposed State Administrative Tribunal will continue to maintain this focus.

Yours sincerely,

Dr Neville Barber
PRESIDENT

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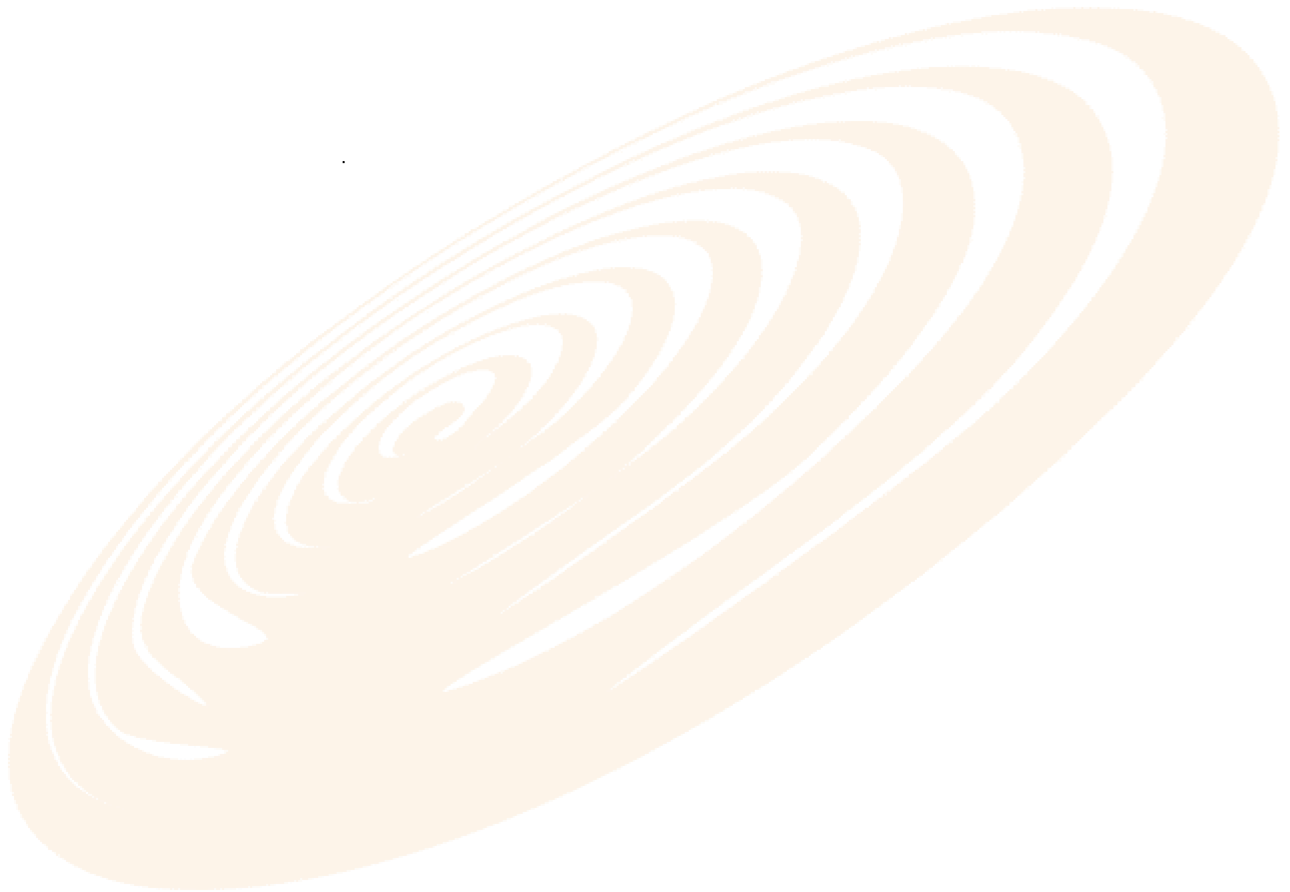


1. 2002 - 2003 IN SUMMARY

The Board has completed its fifth 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 1537 reviews at over 32 different venues across Western Australia. Of the 1537 scheduled reviews, 1059 were completed, this represented a 10.5% increase on the previous financial year. 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. Section 7 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, which were well received.

Attendances at Conferences

The President attended and presented a paper at the World Federation of Mental Health Biennial Congress, held in Melbourne Victoria between 21 and 26 February 2003. This was the first occasion on which the Congress had been held in the Southern Hemisphere. At this Congress, Mr Tony Fowke AM, a member of the Board, was re-elected as President, Oceanic Region, World Federation of Mental Health.

The President also attended the now annual meeting of Presidents and Executive Officers of Review Boards and Tribunals in Sydney, held in June 2003. At this year's meeting, particular attention was paid to member performance appraisal and Ms Julie McCrossin addressed the group.

Review of the *Mental Health Act 1996*

The Act (at section 215) provides for the Minister to carry out a review of the operation and effectiveness of the Act as soon as practicable after the expiration of five years from commencement. In the course of this review, the Minister is required to consider and have regard to:

(a) The effectiveness of the operations of the Board and the Council of Official Visitors;

(b) The need for the continuation of the functions of the Board and the Council of Official Visitors; and

(c) Such other matters as appears to be relevant to the operation and effectiveness of the Act.

The then Minister announced in November 2001 that Professor D'Arcy Holman had been appointed to conduct the review of the Act.

The President has represented the Board on the Stakeholder Committee. The President has also been a member of the working party tasked with looking specifically at the roles and responsibilities of the Mental Health Review Board. In addition, the President has, when possible, provided some assistance to other working parties established for the purposes of assisting the review. Also, both Mr Tony Fowke AM and Ms Sue Lewis have attended some meetings of the Stakeholder committee as deputies for the President.

Legislative Issues

The Board has taken an active role in recommending legislative reform to enhance the Act. For example, in an earlier Annual Report the Board identified areas of legislative concern and proposed appropriate changes.

Awards of Order of Australia

During the year, it was very pleasing to note that three members of the Board were recognised for their contribution to society. Dr Hugh Cook AM received his award for service to medicine in the field of child and adolescent psychiatry, particularly as Chair of the Youth Suicide Advisory Committee. Mr Tony Fowke AM received his award for service as an advocate for the advancement of mental health services in Australia, and to the community and Mr John Casson AM received his award for service to the community, particularly people living with mental illness, through the establishment, provision and promotion of a range of mental health services in Western Australia.

Mr John Casson AM, Mr Tony Fowke AM and Dr Hugh Cook AM at the Investiture Ceremony held at Government House on 28 March 2003.

2. THE MENTAL HEALTH REVIEW BOARD IN REVIEW: 1997 - 2003

The Board has made very significant achievements in its six year history. At commencement, on 12 November 1997, the Board consisted of just seven members. It had a small staff, and premises selected by others. It did not have a computerised database and early reviews were all scheduled manually. When the Act commenced, the Board in fact had no members. The first Board members were appointed a week after the Act commenced.

From these humble beginnings, the Board has evolved into a responsive and well-managed organisation with its focus always on the rights and interests of the persons it was established to review, as well as the broader community.

Education Programme

Over time, the Board developed and increased its membership in all categories (psychiatrists, legal practitioners, and community members). It has engaged in an educational programme of its own members and for the broader community.

In addition to its internal education programmes, the Board has engaged in an extensive public education programme, with the President (sometimes with the assistance of the Registrar) since inception regularly providing lectures and seminars at a variety of venues in Western Australia. In addition, the President has been pleased to present papers at a number of national and international forums.

Case Tracking System

The Board's Case Tracking System (CTS) has been the lynch pin of its ability to discharge the responsibilities given to it under the Act. The Board has continuously developed and upgraded the capacity of the CTS since inception. The CTS not only enables the Board to continue to manage its significant responsibilities with minimal staffing levels, but provides a highly useful tool for the Registrar to discharge her responsibilities under the Act to, amongst other things, keep particulars of every involuntary patient and to ensure that any review required by the Act to be carried out is brought before the Board at an appropriate time.

Handbook

In April 2000, the Board published its *Handbook*, with the intention of making transparent its policies and processes. This was the first occasion in Australia in which a mental health review board or tribunal had attempted such a publication. As a result of further feedback received from interested persons, in July 2001, the Board published a revised *Handbook* which remains available on the Board's website.

Annual Meeting of Presidents and Registrars

Another initiative of the Board was the commencement of annual meetings of Presidents and Registrars/Executive Officers of Mental Health Review Boards or Tribunals. This was initiated in 1999, in conjunction with the Royal Australian and New Zealand College of Psychiatrists Congress, which was held in Perth in 1999. Since then, there has been an annual meeting of

Presidents and Registrars in different capital cities of Australia. The establishment of these meetings has enabled sharing of information and issues, and informed discussions about possible solutions to sometimes intractable problems.

Reviews and Outcomes

Reviews conducted

The Board has discharged its legislative responsibilities diligently throughout its existence, and with care. Since inception, the Board has conducted more than 4,500 reviews in a variety of settings in Western Australia. Though the majority of these reviews have been uncontentious, a significant number have been quite contentious, and this has required considerable skill and expertise by Board members to ensure not only that legislative requirements are met, but that where possible the review process is not abusive of any person.

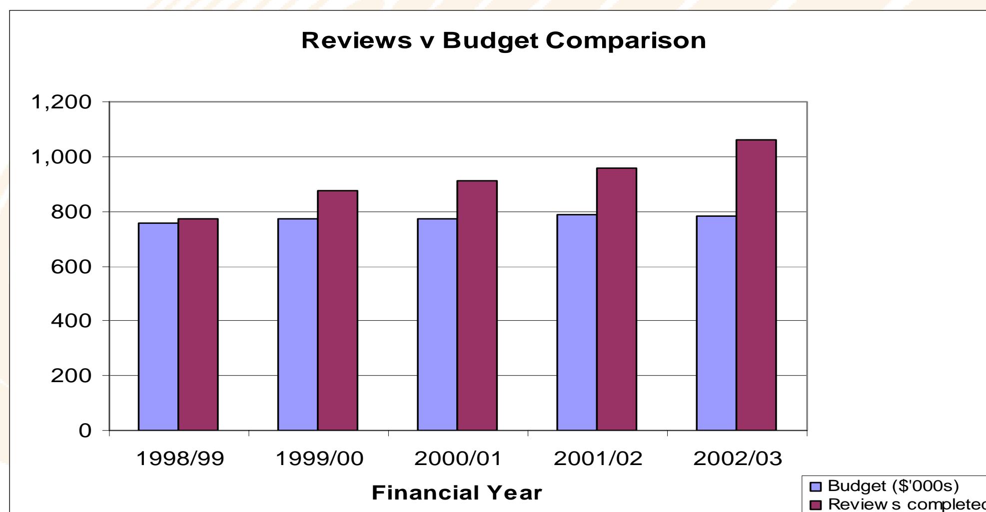
The President has been a 'hands on' manager, and has not only sat in reviews in more than 1500 matters (one third of the total) but has also utilised the experience, knowledge and expertise he has gained in the process to attain his Doctor of Philosophy degree. The thesis, entitled '*Civil commitment and review: Tensions in Law and in Practice*' demonstrates and considers in detail the legal and ethical tensions that abound in the concept of review of civil commitment.

Results of reviews

The number and percentage of persons discharged by the Board has reduced since the Board's commencement. The total number of persons discharged by the Board is 190. However, as noted in both this Annual Report and previous Annual Reports, this figure needs to be seen in context. In particular, it remains the case that approximately 65% of all involuntary (hospital) orders are discharged in the first 28 days. In addition, many persons for whom reviews are scheduled are discharged from involuntary status prior to their scheduled reviews. Thus, it is not surprising that, of those that remain, the Board continues the involuntary orders in the majority of instances. In fact, it can reasonably be suggested that the low level of discharges at reviews demonstrates that the system in Western Australia is working and working well.

Cost of reviews

Despite an increase in demand for Board services every year of its existence, the Board has completed its statutory obligations within an almost static budget. In fact, each year of the Board's existence, the Board's efficiency has improved on the prior year, an outstanding achievement as demonstrated in the following chart.



Significant Events

During its life, the Board has initiated and hosted a number of significant events, and has thus demonstrated that, far from being conservative, it has always looked to develop new opportunities. For example, in November 2000, the Board hosted a lunch held in a park near its premises, designed to facilitate discussion and consultation with a wide variety of mental health community groups. In November 2001, with similar goals in mind, the Board hosted a one day conference entitled Mental Health Law, Past Present and Future which was highly successful and which over a hundred people attended. The commencement of the Annual Meeting is another example of the Board demonstrating initiative.

Future Directions

As noted elsewhere in this Annual Report, the Government is proposing that the Board be replaced by the State Administrative Tribunal. The experience of this Board over its six year history confirms that particular care must be taken to ensure that the new entity does not become merely legalistic in its focus. Though it is right and important that a person's legal rights are protected and reviewed, it is a profound mistake to assume (as lawyers in particular are wont to do) that a patient's rights consist *only* of their legal rights. The Board's now extensive experience demonstrates that such a simplistic notion is not only inaccurate, but also potentially significantly harmful, both for the patient and for the community at large. Rather, the complex area of mental health law demonstrates conclusively that a patient's rights – of whatever nature – cannot be viewed in isolation but must be viewed in context of their other rights and the rights of others in the community. This complex contextual picture is frequently ignored by some consumer advocacy groups, who pursue single interest claims to the exclusion of all others.

Being acutely aware of these complex realities, the Board has always endeavoured to ensure that it operates in a way both respectful of all involved in a review, yet cognisant of the broader context within which a review occurs. If unintended serious consequences are to be avoided by the proposed State Administrative Tribunal, it will be essential for that new organisation to follow the path and model adopted by this Board throughout its existence.

Criticism

Given the complexities and competing irreconcilable tensions in the area of mental health law, it is not surprising that the Board has been the subject of criticism from some groups. The Board commenced its operations in a very hostile environment in which psychiatric services felt at threat and approached the Board somewhat defensively. It has been pleasing to see that psychiatric services have come to accept the Board and its role and that the Board has gained some respect for its services from psychiatric services.

Other groups too have been critical of the Board, and some continue to be so. In some instances, the Board has been criticised for not doing what it is not permitted by law to do. For example, the MHLC persists in criticising the Board for not dealing with treatment issues when there is nothing in the Act which permits the Board to do so.

In any event, the Board well recognises the tensions within the area in which it works and accepts criticism as a necessary part of its work. For example, the Board has been criticised by one erstwhile patient for discharging her from involuntary status – at her request – but who later considered that the decision was not in her best interests. The Board sees such and indeed all criticism as being an essential part of the area within which it operates and to be expected. The only disappointing issue with respect to criticism is that in many instances,

critics of the Board have never given the Board the opportunity of reply, or provided balance in their criticism. For example, whilst the Board in its one day conference in November 2001 invited persons known to be critical of the Board to speak, that same courtesy has never been provided to the Board in return. To this extent, it has been disappointing that some consumer advocacy groups, including in particular the MHLC, have chosen to criticise the Board in a less than open way. For example, the MHLC has trenchantly criticised the Board in each of its Annual Reports. However, in many instances, the material in those Annual Reports has been false or misleading, and in many instances, the MHLC has never discussed its concerns with the Board prior to publication. This is plainly unhelpful, and does not assist mental health consumers to gain a balanced perspective on the many complex issues in the area.

Dedication of Board Members and Staff

On a personal note, it has been the President's privilege to work with a group of professionals as dedicated as those on the Board. It has been gratifying that the Board has been able to attract members of such high community standing as many members of the Board, exemplified not only by the three members of the Board who have been recognised with Australian Honours but by the qualifications and experience of Board members.

It has also been the President's privilege to work with exceptionally dedicated staff members. In particular, Ms Sue Lewis has handled her many responsibilities as acting Registrar with distinction, and to her an enormous debt of gratitude is due. Similar, Mrs Jane Hall-Payn has conducted herself as acting Executive Officer with a very high level of professionalism. It is to be hoped that the capabilities of these staff members will be recognised in the proposed State Administrative Tribunal for in the end the success of the Board in meeting its statutory obligations is largely due to the dedication of these two staff members. The President is very grateful for their contribution, and assistance.

Summary

The Mental Health Review Board continues to properly perform its essential functions under the Act. The Board has established an excellent record of achievement, and has developed processes, procedures and systems and a body of knowledge which is at least comparable to those of similar Tribunals or Boards anywhere in the world. The valuable work done by the Mental Health Review Board has provided an essential base for the proposed State Administrative Tribunal.

3. 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, with appropriate statistical updates. In this way, ease of comparison with earlier Reports is maximised.

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;*

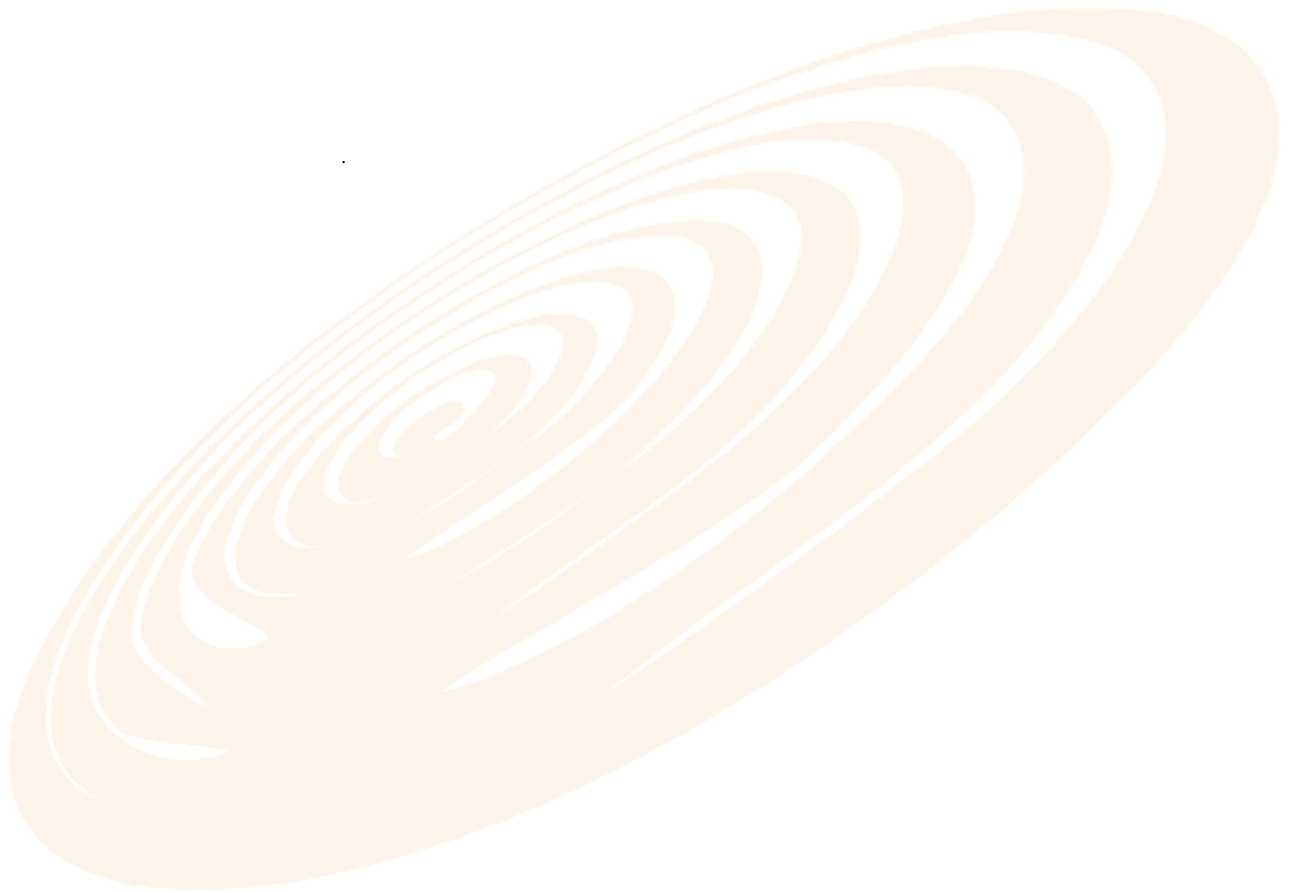
3. When the Board itself considers a further review is appropriate: *section 144.*

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 inquiry.

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



4. MEMBERSHIP OF THE BOARD

At 30 June 2003, the Board consisted of 28 members, as follows:

President
Dr Neville Barber

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

The term of appointment for Dr Jonathon Spear expired on 12 November 2002.

5. ADMINISTRATION OF THE BOARD

At 30 June 2003, the Board's administrative staff members were as follows:

President	**Dr Neville Barber**
A/Registrar	**Ms Sue Lewis**
A/Executive Officer	**Mrs Jane Hall-Payn**
Personal Assistant	None (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 total 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 63 reviews, at venues as diverse as Esperance, Albany, Derby, Kununurra, Moora, Kalgoorlie and Bunbury. 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.

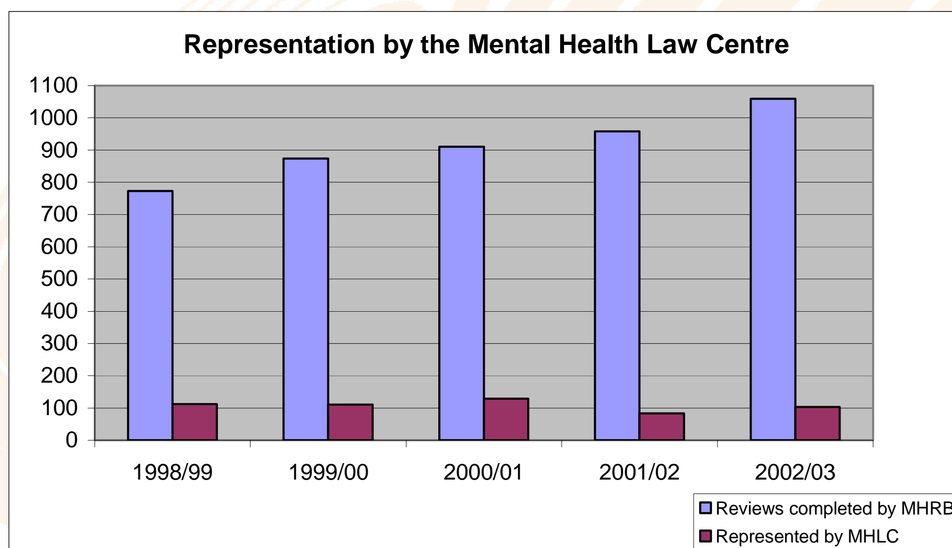
Mental Health Law Centre

In almost all cases of legal representation, the Mental Health Law Centre (MHLC) provided that representation. In total, the MHLC represented patients in 103 reviews (9.7%). Of that number, 3 reviews (2.9%) 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 96 reviews (93.2%) and involuntary status was discharged in the remaining 4 (3.8%). The Table that follows confirms the exceptionally low rate of MHLC representation.

Table 1.

Mental Health Law Centre Representation at MHRB Reviews

	1998/99	1999/00	2000/01	2001/02	2002/03
Reviews completed by MHRB	773	874	910	958	**1059**
Represented by MHLC	112	110	129	83	**103**
	14.5%	12.6%	14.2%	8.7%	9.7%



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 78 reviews (7.4%) during the year. This was a significant increase on the total of 44 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 18% 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 13 reviews this year; with the languages spoken being Somalian, Italian, Cantonese, Serbian, Vietnamese, Bosnian and Croatian.

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 69 occasions during the year, and with the permission of the patient in each instance, observers were present at reviews. Most of the observers were students, under the auspices of the MHLC or the treating service. On other occasions, the observers were new members of relevant organisations, for example, the Council of Official Visitors.

Expenditure Statement

For the period of operation from 1 July 2002 to 30 June 2003 the Board incurred operating expenditure of $825,876.

Board members were paid a total of $293,330 in remuneration, which included fees for review days, training and administrative expenses. These fees are part of the operating expenditure of the Board.

6. 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.

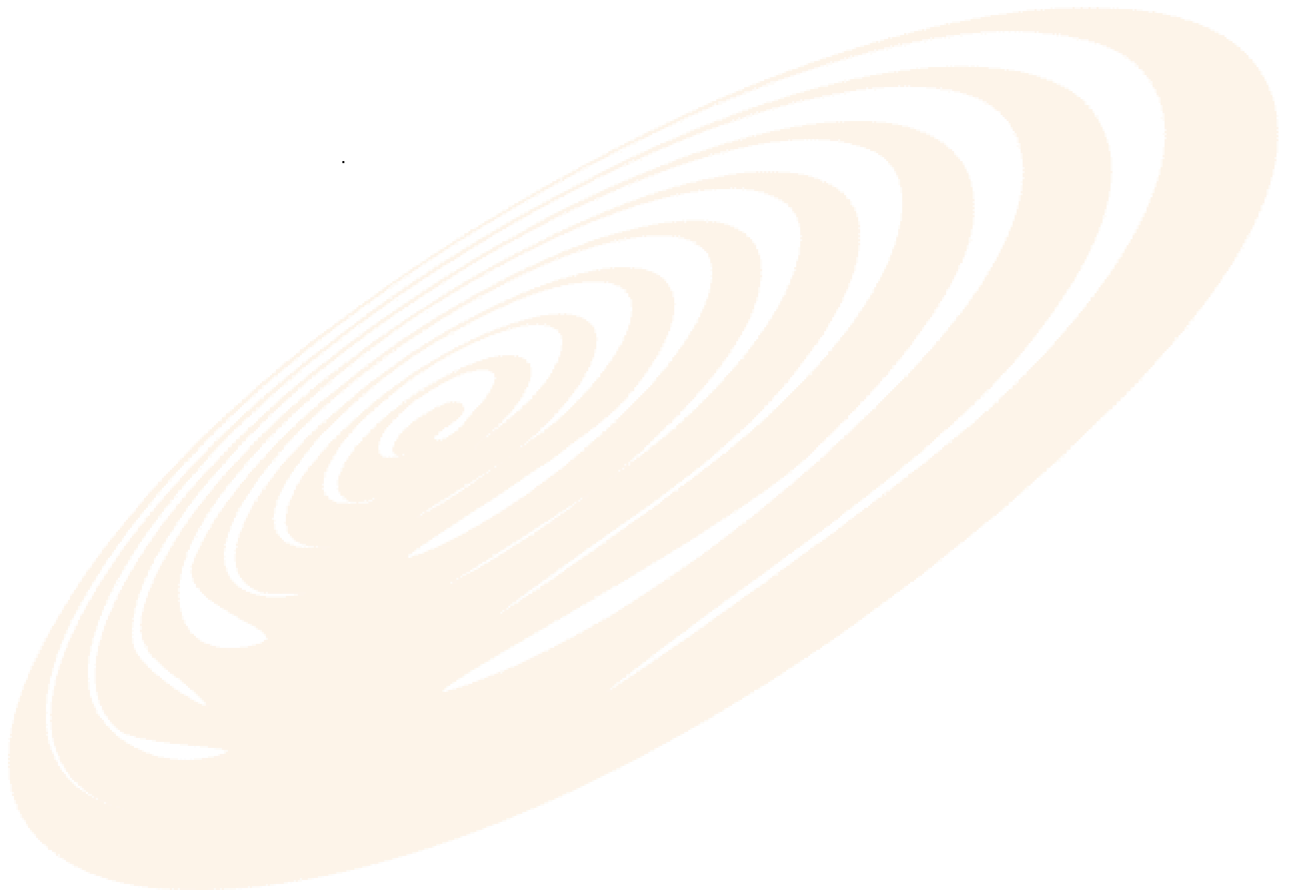
Once all relevant information has been provided, the member of the treating team and the patient may make final submissions or comments. The Board then adjourns and considers the information and makes its decision. The Board then invites the patient back and advises the patient of the decision reached 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).*

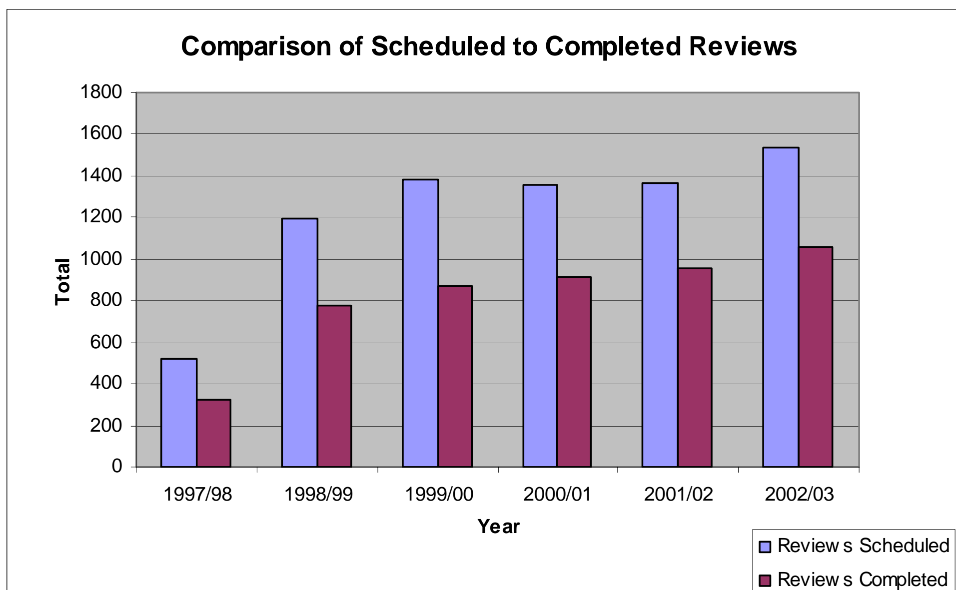


7. STATISTICAL INFORMATION

The Board conducts both periodic and requested reviews for patients who are 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 2 and 3 indicate the number and category of reviews both scheduled and completed since commencement of the Act and Board.

Table 2: demonstrates the increase in reviews completed in each year of the Board's operation.

Table 2.



1. 1997/98 figure is for a 7-month period from the Board's commencement through to 30 June 1998.

Table 3: confirms that a total of 1059 reviews were completed during the year, an increase since inception of 37%.

Table 3.

Comparison in Review Numbers						
Reviews	**1998/99**	**1999/00**	**2000/01**	**2001/02**	**2002/03**	**Variance 1998/99 and 2002/03**
Total Scheduled	1196	1379	1354	1365	1537	28.5%
Total Completed	773	874	910	958	1059	37.0%
Requested Reviews						
CTO *(Scheduled)*	41	44	58	38	73	78.0%
CTO *(Completed)*	32	39	39	23	44	37.5%
Involuntary Detained *(Scheduled)*	275	298	303	229	303	10.2%
Involuntary Detained *(Completed)*	149	156	150	110	162	8.7%
Periodic Reviews						
CTO *(Scheduled)*	263	423	439	546	550	109.1%
CTO *(Completed)*	234	325	374	463	466	99.1%
Involuntary Detained *(Scheduled)*	617	614	554	552	611	-1.0%
Involuntary Detained *(Completed)*	358	354	347	362	387	8.1%

Requested Reviews

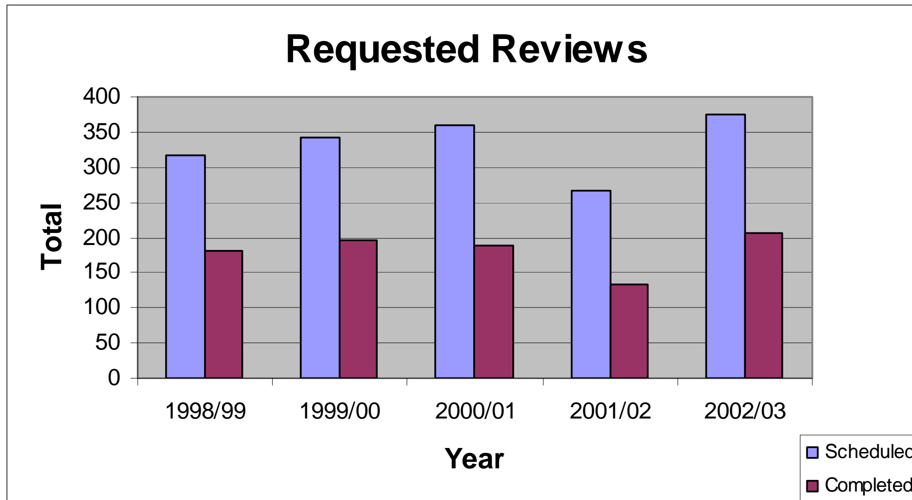
An application for review may be made by the involuntary patient, an official visitor, or any other person, such as the patient's representative, advocate or carer, whom the Board is satisfied has a genuine concern for the patient. *section 142(2).*

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 4: demonstrates the significant increase from the previous year in requested reviews scheduled and completed.

Table 4.



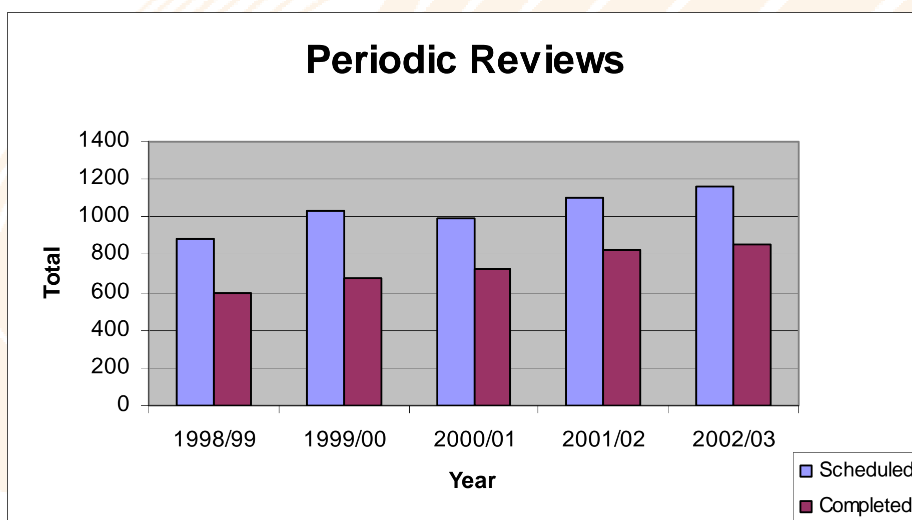
Periodic Reviews

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.*

Table 5: demonstrates that the number of periodic reviews scheduled and completed during the year increased.

Table 5.



Outcome of Reviews

Table 6: demonstrates the number of patients discharged from involuntary status by the decision of the Board at review. For 14 patients (1.3%), the Board made such an order. Of these persons, 8 were on CTOs and 6 were on involuntary detained orders. An additional 343 patients (22.3%) 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 7: 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 6.

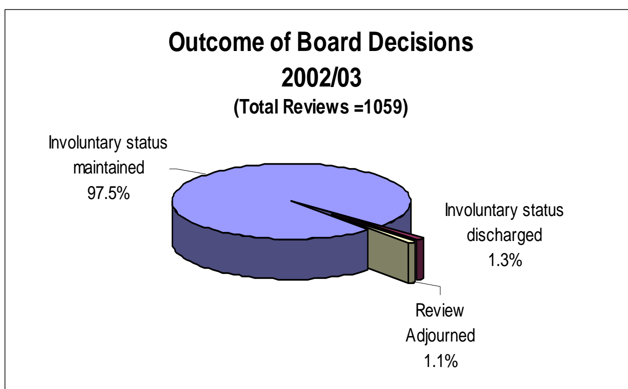


Table 7.

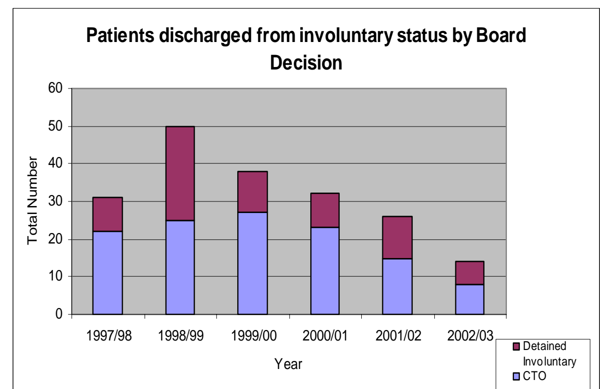
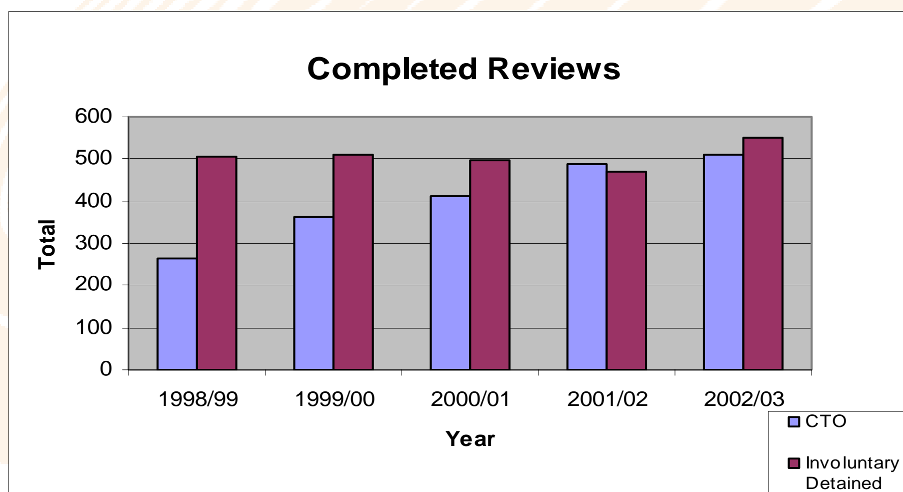


Table 8.

Completed Reviews

	1998/99	1999/00	2000/01	2001/02	2002/03	Variance (1998/99-2002/03)
CTO	266	364	413	486	510	92%
Involuntary Detained	507	510	497	472	549	8%

Table 9.



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. Though there are many reasons why a patient may choose not to attend his or her review, 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 10: 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 10.

Patient Attendance at Reviews

	1998/99	1999/00	2000/01	2001/02	2002/03
Total Reviews	773	874	910	958	1059
Detained Involuntary Reviews	507	510	497	472	549
Patient Attended	469	466	427	421	479
	92.5%	**91.4%**	**85.9%**	**89.2%**	**87.2%**
Patient Absent	38	44	70	51	70
	7.5%	**8.6%**	**14.1%**	**10.8%**	**12.8%**
Community Treatment Order Reviews	266	364	413	486	510
Patient Attended	169	197	221	253	234
	63.5%	**54.1%**	**53.5%**	**52.1%**	**45.9%**
Patient Absent	97	167	192	233	276
	36.5%	**45.9%**	**46.5%**	**47.9%**	**54.1%**
Total Patient Attendance	638	663	648	674	713
	82.5%	**75.9%**	**71.2%**	**70.4%**	**67.3%**

Patients Discharged by Psychiatrists

Table 11: 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 11.

Involuntary Orders discharged within 28 days

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Total Detained Involuntary Cases	1504	2246	2305	2360	2391	2420
Detained Involuntary	797	1428	1498	1561	1552	1507
(Discharged within 28 days)	**53.0%**	**63.6%**	**65.0%**	**66.1%**	**64.9%**	**62.3%**

1. 1997/98 figure is for a 7-month period from the Board's commencement through to 30 June 1998.

8. 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 96 occasions (9.1%). This represents an increase of 152% on the previous year, an increase almost entirely attributable to a change in MHLC policy. The MHLC now insists upon requesting Reasons in each matter in which they have involvement – regardless of whether their client requests Reasons. The result of this change in policy is that the Board has significantly increased costs for production of Reasons which, in some instances, are not required by MHLC clients.

Despite the increase in demand for Reasons brought about by this policy, the average length of time for the preparation of Reasons for the year was 20.4 days, still within the Board's policy guidelines. 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 976 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 10 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 14 occasions of the use of emergency psychiatric treatment for involuntary patients.

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 one complaint.

Complaint

The Issues
A complaint was received from a legal practitioner listing several complaints regarding alleged breaches of the Act in regards to a particular patient.

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.

- It was stated that the patient had made a request for a second opinion because of the patient's dissatisfaction with the psychiatric treatment he was receiving and that the hospital had failed to provide this.

- It was also stated that the patient in attempting to assert his right for a second opinion received a remark from a nurse that the patient had perceived as a threat, as a result he did not pursue his right to a second opinion.

The Inquiry
In response to the complaint, the Board conducted an Inquiry by writing to the relevant authorised hospital and service involved with the completion of the Forms 1 and 3 then receiving and considering their response.

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

- In response to the raised issues, the service provider who completed the Forms 1 and 3 stated it was not possible to confirm whether the patient had been given a copy of the forms, however it was their usual practice to give patients a copy when they were placed on the orders.

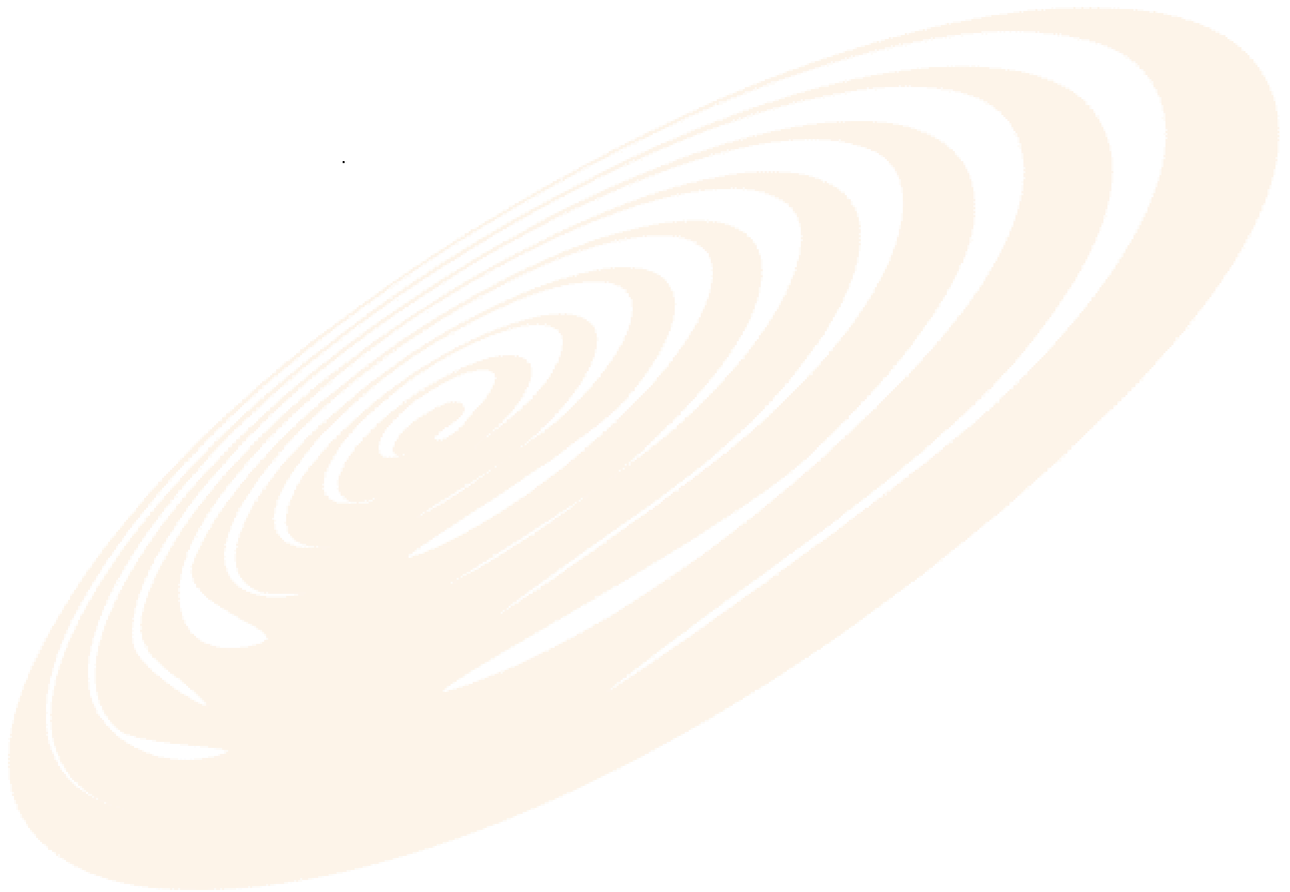
- The response from the authorised hospital in regards to the complaint that the patient was not provided with a second opinion as requested, stated that the patient had in fact been provided with a second opinion from a psychiatrist from another service.

- In relation to the complaint regarding the perceived threat from a member of the nursing staff, the matter had already been reported to the Council of Official Visitors and was being investigated as a separate complaint. Results of the investigation were not complete at the time of the reply, however the Board was advised that they would be sent directly to the patient as soon as they became available.

Apart from the alleged threat incident that had not been finalised, from the facts available to the Board, it was not possible to establish that a breach of the Act had occurred.

Supreme Court Appeal

There were no Supreme Court appeals heard in relation to mental health or Board matters during the year.



9. OTHER ACHIEVEMENTS AND ISSUES

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; Law
- 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, those Annual Reports (and in particular the Annual Report of the MHLC) contained material which was misleading and, frequently, simply wrong. Advice was provided to the MHLC about these matters, with a request that they be corrected.

The Review of the Act

As noted earlier in this Annual Report, in November 2001, the then Minister announced that he had appointed Professor D'Arcy Holman to review the Act (the review). The review became operational in the middle of 2002 and the President was invited to participate in the review by being a member of the Stakeholder Committee and by being a member of the Mental Health Review Board working party. In addition, when possible, the President has attended other working parties, including the Criminal Law (Mentally Impaired Defendants) Working Party and the Treatment Working Party.

At year's end, the review was well underway, and a great deal of discussion had ensued about various aspects of the Act. However, the capacity of Professor Holman to conduct the review in accordance with the Act appears questionable given that the Government has already decided to abolish this Board (see following).

State Administrative Tribunal Report and Subsequent Government Decisions

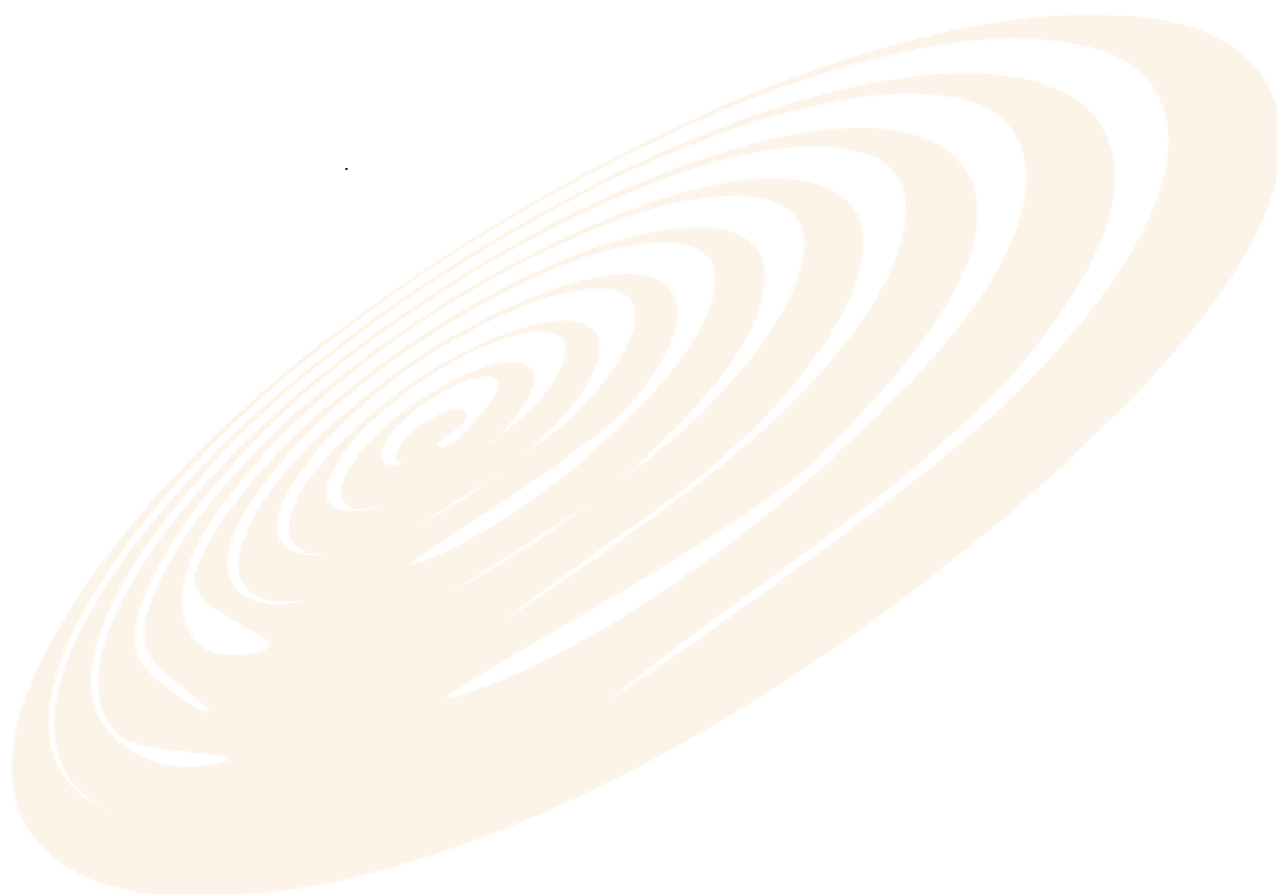
The State Administrative Tribunal Taskforce Report (otherwise known as the Barker Report) was published in July 2002.

The Barker Report discusses the establishment of a State Administrative Tribunal (SAT), to cover the functions of many current Tribunals and Boards. The Barker Report recognised the

very special jurisdiction of this Board and the Guardianship Board and specifically did not propose that the substance of the relevant legislation be altered in any way. The Barker Report in fact proposed the continued existence of this Board and the Guardianship Board, on the basis of the specialised role and the expertise built up by these two Boards. However, the Barker Report also proposed that the two Boards be co-located and aligned with SAT to achieve administrative advantage to the overall Tribunal structure.

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

However, in March 2003, the Board received advice that, in July 2002, the Government decided to abolish the Board (as well as the Guardianship Board) and fully integrate the functions of these Boards into SAT. This is a decision open to Government, but it is plainly different from the recommendations of the Barker Report. The Board hopes that there will be consultation about this change because of the unique issues faced by the Board and its clientele, and to ensure that the expertise of the Board developed over its six-year life, will be harnessed and retained in SAT. The Board will continue to work with Government to ensure that these proposed changes occur in the most effective manner.



10. REASONS FOR DECISION - CASE STUDIES

The Board does not automatically provide written reasons for decision for every determination that it makes. However, 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 Study 1

The patient had been admitted to hospital three times within six weeks in mid 2002 (during which time she had been reviewed by the Board) and was then discharged to a Community Treatment Order (CTO). About six months later, the Board again reviewed the patient's CTO.

For this second review, the patient had obtained a second psychiatric opinion and report, and its author provided information to the Board at the review by telephone.

The patient's treating psychiatrist stated that in her opinion, the patient had a diagnosis of schizophrenia and otherwise met the requirements for continuing the CTO.

The second psychiatrist stated that, in his opinion the patient's illness could best be described as brief psychotic disorder, for which she would require life-long treatment. He stated that though in his meetings with the patient, the patient was initially unconvinced of the need for an oral medication such as Stelazine, she had become more willing to accept this once he had explained the condition in detail. He believed that the patient should be given another opportunity to manage her condition effectively without the use of a CTO.

The patient stated that she had not been non-compliant with her oral medication, except on one occasion.

Section 26(1)(a) mental illness requiring treatment

The Board concluded that the patient had a mental illness as defined in the Act, (though the patient's understanding of her mental illness (however described) was an issue in some contention) and that the patient's mental illness required treatment.

Section 26(1)(b) risk and treatment and its provision

The Board concluded that the patient's mental illness required treatment and noted that despite the submission that the patient was at no risk, the second opinion provider himself considered that the patient would require life long treatment for her mental illness and that, in the absence of that treatment, the patient would be at risk.

Section 26(1)(c) consent to treatment

The patient's legal submission was that the patient was capable of consenting and had done so. In relation to the oral medication, the patient disputed that she had in the past been unconvinced of the need for medication. However, during the review, the patient stated that she was not totally happy with the doctor's decision to keep her oral medication at a particular level. The patient also maintained that there was no reason for her admissions to hospital on two occasions.

In relation to depot medications, the Board concluded that the patient would not accept depot medication as a voluntary patient.

Generally with respect to medication, the Board concluded that the patient's consent to oral medication was at best a qualified consent and that she could not be relied upon to continue to take the treatment required for her mental illness as a voluntary patient. The Board also concluded that the patient took the depot only because it was a condition of her CTO. The Board also concluded that the patient was unable to consent to treatment because her capacity to understand her mental illness was limited. The Board accepted the information provided by the supervising psychiatrist in this regard which in key aspects was corroborated by the provider of the second opinion.

Section 26(1)(d) least restrictive alternative

In relation to the issue of the least restrictive alternative, the question arose whether the Board is obliged to accept the advice of the provider of a second opinion if that advice is that there is a less restrictive alternative available for the treatment of the patient. The Board concluded that it cannot be correct that the Board is obliged to accept a less restrictive option unless it is satisfied that the less restrictive option will result in the patient continuing to adequately receive the treatment he or she requires for his or her mental illness.

The Board concluded that, having regard to the patient's impaired understanding of her mental illness, and a number of other factors, the CTO represented the least restrictive way in which the patient could continue to receive treatment necessary for her mental illness. In reaching this conclusion, the Board noted that the second opinion advocating a less restrictive alternative was based on a false premise. This opinion was based upon the second psychiatrist's understanding of the patient's perspective that involuntary hospitalisation and treatment compromised the patient's attempts to rebuild her life. However, whilst the Board had no doubt that the patient experienced trauma in being taken to hospital against her will, it concluded that the patient's attempts to rebuild her life and her employment were not put at risk by her treatment, but rather by her illness, for which the second opinion provider himself also advocated lifelong treatment.

Case Study 2

The patient had been the subject of a number of previous involuntary orders. The particular circumstances of the current order was that, though the patient had been placed on a Community Treatment Order (CTO) following an admission to hospital, at the date of the review, she had voluntarily returned to the hospital.

It was submitted on behalf of the patient that:

- The legal requirements for the CTO had not been established because the patient was being treated in hospital and therefore the requirements of section 66 of the Act were not met;
- As the patient was being treated in hospital as a voluntary patient, she did not satisfy the section 26 criteria for involuntary status.

The Board provided Reasons for Decision in this matter, and addressed the two issues raised:

1. Can a person voluntarily admitted to hospital remain on a CTO?

Pursuant to section 73(e) of the Act, a CTO ceases to have effect when the person the subject of the CTO '*is admitted to an authorised hospital as an involuntary patient*'. An involuntary patient is defined in section 3 as either a person the subject of an order under sections 43(2)(a), 49(3)(a), 50 or 70 of the Act, or a person the subject of a CTO.

Where a person under a CTO attends voluntarily at an authorised hospital and becomes a patient not subject to an order under the mentioned sections, the person continues subject to the CTO both while a patient and after discharge. However, if a person is made the subject of a detention order under the mentioned sections, the CTO permanently ceases to have effect.

The fact that a person is subject to a CTO at the time of the person's voluntary admission to hospital does not of itself trigger the application of section 73(e) because, although the person is admitted *while* an involuntary patient, he or she is not admitted *as* an involuntary patient within the meaning of section 73. In other words, section 73(e) does not apply because the provision contemplates some causal relationship between the admission and the person's involuntary patient status.

2. If a person on a CTO is voluntarily admitted to hospital, does this mean that the criteria in section 26 and section 66 cannot be satisfied?

Section 66(1)(a) of the Act requires that a psychiatrist is not to make a community treatment order in respect of a person unless satisfied that treatment in the community would not be inconsistent with the objectives set out in section 26(1)(b). That is, a psychiatrist contemplating a CTO, (and the Board reviewing a CTO), must be satisfied that treatment otherwise than as a hospital in-patient (see the definition of 'treatment in the community' in section 3) would be consistent with the protection of the safety of the patient.

In reviewing the CTO, the Board is satisfied that treatment of this patient other than as a hospital in-patient would be consistent with the objects set out in section 26(1)(b) of the Act. The Board notes that, as a voluntary patient in hospital, the patient has the choice of leaving the hospital at any time and the Board is of the view that the provision of treatment in accordance with a CTO during those times when the patient is not in hospital will not compromise the patient's safety. Section 66(1)(a) is capable of being satisfied when the patient is voluntarily in hospital, and is satisfied in the present case. That being a voluntary patient in hospital is legally compatible with a CTO is of course supported by section 73(e) itself.

Bearing in mind its determination of the issues, and the agreed factual situation before it, the Board continued the patient's CTO.

Case Study 3

The patient had been subject to earlier involuntary patient orders under the Act. Recently, the patient had been involuntarily hospitalised, and upon his discharge made the subject of a CTO.

The patient's diagnosis was bipolar affective disorder with psychotic features. The doctor provided information to the Board that the patient's initial diagnosis was an amphetamine induced manic episode. He stated that the CTO was made mainly because at the time of the patient's discharge from hospital he was still relatively unwilling to accept that he had an illness and needed medication. The patient stated that he could continue to take prescribed medication but would prefer to negotiate a reduction in the current dosage. On the patient's behalf, it was submitted that the patient accepts that his recent admission was due to drug induced psychosis, which was not itself a mental illness under the Act.

In relation to the criteria for involuntary status, the Board concluded that the patient suffers from a disturbance of thought and mood which impairs his judgment and behaviour to a significant extent. The Board accepted the doctor's evidence that the patient's symptoms of mental illness continued for more than a week after his most recent admission to hospital, and concluded that the patient's symptoms of mental illness were independent of the active use of illegal drugs or withdrawal of use of illegal drugs and that the CTO would enable to receive necessary treatment for his mental illness. However, the Board was satisfied that the patient had the ability to consent to treatment. Though the patient was proposing a reduction in medication, the doctor agreed that this was an acceptable proposal at this time and was not likely to affect the patient's continuing consent to treatment.

As the Board did not find that section 26(1)(c) of the Act was satisfied, it discharged the patient's CTO.

Case Study 4

The patient had a diagnosis of psychosis not otherwise specified. She was admitted to hospital.

The Board heard that the patient believed that her daughter was an imposter, and that other people in her life were impostors. The patient herself confirmed these views to the Board. On behalf of the patient, it was submitted that:

- Risk to reputation was a risk of self-inflicted harm. In the Act, self inflicted harm [in section 26 (2)] required three components and all three components must be fulfilled. The patient was not at risk to her reputation or finances;
- As the patient was brought up in a particular religious faith, she did not want medication at all;
- Though the notes contained many references about the patient's belief that her children were impostors, there was no reference of harm to the children;
- The patient had stopped eating meat because she did not want to eat her children. This demonstrated that the patient was not someone who would harm her children; and
- The patient was at no risk to herself or others, and should be discharged from involuntary status.

The Board concluded that the patient has a mental illness, which was not disputed.

Section 26(1) states:
A person should be an involuntary patient only if:

(b) *the treatment can be provided through detention in an authorised hospital or through a community treatment order and is required to be so provided in order –*
(ii) *to protect the person from self-inflicted harm of a kind described in subsection (2).*

Section 26 (2) states:
The kinds of self-inflicted harm from which a person may be protected by making the person an involuntary patient are:

(a) *serious financial harm;*
(b) *lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships; and*
(c) *serious damage to the reputation of the person.*

The Board concluded that it is plainly evident that not *all* of the kinds of self-inflicted harm in section 26(2) require satisfaction before section 26(1)(b)(ii) is satisfied. Rather, section 26(1)(b)(ii) states 'to protect the person from self-inflicted harm of *a* kind described in subsection (2)'. (emphasis added).

The Board concluded that the patient's mental illness requires treatment and that treatment can be provided in an authorised hospital. In reaching this conclusion, the Board accepted the opinion of the doctor that the patient's mental illness placed her and her children at risk, particularly when it was clear (and not disputed) that the patient believes her children and her parents and her boyfriend to be impostors.

For these and other reasons, the Board decided to continue the patient's involuntary status.

Case Study 5

The patient had been hospitalised involuntarily and upon discharge was placed on a CTO. On admission to hospital, the patient had been argumentative and grandiose.

There was considerable discussion at the review about the primary issue of whether the patient had a mental illness requiring treatment. The patient's niece who attended the review also stated that she did not believe that her aunt had a mental illness and her aunt was as she always had been.

The majority of the Board concluded that there was insufficient information to be satisfied that the patient had a mental illness as defined in the Act. The minority concluded that, though the patient did have a mental illness, treatment for her mental illness was not required by the use of the CTO because the risks to the patient had not been sufficiently demonstrated. Accordingly, the patient was discharged from involuntary status.

Case Study 6

The patient requested a review of her CTO. At the review, the patient denied that she had a mental illness, and said that she was at no risk and should be made voluntary. The patient's

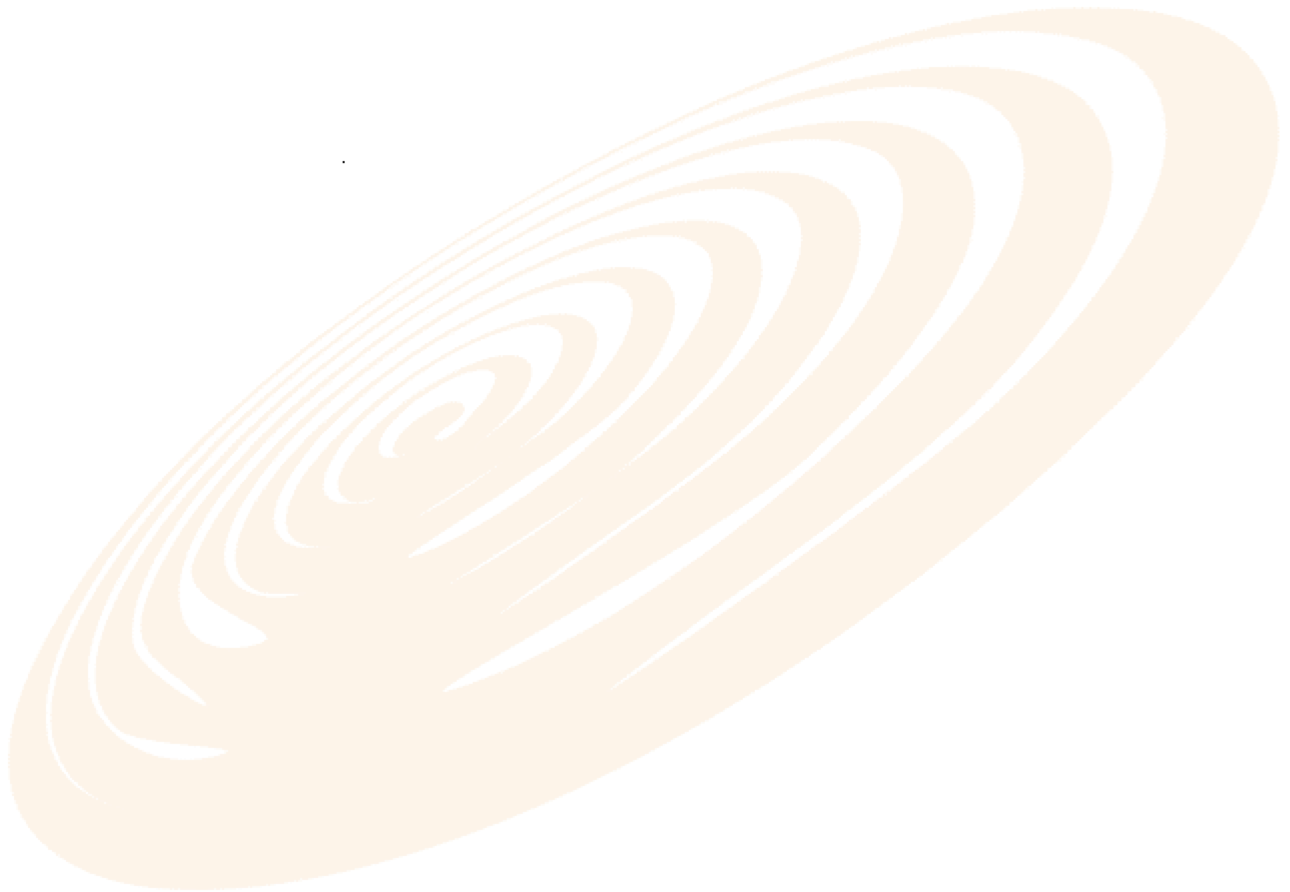
legal representative submitted that the patient had never had a mental illness and would not take medication voluntarily.

The Board concluded that the patient had a mental illness, namely delusional disorder, and accepted the information provided by the doctor (corroborated by earlier psychiatric opinion) in preference to the patient's clearly stated view that she did not have a mental illness. The Board also concluded that the other criteria for the making of the CTO were satisfied.

Case Study 7

The patient was subject to a CTO. A report indicated that the patient's discharge diagnosis was schizo-typal personality disorder. The review was a periodic review. The supervising psychiatrist told the Board that, though the patient had been discharged from hospital as a voluntary patient, it was later decided that an adequate trial of medication should be conducted, for which a CTO was utilised. However, the psychiatrist also told the Board that since the CTO had commenced, the patient had openly stated that he does not comply with prescribed medication and that regular follow up was not assisting.

The Board was satisfied that the patient had a mental illness that required treatment, even though the definitive diagnosis of the patient's mental illness remained unresolved. However, the Board was not satisfied that the treatment could be provided by use of the CTO, given that the patient was not taking the medication prescribed for him (as the treating team were aware, but had not taken any steps to ensure that prescribed treatment was taken). Accordingly, the Board discharged the patient from involuntary status.



11. 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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