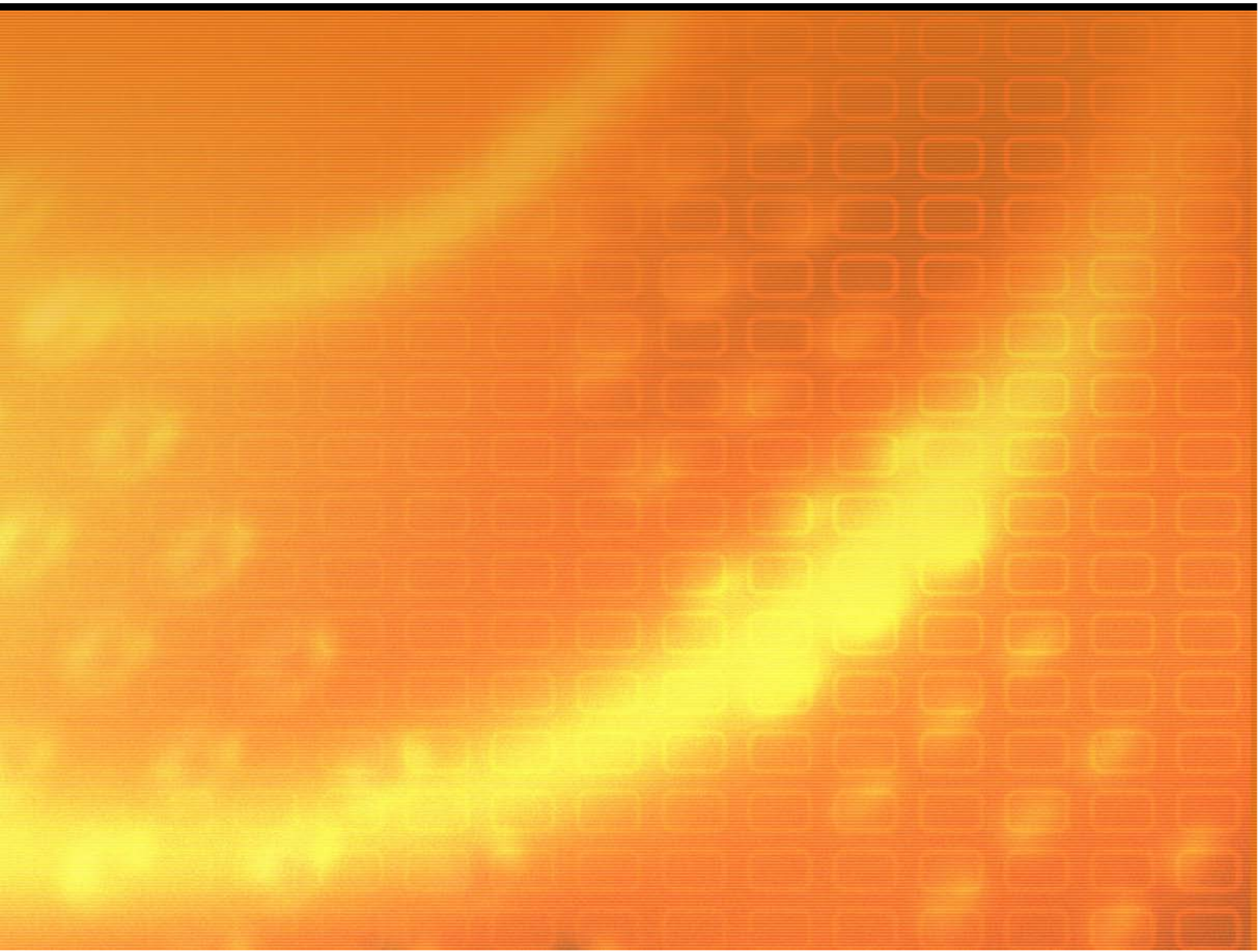
MENTAL HEALTH REVIEW BOARD

Western Australia

Annual Report 2004



To the Hon. Jim McGinty MLA
Minister for Health

Dear Minister

I am pleased to submit to you this seventh 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 2004. (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.

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.

Yours sincerely

Dr Neville Barber
PRESIDENT

CONTENT

1. 2003 - 2004 IN SUMMARY

The Board has completed its sixth 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 1743 reviews at over 32 different venues across Western Australia. Of the 1743 scheduled reviews, 1253 were completed, representing an 18.3% increase on the previous 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 Royal Australian and New Zealand College of Psychiatrists Congress in Christchurch, New Zealand in May 2004.

The President also attended the now annual meeting of Presidents and Executive Officers of Review Boards and Tribunals in Brisbane, held in June 2004.

Country Visits

During the year, the President visited Kalgoorlie and the North Western Mental Health Services (Broome and Kununurra).

Review of the Act

The Board participated in the review of the Act conducted by Professor D'Arcy Holman, which was completed during the year. Professor Holman presented his report to the Minister on 11 December 2003.

Proposed State Administrative Tribunal

During the year, legislation for the proposed State Administrative Tribunal was introduced into parliament. At year's end, the Legislation Committee of the Legislative Council was still considering the proposed legislation.

2. THE MENTAL HEALTH REVIEW BOARD IN REVIEW: 1997 - 2004

The Board has produced very significant achievements in its nearly seven year history. At commencement, on 12 November 1997, the Board had no members, its first members being appointed a week later. It had a small staff, and premises selected by others. It did not have a computerised database and early reviews were all scheduled manually.

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) 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

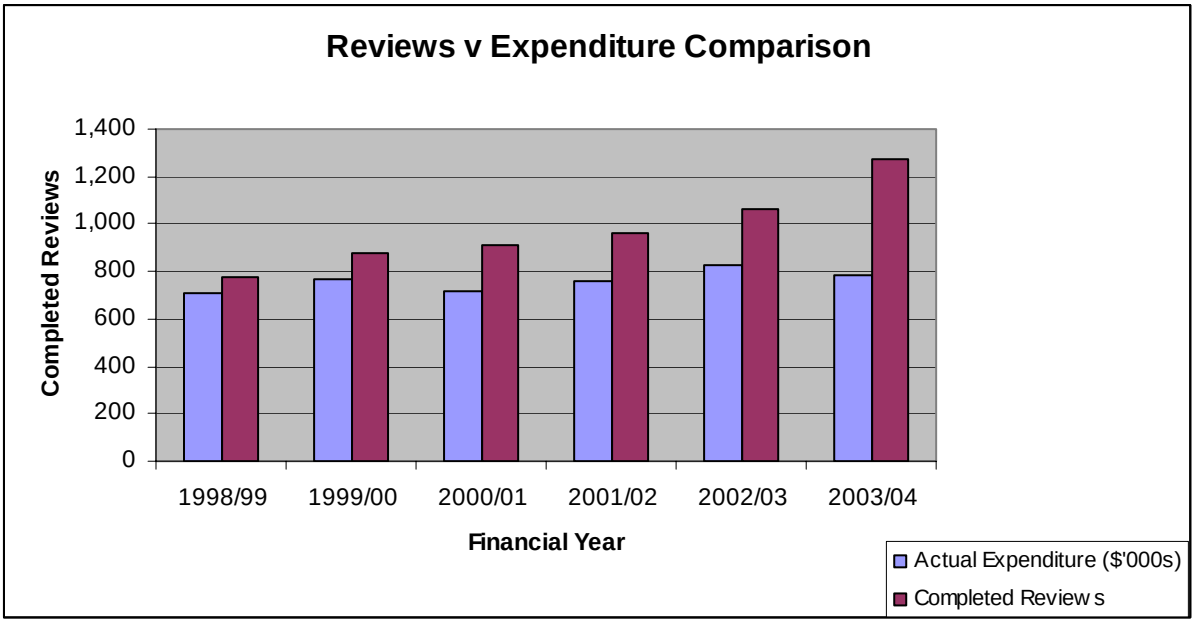
The Board has discharged its legislative responsibilities diligently throughout its existence, and with care. Since inception, the Board has conducted more than 6150 reviews in a variety of settings in Western Australia. Though the majority of these reviews have been uncontentious, a significant number 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.

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 215 to the end of this year. 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 60% 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.



Future Directions

As noted in last year's Annual Report, the Government is proposing that the Board be replaced by the State Administrative Tribunal (SAT). This proposed change, though mooted for some time, has still not occurred, and the uncertainty surrounding the implementation of SAT has been somewhat distracting.

The experience of this Board over its nearly seven 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.

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 to become 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. Similarly, Mrs Jane Hall-Payn has conducted herself as acting Executive Officer with a very high level of professionalism and Mrs Nicole Turner has performed her tasks as acting Personal Assistant with cheerfulness and enthusiasm. (If not for the uncertainty created by the proposed State Administrative Tribunal, these positions would have been advertised and substantively filled).

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 has continued to properly perform its essential functions under the Act, even in a difficult operating environment. 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 2004, the Board consisted of 25 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 2004
Ms Anne Seghezzi	12 November 2004
Mr Colin Watt	12 November 2004
Community Members	
Ms Kerri Boase-Jelinek	12 November 2004
Mr John Casson	12 November 2004
Dr Christine Choo	12 November 2004
Professor David Hawks	12 November 2004
Ms Lynne McGuigan	12 November 2004
Mr Craig Somerville	12 November 2004
Reverend Richard Williams	12 November 2004
Psychiatrist Members	
Dr Ann Bell	12 November 2004
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 John Penman	12 November 2004
Dr Nada Raich	12 November 2004
Dr Martin Sawday	12 November 2004
Dr Patricia Shalala	12 November 2004
Dr Felice Watt	12 November 2004
Dr Andy Zorbas	12 November 2004

The term of appointment for Dr Steve Patchett, Dr Mark Rooney and Dr Prue Stone concluded in November 2003. These three members are thanked for their valuable contribution to the work of the Board.

5. ADMINISTRATION OF THE BOARD

At 30 June 2004, 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 117 reviews, at venues as diverse as Wyndham, Exmouth, Kununurra, Karratha, Moora, Kalgoorlie Esperance, Albany 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.

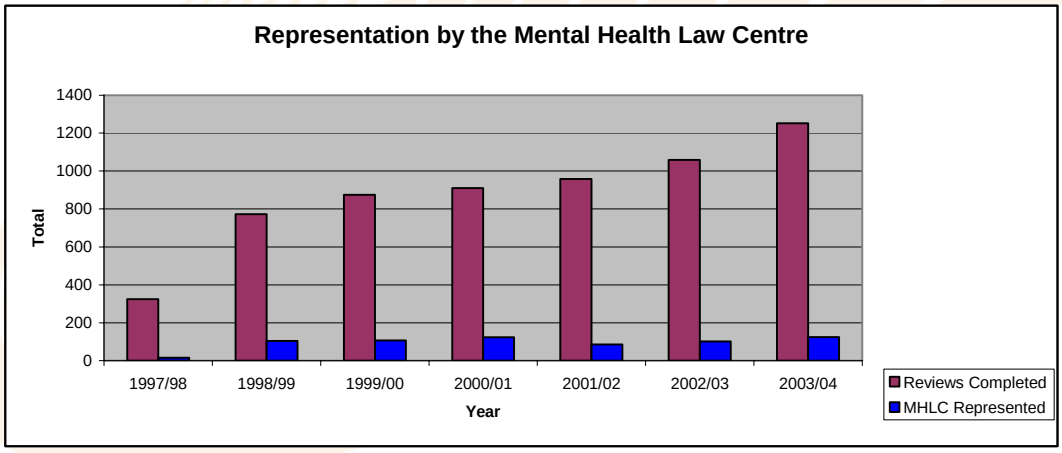
Mental Health Law Centre

In almost all cases of legal representation, the Mental Health Law Centre (MHLC) provided that representation. In total, the MHLC represented patients in 125 reviews (9.98%). Of that number, six reviews 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 114 reviews (95.8%) and involuntary status was discharged in the remaining five (4.2%). The Table that follows confirms the exceptionally low rate of MHLC representation.

Table 1 MHLC at MHRB reviews

Mental Health Law Centre Representation at MHRB Reviews

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Reviews Completed	325	773	874	910	958	1059	1253
MHLC Represented	15	105	107	124	85	102	125
	4.62%	**13.58%**	**12.24%**	**13.63%**	**8.87%**	**9.63%**	**9.98%**



Note: 1997/98 figure is from the Board's commencement through to 30 June 1998

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 105 reviews (8.38%) during the year. This was a significant increase on the total of 78 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 20% 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. This low level of support remains an ongoing concern of the Board.

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 fourteen reviews this year; with the languages spoken being Arabic, Vietnamese, Macedonian Korean, Serbian, Polish 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 fifty-eight 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 2003 to 30 June 2004 the Board incurred operating expenditure of $814,528.

Board members were paid a total of $336,046 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. Comparison of scheduled to completed reviews

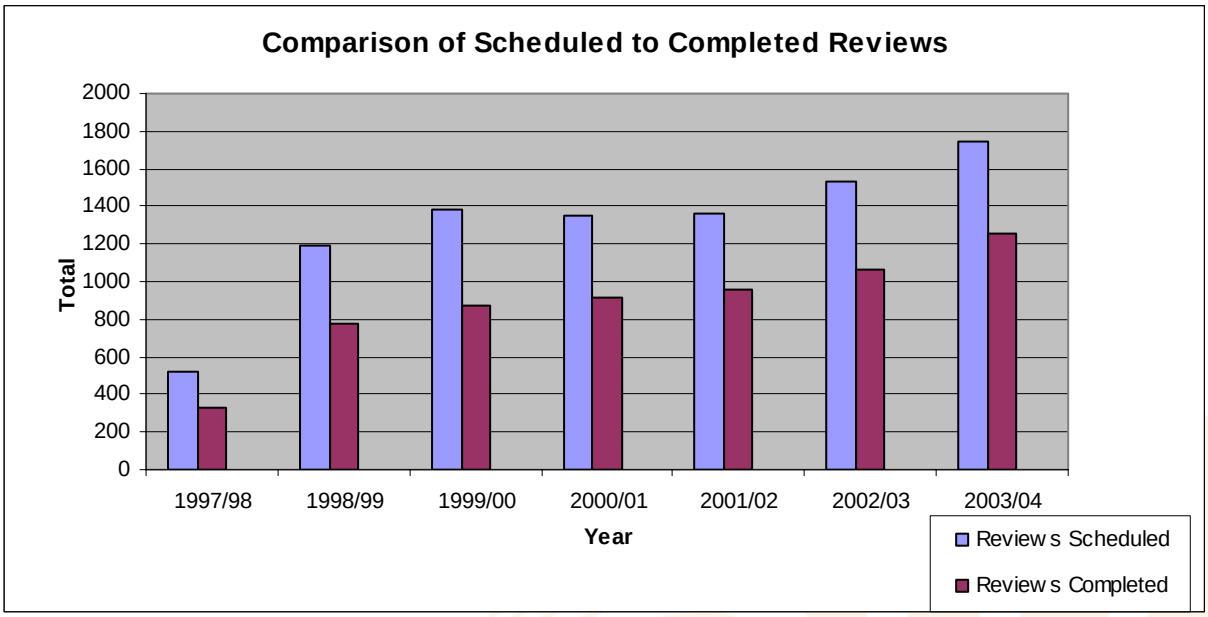


Table 3. Reviews completed

Table 3 confirms that a total of 1253 reviews were completed during the year, an increase since inception of 62 %.

Comparison in Review Numbers							
Reviews	**1998/99**	**1999/00**	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**Variance 1998/99 and 2003/04**
Total Scheduled	1196	1379	1354	1365	1537	1743	45.7%
Total Completed	773	874	910	958	1059	1253	62.1%
Requested Reviews							
CTO *(Scheduled)*	41	44	58	38	73	108	163.4%
CTO *(Completed)*	32	39	39	23	44	74	131.3%
Involuntary Detained *(Scheduled)*	275	298	303	229	303	395	43.6%
Involuntary Detained *(Completed)*	149	156	150	110	162	219	47.0%
Periodic Reviews							
CTO *(Scheduled)*	263	423	439	546	550	576	119.0%
CTO *(Completed)*	234	325	374	463	466	524	123.9%
Involuntary Detained *(Scheduled)*	617	614	554	552	611	664	7.6%
Involuntary Detained *(Completed)*	358	354	347	362	387	436	21.8%

Requested Reviews

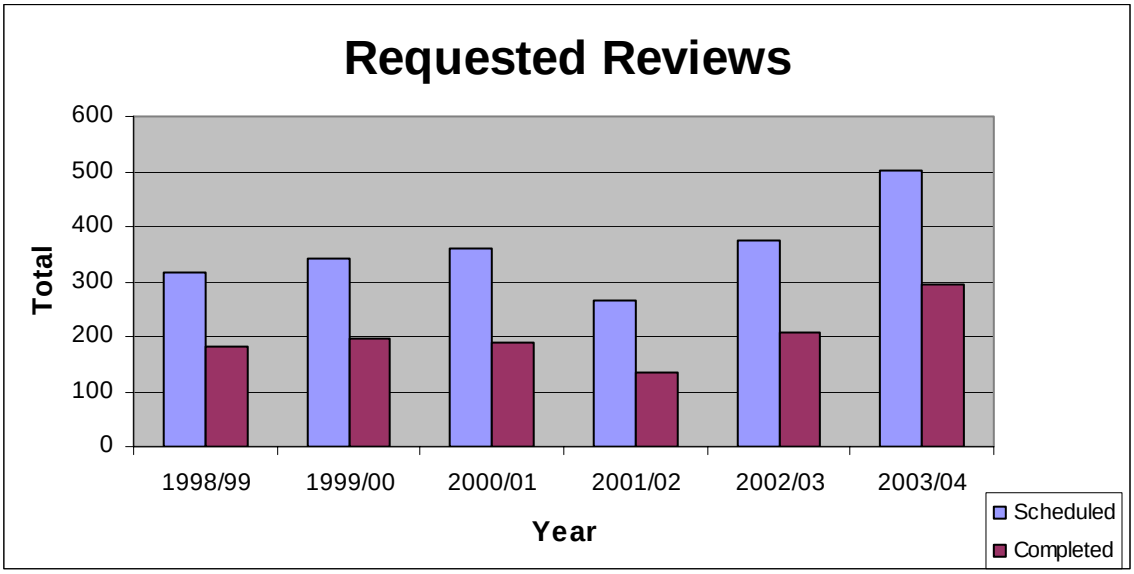
An application for review may be made by the involuntary patient, an official visitor, or any other person, such as the patient's representative, advocate or carer, whom the Board is satisfied has a genuine concern for the patient. *section 142(2).*

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. Requested reviews



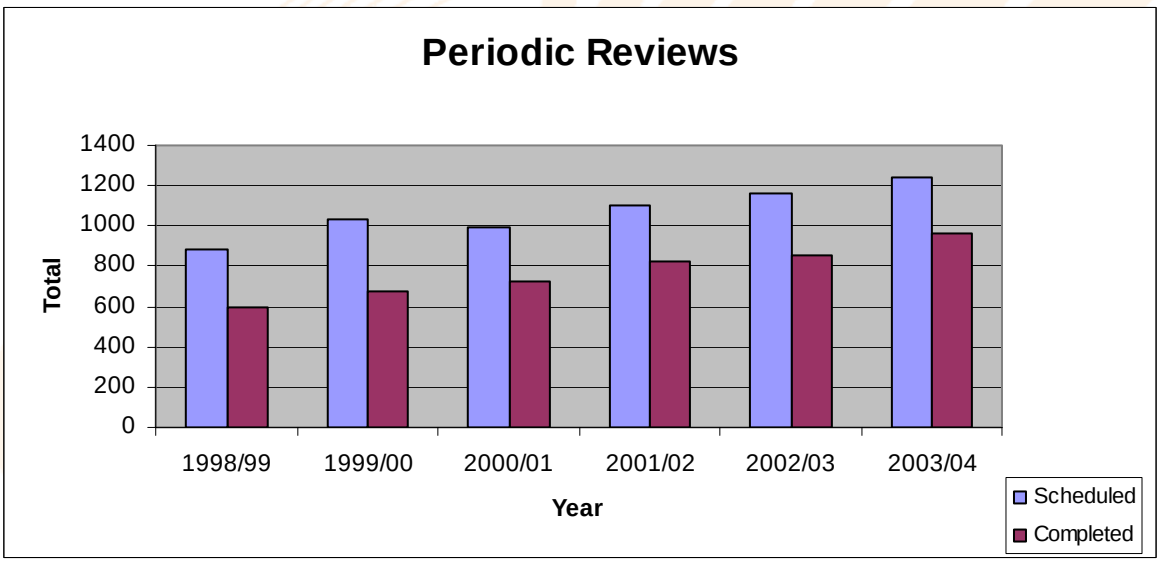
Periodic Reviews

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. Periodic reviews scheduled and completed



Outcome of Reviews

Table 6 demonstrates the number of patients discharged from involuntary status by the decision of the Board at review. For 23 patients (1.8%), the Board made such an order. Of these persons, 19 were on CTOs and four were on involuntary detained orders. An additional 317 patients (18%) 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.

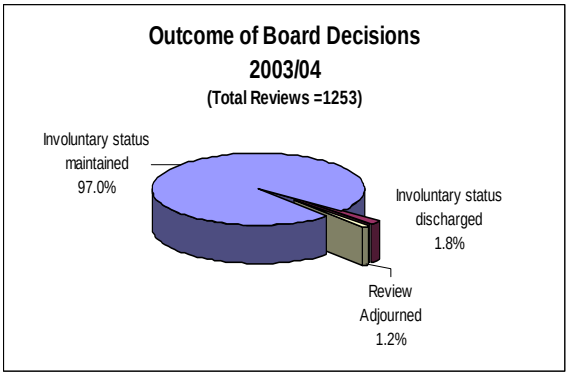


Table 7.

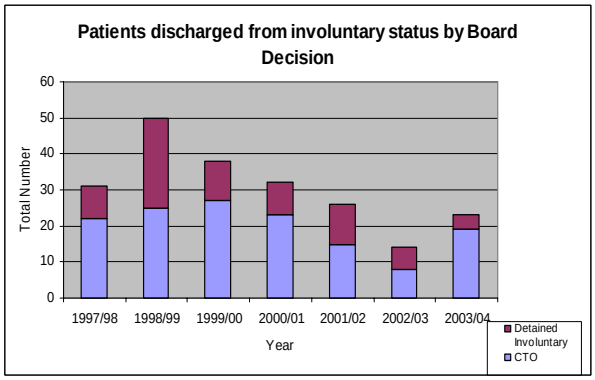
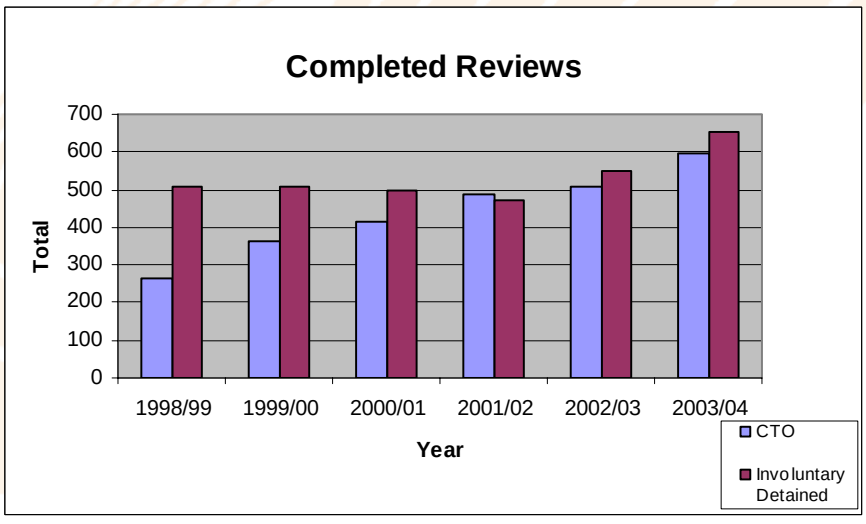


Table 8. Completed reviews

Completed Reviews

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	Variance (1998/99-2003/04)
CTO	266	364	413	486	510	598	125%
Involuntary Detained	507	510	497	472	549	655	29%

Table 9. Completed reviews



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 decrease from the first year of the Board's operation.

Table 10. Patient attendance at reviews

Patient Attendance at Reviews

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Total Reviews	773	874	910	958	1059	1253
Detained Involuntary Reviews	507	510	497	472	549	655
Patient Attended	469	466	427	421	479	568
	92.5%	**91.4%**	**85.9%**	**89.2%**	**87.2%**	**86.7%**
Patient Absent	38	44	70	51	70	87
	7.5%	**8.6%**	**14.1%**	**10.8%**	**12.8%**	**13.3%**
Community Treatment Order Reviews	266	364	413	486	510	598
Patient Attended	169	197	221	253	234	280
	63.5%	**54.1%**	**53.5%**	**52.1%**	**45.9%**	**46.8%**
Patient Absent	97	167	192	233	276	318
	36.5%	**45.9%**	**46.5%**	**47.9%**	**54.1%**	**53.2%**
Total Patient Attendance	638	663	648	674	713	848
	82.5%	**75.9%**	**71.2%**	**70.4%**	**67.3%**	**67.7%**

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 decreased in the last three years. 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

Detained Involuntary Orders

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Total Detained Involuntary Cases	1504	2246	2305	2360	2391	2420	2488
Detained Involuntary	797	1428	1498	1561	1552	1507	1470
(Discharged within 28 days)	53.0%	63.6%	65.0%	66.1%	64.9%	62.3%	59.1%

Note:1997/98 figure is for a 7-month period from the Board's commencment 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 that reasons are provided within 21 days of request.

During the year, reasons were requested on 134 occasions (10.7%). The average length of time for the preparation of Reasons for the year was 18 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 1180 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 37 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 six 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 patient's legal representative submitted a complaint under section 146 with the Board.

The complaint had five parts:

1. Failure to explain the patient's rights in relation to proceedings before the Board (this complaint alleged that the patient had a learning disability and that the notice of review should have been brought to the attention of the patient's family, and as her father was her guardian);

2. Failure to accord a right to be heard (this complaint alleged that the patient's family should have been given opportunity to present evidence at the review);

3. Failure to take into account a patient's disability (this complaint alleged that the Board should have formed the opinion that the unrepresented appearance of the patient at the review would have been detrimental to her health);

4. Failure to accord a second opinion (this complaint alleged that the authorised hospital had not provided a second opinion as requested);

5. Failure to accord the right to visitors (this complaint alleged that the authorised hospital had failed to allow the patient her right to receive visitors.

Of the five issues raised in the complaint, the first three related to the Board. The final two related to the conduct of the authorised hospital. Following investigation, the Registrar, to whom the complaint had been referred by the Board, provided a written response to the legal representative.

The legal representative was advised:

- In response to the first issue, Item 1 of the Second Schedule states that the Board is required to give notice of a review '*to a person who is a party to proceedings*'. The patient's family were not parties and indeed the patient's father did not become the patient's guardian until some months after the complaint issued. However, the Board's letter to service providers has now been amended to specifically seek information about whether a guardian has been appointed for a patient to be reviewed. Upon receipt of advice that a guardian has been appointed, the Board will also notify the guardian of the scheduled review.

- In response to the second issue, this complaint raised the same issue as the first complaint, addressed above.

- In response to the third issue, the complaint did not fall within the ambit of section 146 of the Act. Item 3 of Schedule 2 gives the Board discretion in this matter.

- In response to the fourth issue, the Board received advice that the psychiatrist 'most certainly' did interview the patient to give his second opinion. Therefore, the complaint was not substantiated.

- In response to the fifth issue, the authorised hospital advised that the patient's family had spent much time visiting the patient and further, that the section of the Act neither mentions the time that visiting should be nor regulates its duration. In all the circumstances, the complaint was not substantiated.

Supreme Court Appeal

Two appeals in relation to mental health or Board matters were filed in the Supreme Court during the year. The first of these was filed on 12 November 2003 and the second on 11 June 2004. However, neither appeal was concluded during the year and therefore neither is reported here.

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.

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.

The Review of the Act

As noted earlier, the Board participated in Professor Holman's review of the Act. Board participation consisted of the President being on the Stakeholder Committee (and, when he was unavailable Mr Tony Fowke or Ms Sue Lewis participated in his stead). The President was also a member of the Mental Health Review Board working party, and the Criminal Law (Mentally Impaired Defendant's Working Party) as well as temporarily being a member of the Treatment working party.

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

A patient was involuntarily admitted to hospital. Through her legal representative, she applied for a review.

At the review, the lawyer sought that the Board review:

- The psychiatrist's decision under section 59 to refuse the patient's request for leave from the authorised hospital for the purposes of being seen by a psychiatrist of her choice;
- The decision to refuse access to medical records and that the Board make a decision regarding the definition of 'suitably qualified person' for the purposes of section 161(3) of the Act;

- Pursuant to section 142(1)(c) the psychiatrist's decision to decline the patient's request for a transfer to another authorised hospital;

- The patient's involuntary status.

The Board's determination

1. Application for review of the decision to not release the patient's file to her

In the Board's view, and contrary to the submission received, section 142(1)(e) does not extend to permit a review by the Board of a decision not to grant document access to the patient or to a person nominated by the patient under section 161(3). It is significant in this context that sections 160 and 161 are dealing not only with involuntary patients but also with mentally impaired defendants and it is noted that the Mentally Impaired Defendants Review Board, established under the *Criminal Law (Mentally Impaired Defendants) Act 1996* does not have the power to review a decision not to grant access to documents. Further, it is noted that section 170 (which is also in Part 7) makes specific provision for review by the Board but only against an order made by a psychiatrist under section 169.

The Board's interpretation of section 142 of the Act is consistent with the Board's powers under section 145 of the Act: though section 145(1) is couched in broad terms, the examples set out in section 145(2) of the Act of specific powers which may be exercised do not suggest the broad interpretation of section 142(1)(e) proposed in the lawyer's submission. More particularly, if section 142(1)(e) was intended to permit a review by the Board of a refusal of access to documents under sections 160-161, one would have expected that the consequential powers which could be exercised by the Board in relation to documentary access would be specifically listed in section 145(2).

The Board also notes that denial of access to documentation could be the subject of a complaint made in accordance with section 146 of the Act. Section 146, in using the term 'rights given by the Act' very deliberately reflects the terminology of 'rights' equally deliberately used in section 160. It is perhaps significant in this context that section 160 in adopting the approach of recognising 'rights' in the patient rather than per se imposing obligations on the hospital or department, thereby avoids the language of 'decisions' – essential for the operation of section 142(1)(e). Therefore, it seems evident that the Board's powers do not extend to a review of the decision not to grant document access.

For these reasons, the Board concluded that it did not have the power to review the decision of the person in charge of relevant documents not to provide those documents, and therefore declined the request to do so.

2. Application for a decision about the definition of 'suitably qualified person'

Though the lawyer at the commencement of the review requested that the Board determine who constitutes a 'suitably qualified person' for the purposes of section 161 (3) of the Act, this request had not been put in writing, and thus fell outside the parameters of section 142 of the Act. It was also uncertain whether this request was continued as the patient's lawyer did not refer to it again. In all the circumstances, the Board considered that it was not required to make a determination in this regard and did not do so.

3. Application for review of the psychiatrist's decision to not allow the patient leave from the hospital

It was submitted that the Board could review the decision of the psychiatrist to not approve leave from the hospital so as to enable the patient to be seen by a psychiatrist of her choice.

During the review, the Board contemplated that this was a matter of treatment and not one it could review. However, it proceeded to hear evidence about the issue. The evidence of the hospital psychiatrist was that he had not granted the patient leave from the hospital to visit a private psychiatrist for reasons related to treatment and also practical reasons. The Board accepted the evidence that at the time the request for leave was made, the patient was too unwell to leave the authorised hospital. The Board also accepted that there were a number of practical issues that mitigated against him granting the request. These practical issues included the number of staff members that would be required to accompany the patient (and the accompanying shortage of staff members that would arise at the hospital), potential risks to those staff members, in view of the patient's alleged involvement in one violent incident, and his concerns about the patient's capacity to escape from the care of the staff members whilst outside of the authorised hospital.

In all the circumstances, the Board decided that it did have the capacity to review the decision the psychiatrist made about the patient's application for leave, sought in accordance with section 59 of the Act. However, in this instance, the Board accepted the evidence of the hospital psychiatrist as to why he had not granted the request for leave. Therefore, the Board decided not to vary the psychiatrist's decision in this regard.

4. The decision in relation to the patient's involuntary status

The Board heard a considerable amount of information in relation to the criteria for involuntary status, and decided on the basis of all information available to it that the patient's involuntary status should be continued.

Following the review, the patient was placed on a Community Treatment Order (CTO). The Board's decision was then appealed to the Supreme Court but the matter was not progressed further in that Court in the financial year. Subsequently to the filing of the appeal, the patient's CTO was revoked and she was involuntarily readmitted to hospital. At her request, a further review was held, in which the Board decided to continue the patient's involuntary status.

Case Study 2

The patient was made subject to an involuntary hospital order in August 2003 and subsequently placed on a CTO. The patient chose not to attend her first review and her involuntary status was continued. She then requested a further review, which was scheduled. At that review, the Board was provided a report which indicated that the patient had unilaterally halved the dosage of medication she had been prescribed. The patient's lawyer submitted that the patient accepted that she had a mental illness and had been compliant with medication, save for the issue mentioned, which she had brought to the attention of her psychiatrist. The Board concluded that the patient had a mental illness (not disputed) and that the patient was a risk to herself and her son in the absence of treatment. However, in relation to consent, the patient's position, supported by her mother, was that she was compliant with treatment and would continue to be compliant with treatment (including but not limited to taking medication).

There was a lack of information available to the Board about some aspects of this criterion. For example, there was no definitive information available about the extent of the patient's compliance with medication in the past (though, as noted, both the patient and her mother stated that currently she was compliant with medication). The Board also noted that the patient had, in the two years since her first involuntary admission to hospital, been treated voluntarily up until her second involuntary admission.

In all the circumstances, the Board was not persuaded that the patient would not continue her treatment in the absence of the CTO and therefore was not satisfied that this criterion had been met. Accordingly, the involuntary order was discharged.

Case Study 3

The patient was the subject of an involuntary (hospital) order under the Act and was then placed on a CTO. Prior to the review, the patient's lawyer wrote to the Board seeking that the Board review the psychiatrist's decision to not release some material from his file to the patient (though the treating psychiatrist agreed to the patient and his lawyer viewing the whole file in the presence of a psychiatrist, this was not agreed by the patient or the lawyer.

For the reasons mentioned in Case Study 1, the Board decided that it did not have the power to review the decision of a psychiatrist to not release some material to the patient. The Board then proceeded to hear other relevant information in relation to the need for the patient to remain subject to a CTO.

On the basis of the information presented to it, the Board concluded that the patient continued to satisfy the criteria for involuntary status and made an order continuing the patient's CTO.

Following this decision, the patient through his lawyer appealed to the Supreme Court. Originally, the appeal was on the grounds that the Board erred in law in finding that it did not power to review the decision to decline to provide copies of the patient's file to the patient or his nominated representative, that the Board erred in law in finding that it did not have the power to review the decision to decline access to the patient's representative nominated for the purposes of section 161(3) of the Act; and that the Board failed to accord the patient procedural fairness in that the patient was declined access to his medical records. In June 2004, the patient's lawyer amended her application but since that time, no further steps in relation to the appeal appear to have been taken. In the same period, the patient's CTO was discharged, but in April 2004 (four months later) a new CTO was written for the patient.

Case Study 4

By application, the patient's lawyer sought a review of the patient's CTO. The patient has a number of involuntary orders under the Act, going back to 1998. The patient has also had one prior completed review. On that occasion, the Board continued the patient's involuntary status.

The Board and the patient were provided a report which indicated that the patient had a diagnosis of schizophrenia and that she otherwise met the criteria for the CTO. However, during the review, the psychiatrist told the Board that, as the patient had given her commitment to continue with necessary treatment in the review, he would be satisfied with that.

The Board concluded that the patient had a mental illness best described as delusional disorder and accepted the psychiatrist's opinion in this regard (with which, the Board accepted, the patient agreed). The Board also found the risk criterion established. However, the Board accepted both the patient's statements that she would continue with necessary treatment for her mental illness and the psychiatrist's acceptance of that consent, and found that, as the patient was consenting to treatment, the consent criterion was not satisfied. Accordingly, the Board discharged the patient's CTO.

In the reporting period, the patient was not made subject to any further involuntary orders.

Case Study 5

The patient has been subject to many involuntary orders under the Act. Indeed, he has rarely not been subject to an involuntary order over the last two years and has spent much of that time in hospital. The Board has reviewed the patient on eleven previous occasions, mostly on a periodic basis, though this review was a requested review.

At the review, the patient's psychiatrist was unavailable. Present was a Registrar who had only just joined the treating team. He and another doctor (not a psychiatrist) had written and signed a report for the Board.

The patient's lawyer raised as a preliminary issue a number of issues relating to the report, and the form 9. The patient's lawyer submitted amongst other things:

- The decision to detain in the Form 9 is what is being reviewed at the hearing;
- Evidence (by report or in person) of anyone other than the consultant who formed the opinion that formed the basis of the Form 9 was objected to as insufficient – evidence from the consultant justifying the opinion is what is required;
- Alternatively, another psychiatrist (other than the one who signed the form) familiar with the patient's care – "a person who has the ability to apply the s. 26 criteria" - could give the evidence. The available doctors did not have sufficient expertise to give the evidence in their own right because they were not psychiatrists;
- An opportunity to cross-examine the consultant was required on a natural justice basis;
- In any event, evidence of the new Registrar alone was insufficient given his limited involvement with the patient.

Approach taken by Board

- As a mandatory review of the patient's status was not immediately required, the Board offered the patient the opportunity to adjourn to a date when the psychiatrist was available. However, after a short break for instructions, the patient's lawyer advised the Board that the patient wished the matter to proceed and did not wish to adjourn the hearing;

- As the objection was renewed, (though, it should be noted, the lawyer did not provide a specific section in the Act upon which he was relying in support of his objection when requested to do so), the Board determined that it would reserve its decision on the legal questions raised in the submission but that it would proceed to hear the matter so that, having in due course ruled on the legal questions, it could then proceed to complete the review on the available evidence if thought appropriate;

- The review then proceeded in the usual way with the Registrar and the patient giving evidence and the patient's lawyer asking questions and making submissions.

Decision on evidentiary point

The Board later gave its reserved decision. It found that:

Given:

- There are no statutory provisions in the Act as to the type of evidence required on review;

- The Board is required to be satisfied of section 26 matters on balance of probabilities;

- The Board is required to act according to equity and good conscience and the substantial merits of the case without regard to technicalities and legal forms;

- The Board is not constrained by rules of evidence but may inform itself as it sees fit;

- The Board is required to act fairly and in accordance with natural justice; and

- The Board is required to consider the medical and social history and the social circumstances of the patient;

The Board determined that:

- The review is not a review of the decision made by the psychiatrist at the time of the signing of the forms. It is a review as to whether the patient as at the time of the hearing should continue to be involuntary;

- It is not mandatory that evidence on review come directly by report or in person from the psychiatrist who signed the forms or any other involved psychiatrist;

- Evidence in support of involuntary status can be received from members of a treating team/medical practitioners/mental health practitioners who are familiar with the patient's situation and who can give their own evidence (opinion within their expertise, and fact) and also "secondary evidence" as to the views of the psychiatrist as to diagnosis and treatment and as to the information that has been received by other medical practitioners and mental health practitioners who have been involved with the patient and their opinions;

- The weight to be attached to such evidence is a matter for the Board to determine on each occasion;

- If the Board feels in any particular case that such evidence is insufficient and that further information is required from the consultant (or others), it can adjourn or if the patient still wishes to cross examine the consultant, an application to adjourn can be made and be either refused or agreed to by the Board.

The Board further determined that:

- The Registrar did in fact have sufficient knowledge of the patient's circumstances to provide cogent evidence to the Board;

- That their evidence in combination with the other information available to the Board (the medical case notes – to which the Board felt it could legitimately have regard, the report provided, previous reports and the information from and presentation of the patient at the hearing, satisfied the Board that the section 26 criteria had been met as detailed below;

- The evidence before the Board was such as would enable it to make a fair determination.

The Board was satisfied that the criteria for involuntary status were satisfied.

Case Study 6

The patient was subject to a CTO. She had earlier involuntary orders, including three under the Act. The Board reviewed the patient in January 2003 and continued her CTO. A further CTO was written and the patient requested a review of it.

The psychiatrist attended the review and gave evidence that the patient has chronic paranoid schizophrenia. The patient, who brought her employer to the review, disputed the diagnosis. Though the patient disputed aspects of her treatment and her diagnosis in this review, she also maintained that she had never denied that she has psychotic illness. She also emphasised that she had been carrying out her employment for four years without a CTO.

The patient's employer supported the patient. The Board concluded that the patient had a mental illness requiring treatment. In relation to consent, the Board received conflicting information about the patient's capacity to consent to treatment. The patient stated that she was consenting to treatment for her mental illness, whereas the psychiatrist had some doubts about the patient's capacity to consent to treatment, citing the patient's three periods of hospitalization within a short period of time in 2002. In the end the Board, having carefully considered all information available to it, was not satisfied that the patient could not be relied upon to continue with treatment for her mental illness but rather decided to accept the patient's assurances that she would continue with the necessary treatment for her mental illness. Accordingly, section 26 (1)(c) of the Act was not satisfied and the CTO was discharged.

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

Website: www.mhrbwa.org.au

Contact Details

Mental Health Review Board
Suite 10, Level 2
12-14 Thelma Street
WEST PERTH 6005

Telephone: (08) 9226 3255
Facsimile: (08) 9226 3277