Annual Report 2005

Mental Health Review Board
Western Australia

MENTAL HEALTH REVIEW BOARD

The Honourable Jim McGinty MLA
Minister for Health
77 St Georges Terrace
PERTH WA 6000

Dear Minister

I have pleasure in submitting to you a report from the Mental Health Review Board for the year ended 30 June 2005.

The *Mental Health Act 1996* does not require the Board to produce an annual report. However, s 148 of the Act authorises the Board to report to the Minister on any matter it thinks should be considered by the Minister - and the Board has adopted the practice of providing a report each year. This annual report is produced in the interests of accountability and openness, and so that members of the public may be better informed about the role and functions of the Board in the protection of the rights of patients under the Act. In line with government policy this report is available primarily upon the Board's website (www.mhrbwa.org.au).

As you know, the year under review was one of change for the Board. The Board physically relocated to 12 St Georges Terrace, Perth, where it is co-located with the State Administrative Tribunal, which provides administrative support for the Board. I was appointed President of the Board with effect from 1 January 2005 and I would like to take this opportunity to express my appreciation for the work done by my predecessor, Dr Neville Barber, who was President of the Board from its establishment in 1997 until December 2004. I would also like to express my appreciation for the dedicated service of Ms Sue Lewis and Ms Jane Hall-Payne, who were the Board's administrative officers for several years until early 2005.

This report provides information about the Board and its activities in the year under review and provides certain statistics for previous years for comparative purposes.

Yours sincerely

Murray Allen
PRESIDENT

11 November 2005

CONTENTS

PART 1: *MENTAL HEALTH REVIEW BOARD – ROLES AND FUNCTIONS*

The Board is established under Part 6 of the *Mental Health Act 1996* and consists of a President and other members appointed by the Governor on the recommendation of the Minister for Health. Details of the membership of the Board in the year to 30 June 2005 are set out in Part 2 of this Report.

The Act sets out the functions and powers of the Board, which include:

- The conduct of reviews of the status of all involuntary patients in accordance with the requirements of the Act: ss137 - 145. This is the most important function of the Board. Further information about this function and the Board's performance of it is set out in later parts of this Report.

- The keeping of particulars concerning every person who is an involuntary patient under the Act, based on information provided by authorised hospitals and mental health clinics: s24. The Board maintains a comprehensive, computerised database for this purpose.

- 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: s 146.

- The Minister for Health may direct the Board to enquire into any matter to do with the administration of the Act: s 147. In the year under review, there was no direction from the Minister to conduct such an enquiry.

- On the written application of an involuntary patient the Board may review any order made by a psychiatrist to restrict or deny certain entitlements granted to patients under the Act: s 170.

- The Board may approve the performance of psychosurgery on a patient: s 101. Since its establishment no application has been made to the Board to approve psychosurgery.

- The Board may consider whether electroconvulsive therapy should be performed on a patient where one psychiatrist does not approve a recommendation by another psychiatrist that the therapy be performed: s 106. Since its establishment the Board has never received a referral of such a matter for consideration.

- The Board may review a determination made by a psychiatrist that an involuntary patient is not capable of voting under the *Electoral Act 1907*: s 203. During the year the Board received the first application ever made under this provision, further details of which are set out in Part 8 of this Report as a case study.

PART 2: *MEMBERSHIP OF THE BOARD*

At 30 June 2005 the following persons were members of the Board. After 30 June 2005 Ms Dean and Mr Mansveld, both of whom are full-time members of the State Administrative Tribunal, resigned their appointments as members of the Board. The expiry date of the terms of appointment for all members of the Board is 1 January 2008.

President		Mr Murray Allen
Lawyer Members	Mr Henry Christie	Mr Tony Fowke
	Ms Hannah Leslie	Ms Anne Seghezzi
		Mr Colin Watt
Community Members	Mr Donna Dean	Ms Kerri Boase-Jelinek
	Prof David Hawks	Mr Jack Mansveld
	Ms Lynne McGuigan	Mr Craig Somerville
	Ms Josephine Stanton	Mr Gerry Warner
Psychiatrist Members	Dr Ann Bell	Dr Peter Burvill
	Dr Hugh Cook	Dr John Penman
	Dr Martin Sawday	Dr Felice Watt
	Dr Andy Zorbas	

During the year to 30 June 2005 the terms of appointment for the following Board members concluded. The valuable contribution to the Board of all these Members is greatly appreciated.

President		Dr Neville Barber
Community Members	Mr John Casson	Dr Christine Choo
		Rev Richard Williams
Psychiatrist Members	Dr Sudarshan Chawla	Dr Brendan Jansen
	Dr Christine Lawson-Smith	Dr Nada Raich
		Dr Patricia Shalala

When dealing with all matters within its jurisdiction, other than matters involving the approval of psychosurgery, the Board is required to be constituted by three members - a psychiatrist, a legal practitioner and a community member: s 129.

Board members are entitled to such remuneration and allowances as the Minister for Health from time to time determines. In May 2005 the Minister made a determination that revised the remuneration of members as set out in the previous determination of December 2000.

PART 3: *THE REVIEW OF INVOLUNTARY PATIENTS*

As noted in Part 1 of this Report, the Board's primary role under the Act is to review the status of persons who are ordered to be involuntary patients under the *Mental Health Act 1996*.

Who is an Involuntary Patient?

Under the Act a psychiatrist may order that a person be an involuntary patient by making one of two types of orders:

- that the person be admitted to, and detained in, an authorised hospital; or
- that the person be the subject of a community treatment order ("CTO") - an order that requires the patient to comply with a treatment plan specified in the CTO but which otherwise enables the patient to live in the community.

Before a person can be made an involuntary patient (of either type) the psychiatrist must be satisfied of all the requirements set out in s 26 of the Act, the terms of which are summarised on page 21 of this report.

Before a psychiatrist can make an order that a person be detained in an authorised hospital as an involuntary patient the psychiatrist must first consider whether the objectives of the Act would be better achieved by the making of a CTO for the person: s 65. A CTO is not to be made unless the psychiatrist is satisfied of various matters, including whether treatment in the community would be inconsistent with the objectives of avoiding the types of risks set out in s 26; and whether suitable arrangements can be made for the care of the person in the community.

The Types of Reviews

The Board is authorised and required under the Act to conduct reviews of the status of involuntary patients in the three situations described below.

(a) Period Reviews

The Act requires the Board to conduct a review of a patient's involuntary status within time periods prescribed in the Act, namely:

- As soon as practicable, and in any event not later than eight weeks, after the person became an involuntary patient status: s 138. Such a review is known as an ***"initial period review"***.

- If a patient's involuntary status continues beyond the initial period, then the Board is required to conduct further reviews not later than six months after the

initial period review and every six months thereafter: s 139. Such a review is known as a ***"6-month period review"***.

For the purpose of determining the timing of period reviews, the Act (s 140) provides that if a person becomes an involuntary patient again within seven days of ceasing to be an involuntary patient, then the person is taken to have been continuously an involuntary patient despite that gap.

When conducting a period review, the Board's task is to determine whether or not the order by which the patient became an involuntary patient should continue to have effect.

(b) Requested Reviews

An involuntary patient (or a member of the Council of Official Visitors, or any other person whom the Board considers has a genuine concern for the patient) may request the Board to conduct a review: s 142. Such a review is known as a ***"requested review"***. The request may be made at any time except within 28 days after the Board has made a determination that involved considering substantially the same issue as would be raised by the requested review: s 142(3). In a requested review the Board may be asked to review:

- whether a person should continue to be an involuntary patient - either detained in an authorised hospital or on a CTO;
- whether a patient detained in an authorised hospital should be transferred to another authorised hospital;
- whether the responsibility for supervising a CTO or ensuring that a patient receives the treatment specified in a CTO should be transferred to some other person; or
- any other decision made in relation to an involuntary patient: s 142(1).

(c) Own Motion Review

The Board can also conduct a review of the case of an involuntary patient at any time if the Board considers it appropriate to do so: s144.

The Board's Powers on a Review

When carrying out a review the Board may determine any matter coming before it for consideration and may make such orders in respect of the matter as it thinks appropriate, including:

- that the person is no longer an involuntary patient;
- that a CTO be made in respect of the person, including giving directions about the terms of the CTO; and
- if the person is already the subject of a CTO, varying the CTO or giving directions about it.

Scheduling of Reviews

When a person is made an involuntary patient or any subsequent orders are made continuing the person's involuntary status (such as an order extending a CTO), the Board is provided with a copy of the relevant documentation. That information is used for the purpose of scheduling reviews in accordance with the requirements of the Act.

A notice providing details of the date, time, and venue of each review, accompanied by an explanatory letter and brochure, is forwarded (approximately 7 to 14 days before the review date) to the following people:

- the patient;
- the applicant for the review (if the review has been requested by someone other than the patient);
- if the patient is detained in hospital - the treating psychiatrist and the clinical nurse specialist responsible for the patient;
- if the patient is on a CTO - the supervising psychiatrist and the responsible practitioner;
- the patient's representative (if applicable).

If the Board is aware that the patient has a guardian appointed under the *Guardianship and Administration Act 1990* then the Board will also give a notice of the review hearing to the guardian. The Board will not always be aware of such an appointment. The parents or other family members of an involuntary patient sometimes ask the Board whether they can be notified of a review hearing date. The Board encourages the attendance of family members and friends of a patient at review hearings but is unable, for reasons of confidentiality, to inform such people of the details of the review. The Board is obliged to protect the confidential nature of the hearing process and the patient's right to privacy. However, in the letter concerning the hearing sent to the treating or supervising psychiatrist, the Board requests the assistance of the psychiatrist in informing family members of the hearing details. On many occasions family members or other concerned persons do attend review hearings, further details of which are set out in Part 5 of this Report.

Venues and Teleconferencing

Involuntary patients may be detained in hospitals, or their CTOs may be supervised by mental health clinics, throughout the State - although the majority are in the metropolitan area. Accordingly, the Board must make appropriate arrangements for review hearings throughout the State.

For patients in authorised hospitals or on CTOs in the metropolitan area the Board conducts review hearings at the authorised hospital or the clinic concerned. For patients outside the metropolitan area the Board conducts review hearings by way of teleconferencing technology, which allows the patient to attend his or her local clinic or hospital for the hearing. During the year the Board conducted review hearings using teleconference facilities at 20 regional locations from Wyndham to Esperance involving 125 reviews (117 in the year to 30 June 2004).

The Board would prefer to hold all review hearings on a "face to face" basis, with all participants present in the one room - but that is simply not possible in a state the size of Western Australia. Teleconferencing allows the participants in a review to see and speak to each other despite being great distances apart and is, in the Board's opinion, preferable to holding hearings by way of the telephone alone. At times, however, difficulties in making teleconference connections can cause delays and poor picture quality can reduce the ability to see the demeanour of a person.

Interpreters

It is a fundamental principle of procedural fairness that a person about whom a decision may be made must be able to understand what is being said in a hearing. Accordingly, if the Board becomes aware that a patient who is to be reviewed, or a person who may give information to the Board at the hearing on behalf of the patient, does not fully understand the English language, then the Board will arrange for the attendance of an interpreter at the review hearing. The Board relies, primarily, on hospitals and mental health clinics to advise that an interpreter is or may be required.

During the year 24 reviews were scheduled involving interpreters in 11 languages, namely Vietnamese (8 reviews), Croatian (4), Italian (3), Swahili (2), Auslan (1), Indonesian (1), Macedonian (1), Malaysian (1), Persian (1), Serbian (1) and Somali (1).

Co-operation from Hospitals and Clinics

The Board is required to schedule and conduct many hundreds of reviews each year, both on a face-to-face basis and by teleconference. It can do so in an efficient manner only with the co-operation and assistance of the staff and management of authorised hospitals and mental health clinics – and the Board is most grateful for the high level of co-operation that it does receive. The Board considers, however, that on a small number of occasions the physical facilities and the level of co-operation and assistance provided to the Board has fallen short of what might reasonably be expected. Examples include:

- At some venues the rooms provided to the Board are not adequate for the holding of a hearing because they are too small to accommodate the Board members, patients and representatives/family, and members of the treating team who attend.

- Some rooms are inadequate in that they do not have a table that is large enough for the Board to set up its recording equipment or for Board members to set out their files and make a proper note of the matters discussed.

- In some cases the rooms are consultation/treatment rooms and may convey the impression to patients that the review hearing is connected with their treatment – and thus convey the impression that the Board is in some way connected with the hospital/clinic and is not independent.

- On occasions the report from the treating psychiatrist or other member of the treating team is not provided to the Board (or the patient) a sufficient time before the hearing and, at times, is not sufficiently comprehensive.

- In some cases no member of the treating team with up-to-date information about the patient's progress and current situation is available at the hearing to provide information needed by Board members in order to make an informed decision about the patient's involuntary status. In some cases this may require a review hearing to be adjourned.

The Board is aware that some of the above can be attributed to the limited facilities available at hospitals/clinics and to the pressure that clinicians are under because of high caseloads. The Board has, and will continue to, make its requirements known to the venues so that progress can be made in overcoming these problems. The Board considers that it is important to address these matters in an open and direct manner because the circumstances of the Board's hearings affect directly the dignity and comfort of patients and the consideration due to them at hearings.

PART 4: *STATISTICAL INFORMATION ABOUT REVIEWS*

During the year to 30 June 2005, 2988 persons commenced periods as involuntary patients as a result of orders that they be detained in an authorised hospital (2638 persons) or community treatment orders ("CTOs") (350 persons). These represent an overall increase of 8% over the previous year's corresponding figures, with increases of 6% for detained patients and 25% for CTO patients. In the same period 622 persons who had previously been detained in hospital were discharged from hospital on a CTO and 399 persons who had previously been the subject of a CTO had their CTOs extended for a further period. The position over the years is as shown in Table 4.1.

Table 4.1: Persons Commencing/Continuing Periods as Involuntary Patient

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
Involuntary status *commenced* by orders:							
• **detaining in hospital**	2246	2305	2360	2391	2420	2488	2638
• **new CTO**	120	153	165	242	249	278	350
Total	2366	2458	2525	2633	2669	2766	2988
Involuntary status *continued* by orders for:							
• **CTO on discharge from hospital**	303	370	408	474	456	623	622
• **extending a CTO**	114	189	194	257	271	363	399

An order that first makes a person an involuntary patient detained in hospital can only operate for 28 days. Before the end of that period a psychiatrist must examine the patient and decide whether to discharge the patient outright, make a CTO for the patient, or continue the person's status as an involuntary detained patient.

Many persons who are detained in an authorised hospital are discharged from involuntary status within that first 28-day period. Over the last seven years approximately 60% of all persons who are detained in hospital are discharged outright (ie they cease to be an involuntary patient) in that time period. The details are set out in Table 4.2.

Because of the relatively high discharge rate for patients detained in hospital the Board does not usually schedule initial period reviews for such patients in the first 28 days - because, on average, at least 60% of those patients will be discharged in that period. Such patients can, and many do, request reviews during that initial period.

Table 4.2: Involuntary Patients Detained in Hospital and Discharged in first 28 Days

	1998/ 99	1999/ 00	2000/ 01	2001/ 02	2002/ 03	2003/ 04	2004 /05
Number commencing as detained patients	2246	2305	2360	2391	2420	2488	2638
Number discharged outright in 28 days	1428	1498	1561	1555	1507	1470	1586
Discharge rate (%)	63.6	65.0	66.1	64.9	62.3	59.1	60.1

In addition to those patients who are discharged from involuntary status in the first 28 days, a substantial further percentage is discharged after the Board has scheduled a review but before the review is actually held. Table 4.3 shows the numbers of reviews scheduled and completed in the year under review (1826 and 1203 respectively) compared to previous years.

Table 4.3: Numbers of Reviews Scheduled and Completed

	1998 /99	1999 /00	2000 /01	2001 /02	2002 /03	2003 /04	2004 /05
Total reviews scheduled	1196	1379	1354	1365	1537	1744	1826
Total reviews completed	773	874	910	958	1059	1253	1203

The 1203 reviews completed in the year fell into the categories shown in Table 4.4

Table 4.4: Numbers and Types of Reviews Completed – 2004/05

	Total	Patients detained in hospital			Patients on a CTO		
		Requested Reviews	Initial Period Review	6-month Period Review	Requested Reviews	Initial Period Review	6-month Period Review
Number of reviews completed	1203	162	263	126	63	362	227

As indicated in Table 4.3, 623 reviews were scheduled but not completed during the year. This represents 34% of all scheduled reviews and underlines the practical difficulties encountered by the Board in the efficient scheduling and conduct of its statutory function to carry out reviews of all involuntary patients. In approximately 60% of the reviews that were cancelled the reason for the cancellation was that the patient concerned had ceased to be an involuntary patient by the appointed date for the review. Often the patient's discharge occurs on the day of, or only one or two days prior to, the review. When reviews are cancelled so close to the hearing date it is impossible for the Board to schedule a replacement review on that day.

The reasons for the cancellation of the reviews are shown in Table 4.5.

Table 4.5: Reasons for Cancellation of Review Hearing – 2004/05

Patient no longer involuntary	381
Patient discharged from hospital on a CTO	59
Cancelled at psychiatrist's request	45
Patient transferred between hospitals	30
Withdrawal of request for a review	23
Cancelled at request of patient or representative	22
CTO revoked and patient readmitted to hospital	21
Cancelled at Board's request	20
Other reason for cancellation	22
Total cancelled	623

In the case of patients discharged from an authorised hospital in the metropolitan area on a CTO, the Board will usually continue with the review hearing and not cancel it if the patient lives in the metropolitan area - and hence has the opportunity to attend the hearing. However, if the patient is discharged from an authorised hospital in the metropolitan area (where the review is scheduled to take place) and returns to his/her home in a regional centre, then the Board will usually cancel the scheduled review - because the patient would not have a reasonable opportunity to attend the hearing. Similarly, if a patient is transferred from one authorised hospital to another the review will usually be cancelled because the patient would not be able to attend a hearing scheduled to take place at the first hospital.

Outcomes of Reviews

In the vast majority of review hearings the essential issue for the Board to determine is whether the patient's status as an involuntary patient should continue. In Australia and elsewhere the proportion of cases in which a body such as the Board discharges a patient from involuntary status is relatively low. That is also the case in Western Australia. This state of affairs should not necessarily be seen as surprising or as reflecting a failure of the Board (or like entities) to carry out its duties with rigour. Mental health practitioners are now well experienced in the requirements of the Act and, given the percentages shown above of patients who are discharged from involuntary status in the first 28 days or immediately prior to the review hearings taking place, those patients who might be regarded as "borderline" will usually have been discharged by a decision of the treating psychiatrist.

As shown in Table 4.6, in the year under review the Board discharged 30 patients from involuntary status, a considerable increase on the previous year. Two of the 30 were patients detained in hospital and 28 were patients on a CTO.

Table 4.6: Patients Discharged from Involuntary Status

	1998 /99	1999 /00	2000 /01	2001 /02	2002 /03	2003 /04	2004 /05
Total reviews completed	773	874	910	958	1059	1253	1203
Patients discharged from involuntary status							
- **detained**	25	10	9	11	6	4	2
- **on CTO**	25	28	22	15	8	19	28
Total	50	38	31	26	14	23	30

Reasons for Decision

In the vast majority of cases the Board announces its decision on the review at the end of the hearing. Only very occasionally does the Board reserve its decision about a matter. When announcing its decision the Board will usually state, at least briefly, its reasons for the decision that it has made so that the patient, any representative, and members of the treating team will be able to understand why the Board has made that decision.

However, the Act (cl 15 of Schedule 2) requires the Board to provide a written statement of the reasons for a decision if a party to the proceedings requests a written statement. On occasions the Board will also prepare a statement of the reasons for a decision of its own initiative if the matter is considered to raise significant issues. The Board must also prepare a statement of reasons if an appeal against the Board's decision is lodged with the State Administrative Tribunal (see Part 6 of this Report).

In the year under review the Board prepared a written statement of reasons for its decisions on 58 occasions, a very pleasing reduction of over 50% on the number in the previous year, as is shown in Table 4.7 below.

Table 4.7: Written Statements of Reasons for Decision Prepared by the Board

	2000/01	2001/02	2002/03	2003/04	2004/05
Number of statements of reasons					
• **requested by patient or representative**					50
• **Board's own initiative**					3
• **Initiated by appeal**					5
Total Number	56	40	96	133	58

PART 5: *PATIENT ATTENDANCE AND REPRESENTATION AT REVIEWS*

At a review hearing any party to the proceedings may appear personally (unless the Board considers personal appearance would be detrimental to the health of the person), or may be represented by a legal practitioner or (with the leave of the Board) any other person.

The Board considers that it is highly desirable that patients both attend their review hearings personally and be represented at them - either by a legal practitioner or some other person. Accordingly, the Board sends to each patient (with the notice of hearing) a brochure containing the contact details of the Mental Health Law Centre and the Council of Official Visitors, both of which may be able to represent patients at review hearings.

Patient Personal Attendance at Hearings

Table 5.1 shows the number and percentages of patients who attended their review hearings in 2004/05 compared with previous years - and shows a small increase in the attendance rates for both categories of patients and overall. Not unexpectedly, a higher proportion of patients detained in hospital have consistently attended review hearings than have patients on CTOs.

Table 5.1: Patient Attendance at Review Hearings

	1998/ 99	**1999/ 00**	**2000/ 01**	**2001/ 02**	**2002/ 03**	**2003/ 04**	**2004/ 05**
Total reviews completed	773	874	910	958	1059	1253	1203
Total reviews - detained patients	507	510	497	472	549	655	551
• **Patient attended**	469	466	427	421	479	568	492
• **Patient attendance rate (%)**	92.5	91.4	85.9	89.2	87.2	86.7	89.3
Total reviews – CTO patients	266	364	413	486	510	598	652
• **Patient attended**	169	197	221	253	234	280	333
• **Patient attendance rate (%)**	63.5	54.1	53.5	52.1	45.9	46.8	51.0
Total Patient attendance	638	663	648	674	713	848	825
Overall patient attendance rate (%)	82.5	75.9	71.2	70.4	67.3	67.7	68.6

Representation and Support for Patients at Hearings

In addition to representation by the Mental Health Law Centre or the Council of Official Visitors, patients often receive support and assistance at review hearings from other sources.

Table 5.2 sets out details of the extent of representation and assistance received by patients at the various types of review hearings conducted by the Board during 2004/05. Although legal representation overall was a relatively low 8.3%, it was as high as 37% for requested reviews for patients detained in hospital. Some other form of representation or support was available in 19.0% of all reviews, rising to 46.9% for requested reviews by detained patients. It is not possible, from the data available, to calculate the proportion of all reviews attended by some person other than a lawyer to represent, support or assist the patient - because some reviews were attended by both a lawyer and some other person (such as a family member). However, the data in Table 5.2 provide a basis against which comparable figures for future years can be compared.

Table 5.2 Patients Represented or supported at Review Hearing - 2004/05

	Detained in Hospital			Community Treatment Order			Total
	Requested Review	Initial Period Review	6-month Period Review	Requested Review	Initial Period Review	6-month Period Review	
Mental Health Law Centre	60	9	3	21	4	3	100*
Council of Official Visitors	41	12	1	12	7	8	81*
Health Consumers' Council	3			2		3	8
Spouse, partner, family member	21	18	4	6	43	24	116
Friend	11	3	1		6	2	23
Aboriginal psychiatric service					1		1
Total reviews completed	162	263	126	63	362	227	1203
Rate of legal representation (%)	37	3.4	2.4	33.3	1.1	1.3	8.3
Rate of other form of representation or support (%)	46.9	12.5	4.8	31.7	15.7	16.3	19.0

*Note: In 2003/04 the Mental Health Law Centre and the Council of Official Visitors represented patients at 125 and 105 reviews respectively.

During the year the Board participated in, and partly funded, a qualitative research project with the Council of Official Visitors, the Mental Health Law Centre and the Health Consumers' Council that explored whether and why patients did or did not seek representation of some sort at review hearings, and why patients on a CTO did or did not attend the hearings. The results of the project are under consideration with a view to devising strategies that might increase the proportion of patients who attend and seek representation at reviews.

PART 6 APPEALS TO THE STATE ADMINISTRATIVE TRIBUNAL

Appeals from Decisions of the Board

Prior to 1 January 2005 a person dissatisfied with a decision of the Board could appeal the decision to the Supreme Court of Western Australia. The commencement and conduct of such an appeal was an expensive and onerous matter, and not one that a patient or family member would lightly undertake. It is not surprising, therefore, that between the Board's establishment in 1997 and the end of 2004 only a very small number of appeals were lodged with the Supreme Court and, of those, only two proceeded to a final hearing and determination by the Court. One consequence of this was that many legal issues involving the correct interpretation of the *Mental Health Act 1996* were not authoritatively determined by the Court.

With effect from 1 January 2005 amendments to the Act removed the right of appeal to the Supreme Court and replaced it with a right of appeal to the State Administrative Tribunal ("the Tribunal"). No fees are payable on the filing of such an appeal – which can be instituted by a single form. These easier and cheaper procedures have resulted in a substantial increase in the number of appeals from decisions of the Board being lodged with the Tribunal up to 30 June 2005. The Board welcomes this development because it offers the possibility of the Tribunal determining important questions of law involving the interpretation of the Act that can arise in Board proceedings.

When the Tribunal hears appeals from the Board it must do so by a panel consisting of a legal practitioner, a psychiatrist (or, in some cases, a medical practitioner who is not a psychiatrist), and a third person who is neither a legal practitioner nor a medical practitioner. The Tribunal conducts a hearing *de novo* and is not confined to matters or material that were before the Board. The purpose of the Tribunal hearing is to produce the correct and preferable decision at the time the Tribunal makes its decision. Persons who are dissatisfied with a decision of the Tribunal may appeal that decision to the Supreme Court.

Table 6.1 shows the numbers of appeals lodged with the Tribunal from decisions of the Board, and the outcomes thereof in the periods before and after 30 June 2005. By 30 June 2005 many of the appeals had been withdrawn by the applicant or dismissed by the Tribunal without a hearing of the merits of the appeal. Two appeals went to a final hearing prior to 30 June 2005 and a further one went to final hearing after that date but before 31 August 2005. In two of the three cases the Tribunal dismissed the appeal and affirmed the Board's decision. In the third case the Tribunal found that it did not have jurisdiction to determine the appeal because the patient concerned had, after the Board's decision, been discharged from involuntary status.

Table 6.1: Appeals to State Administrative Tribunal from Decisions of the Board

		Number of Appeals
• **Appeals pending in Supreme Court at 31 December 2004 and transferred to State Administrative Tribunal**		2
• **Appeals lodged 1 January 2005 to 30 June 2005**		17
		19
Finalised prior to 30 June 2005		
• **Withdrawn/Dismissed without hearing**	7	
• **Dismissed after hearing – Board's decision affirmed**	1	
• **Finding of no jurisdiction**	1	9
In progress at 1 July 2005		10
Finalised prior to 30 August 2005		
• **Withdrawn/Dismissed without hearing**	4	
• **Dismissed after hearing – Board's decision affirmed**	1	5
In progress at 31 August 2005		5

Referrals of Questions of Law to the State Administrative Tribunal for Determination

Prior to 1 January 2005 the Board had the power to state a case to the Supreme Court on a question of law arising in proceedings before the Board for the opinion of the Court. The Board did not exercise that power up to that date.

The amendments to the Act that came into effect on 1 January 2005 removed that power and, in its place, gave the Board the power to apply to the Tribunal for the determination of any question of law arising in proceedings before the Board. In the period up to 30 June 2005 the Board made one application of this kind to the Tribunal, further details of which are set out in Part 9 of this Report.

PART 7 OTHER MATTERS

Notifications to the Board

The *Mental Health Act 1996* requires the Board to be notified of the occurrence of certain types of events when they occur – both in relation to involuntary patients and persons who are not involuntary. Persons in the latter category are often those who have been referred to a hospital (either an authorised hospital or some other hospital) for examination to determine whether or not they should be made an involuntary patient – but at the time of the event occurring they have not been made involuntary. Information about the notifications received by the Board is contained in this Part and summarised in Table 7.1.

Patients Placed in Seclusion

"*Seclusion*" means "*sole confinement in a room that it is not within the control of the person confined to leave*". A patient in an authorised hospital (involuntary or otherwise) may be placed in seclusion only if it is authorised by a medical practitioner or, in an emergency, a senior mental health practitioner. Seclusion can only be used if it is necessary for the protection, safety, or wellbeing of the patient or another person. Particulars of each seclusion must be recorded, and the patient must be observed at regular intervals.

Mechanical Bodily Restraint

"*Mechanical bodily restraint*" is defined by the Act to mean restraint that prevents the free movement of a 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. A person may only be so restrained if it is authorised by a medical practitioner or, in an emergency, by a senior mental health practitioner and the restraint is necessary for the medical treatment of the patient; the protection, safety, or wellbeing of the patient or another person; or to prevent the patient from persistently destroying property.

Emergency Psychiatric Treatment

"*Emergency psychiatric treatment*" means psychiatric treatment that is necessary to save a person's life or to prevent a person behaving in such a way that can be expected to result in serious physical harm to the person or any other person. Such treatment may be given without any consent or approval that would otherwise be required if it were not emergency psychiatric treatment. A person receiving emergency psychiatric treatment may, but need not be, an involuntary patient.

It should be noted that the employment of seclusion, mechanical bodily restraint and emergency psychiatric treatment is often required on a number of occasions for the same patient, so the numbers shown in Table 7.1 do not represent the number of individual patients involved. In addition there is, inevitably, considerable overlap between the ways in which certain events can be characterised by the hospitals concerned. For example, a hospital will often send to the Board a report about emergency treatment that could have been reported as the use of seclusion or mechanical restraint. Complicating the problem of how to

characterise the particular event is the fact that the Health Department has never provided hospitals with a standard form to use when reporting these events - and the forms actually used vary considerably. Because of the variations and overlap in the way that these events are reported, the numbers shown in Table 7.1 should be regarded as an approximation only of the use of the three types of management of patients. The total number of the three types of events may provide a better picture of the overall extent of the use of these management/treatment tools than does the number for each individual type.

Table 7.1 Notifications to the Board

	2003/04	**2004/05**
Seclusion of Patients		
- **Involuntary patients**	1188	1487
- **Other patients**	459	596
Mechanical Bodily Restraints		
- **Involuntary patients**	37	20
- **Other patients**	3	2
Emergency psychiatric treatment		
- **Involuntary patients**	6	31
- **Other patients**	256	301

The review of the Act conducted by Professor Holman has recommended significant changes to the provisions of the Act relating to the use and reporting of seclusion, mechanical bodily restraints and emergency psychiatric treatment, including recommendations that the reporting should be to the Chief Psychiatrist - who should be able to prescribe standard forms to be used for reporting. The Board supports such proposals, but considers that the Board also needs to be informed of the occurrence of such events (in relation to involuntary patients) because it is relevant and useful to the Board's reviews of each involuntary patient.

Complaints to the Board

The Board is empowered by s 146 of the Act 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.

A person aggrieved by a matter arising under the Act may also complain about the issue to the Council of Official Visitors and to the Office of Health Review, which bodies also have authority to enquire into such matters. The Board has not, in recent years, received a large number of complaints and, in the year under review, received only one complaint. The complaint concerned the alleged failure to allow an involuntary patient to have access to his cigarettes, and the alleged inappropriate use of seclusion. The matter remained under examination at 30 June 2005.

PART 8 BOARD DECISIONS – CASE STUDIES

The vast majority of decisions made by the Board when conducting reviews of the status of involuntary patients turn on the particular facts of the individual case. As would be expected, the facts and circumstances of each case are unique, and the Board must make findings of the material facts, to which must be applied the relevant principles of law. Some reviews, however, raise significant questions about the correct interpretation of the *Mental Health Act 1996* in matters such as the statutory criteria for being an involuntary patient or the nature and extent of the Board's powers.

The statutory framework

In every case the Board must consider whether the requirements of the Act relating to when a person can be made an involuntary patient are satisfied. As mentioned in Part 3 of this Report a psychiatrist cannot order that a person should become an involuntary patient unless satisfied that all of the requirements set out in s 26 are satisfied. Section 26 provides that a person can be an involuntary patient only if:

> "(a) the person has a mental illness requiring treatment;
>
> (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 -
>
> (i) to protect the health or safety of that person or any other person*;*
>
> (ii) to protect the person from self-inflicted harm of a kind described in subs (2)*;* or
>
> (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*;* and
>
> (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."

The kinds of self-inflicted harm from which a person may be protected by making the person an involuntary patient are specified in the Act as:

> "(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."

Section 4 of the Act provides that a person has a mental illness (for the purposes of the Act) if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent. However, s 4 also provides that a person does not have a mental illness by reason only of one or more of the following, namely that the person:

"(a) holds, or refuses to hold, a particular religious, philosophical or political belief or opinion;

(b) is sexually promiscuous, or has a particular sexual preference;

(c) engages in immoral or indecent conduct;

(d) has an intellectual disability;

(e) takes drugs or alcohol;

(f) demonstrates antisocial behaviour".

When performing its functions under the Act the Board must seek to ensure that the objects of the Act are achieved so far as they are relevant to the performance of the Board's functions. Section 5 of the Act sets out that the objects of the Act include:

"(a) to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity;

(b) to ensure the proper protection of patients as well as the public; and

(c) to minimise the adverse effects of mental illness on family life."

If a psychiatrist proposes to make an order that a person become, or continue to be, an involuntary patient detained in an authorised hospital, the psychiatrist must first consider whether the objects of the Act would be better achieved by making a community treatment order ("CTO"). However, the psychiatrist must not make a CTO in respect of a person unless satisfied that:

(a) treatment in the community would not be inconsistent with the objective of avoiding the types of risks set out in s 26;

(b) suitable arrangements can be made for the care of the patient in the community;

(c) a suitable medical practitioner or mental health practitioner is available to ensure that the patient receives the treatment outlined in the CTO; and

(d) a psychiatrist is available to supervise the carrying out of the CTO.

The Board approaches its review function with the above statutory framework in mind. Below are some examples of decisions made by the Board during the year that were unusual, raised issues of principle, or illustrate the Board's general approach.

Case No 1: Whether the patient suffers from a mental illness – religious beliefs

The patient had many admissions to hospital under the Act or the preceding legislation, and had been diagnosed as having chronic schizophrenia. At the review hearing an important issue raised on behalf of the patient was whether or not he suffered from a mental illness for the purposes of the Act. It was contended that the patient held strong religious beliefs; believing that he was a medium for, and could communicate with, God, Jesus Christ and a deceased relative, and that his psychotic symptoms could be explained by these beliefs.

The Board was prepared to accept that the patient held religious beliefs, which might include beliefs about the ability to communicate with God or deceased persons. However, the Board considered that, whatever the substance of the patient's religious beliefs, there were aspects of his delusional thinking that were unrelated to religious ideas and which centred on deluded thoughts about the conduct of his father, his previous employer, and others, towards him now and in the past. These were matters that were not, in the Board's opinion, explicable by reference to religious beliefs or opinions. Whatever the patient's religious beliefs, they were not the only matters that were causing the substantial disturbances of mood and thought from which the patient suffered and which impaired his judgment and behaviour to a substantial extent - as evidenced by the patient becoming involved in an altercation in which he had injured his father, and his beliefs that he had recently had a large lottery win.

The Board concluded that the patient had a mental illness that required treatment, that the other requirements of s 26 of the Act were satisfied, and a CTO was not appropriate. Accordingly, the Board ordered that the applicant continue to be an involuntary patient detained in hospital. In a subsequent appeal to the State Administrative Tribunal by the patient the Board's decision was affirmed.

Case No 2: Whether the required treatment can be provided on a voluntary basis

The patient, who had a long history of admissions to hospital over many years, was the subject of a CTO. On the evidence available to Board at the review the Board was satisfied that the patient had a mental illness that required treatment. However, the evidence at the review from the supervising psychiatrist of the CTO was that the patient was currently compliant with his medication and was cooperating at a high level with the psychiatrist. The psychiatrist considered that such cooperation was more likely to continue under a voluntary arrangement than under an involuntary one - because invoking the provisions of the Act in relation to involuntary treatment aroused antagonism in the patient.

Accordingly, the Board was satisfied that the treatment required by the patient could be adequately provided to him as a voluntary patient. Because each one of the preconditions for a person to be an involuntary patient set out in s 26 must be satisfied, and one of them was not in this case, the Board made an order that the patient should no longer be an involuntary patient.

Case No 3: Whether the patient suffers from a mental illness – absence of present symptoms

This case involved a patient on a CTO, and one issue to be determined by the Board hearing was whether or not she had a mental illness that required treatment. The Board received considerable evidence that, in the recent past, the patient had been disturbed in her mood and thought - but that, as at the time of the review hearing, the patient was (albeit reluctantly) accepting her prescribed medication and was not displaying any psychotic symptoms. In those circumstances the question for the Board was whether or not the absence of symptoms at the time of the review hearing necessarily meant that the patient did not suffer from a mental illness.

The Board concluded that the absence of signs of disturbances of thought or mood and the absence of any consequential impact on judgment and behaviour did not mean that a person does not presently have a mental illness for the purposes of s 26. Although s 26 and s 4 speak in the present tense, the Board did not consider that those sections required a finding that a person does not have a mental illness if the symptoms of an underlying mental condition are controlled by medication that is received (and might not otherwise be received) as a result of being an involuntary patient. In other words, the Board did not consider that a person ceases to have a mental illness if the symptoms of that illness are under control because of medication. The Board drew an analogy with the position of a person suffering from hypertension, diabetes or a similar disorder - who does not cease to have that disorder because medication controls the symptoms of it.

On the facts of the case the Board was satisfied that the patient, in the recent past when she was not in receipt of prescribed medication, had exhibited thought disorder and disturbances of perception and mood, and that these disturbances had impaired to a substantial degree her judgment and behaviour at the time. Accordingly, the Board concluded that the patient had a mental illness for the purposes of the Act.

Case No 4: The Board's power to order that a CTO be made

This case concerned an involuntary patient who had been detained in an authorised hospital continuously for more than seven years, with a long-standing diagnosis of schizophrenia. At the review hearing the Board concluded that the patient satisfied the criteria for being an involuntary patient. However, it was contended on behalf of the patient that, instead of being detained in an authorised hospital, she should be the subject of a CTO so that she could live in the community. That raised for the Board's determination the question of whether the Board has the power to either make a CTO or to direct that a CTO be made for an involuntary patient. In the past differing opinions have been expressed, both within the Board and externally, about the Board's powers in that regard.

In the present case it was contended by the treating team that, even if the Board had the power to direct that a CTO be made, it should not exercise that power if the treating team considered that a CTO was not an appropriate vehicle for the treatment of the patient. It was submitted that, if a psychiatrist considers as a matter of clinical judgment that a CTO is

inappropriate for a particular patient, then the psychiatrist should not be placed in the position of having to make a CTO, even if the Board considers one to be appropriate.

Section 145 of the Act specifically provides that the Board may order that a CTO be made in respect of a person. The Board considered that that section, in the context of the Act as a whole, shows a clear intention that at a review of a patient detained in hospital the Board should be able to decide that the patient should remain an involuntary patient, but that he or she should be the subject of a CTO.

Necessarily, the possibility of the Board ordering that a CTO be made will only arise when the treating team does not think that a CTO is an appropriate option - because otherwise the treating team would have already made a CTO in respect of the patient. The Board considered that it is unlikely that Parliament would have intended that the power expressly given to the Board to order that a CTO be made would be rendered useless because one or more psychiatrists disagreed with the Board's opinion. The primary function and duty of the Board is to review decisions made by psychiatrists in relation to involuntary patients and to, where the Board considers it appropriate, exercise the powers conferred upon it by the Act. There will be occasions when the Board disagrees with the assessment of a psychiatrist - such as when the Board decides that the criteria for involuntary status in s 26 are not satisfied and discharges a person from being an involuntary patient.

The Board accepts that a psychiatrist is required to make clinical and ethical judgments concerning patients, but a psychiatrist who is ordered by the Board to make a CTO is in no materially different position to any other person exercising powers under a statute who is ordered by a reviewing tribunal to do something that he or she would prefer not to do. The Board noted that the Chief Psychiatrist can, under s 12 of the Act, give a psychiatrist instructions regarding the treatment of a patient and the psychiatrist must comply with those instructions.

There remains a role for the treating psychiatrist in the setting of the terms of the CTO. Subject to any directions of the Board, the psychiatrist can set terms that might be regarded as onerous to the patient. If the patient is dissatisfied with those terms then the patient can request a further review by the Board - or the Board could convene a further review on its own initiative - and the Board could, if it considers the terms of the CTO to be inappropriate, vary those terms pursuant to s 145(2)(c). Similarly, if the psychiatrist who is ordered by the Board to make a CTO is dissatisfied with that decision then the psychiatrist (or the mental health service concerned) can either request the Board to conduct a further review of the patient or appeal the Board's decision to the State Administrative Tribunal.

Accordingly, the Board was satisfied that it had the power to make an order that a CTO be made in respect of the patient. However, on the evidence before the Board, it considered that the objectives of the Act would not be better achieved by making a CTO in respect of the patient. The Board considered that the patient should continue to be detained in the authorised hospital.

Case No 5: The nature of risk factors

In the case referred to as Case No 4, another issue that arose for the Board's determination was whether psychiatric treatment was required by the patient in order to avoid certain types of risks. One of the risks identified by the treating team was that the patient was HIV positive and had, on a number of occasions when she had absconded from hospital, engaged in unprotected sexual activity. Section 4 of the Act provides that a person does not have a mental illness by reason **only** that the person is sexually promiscuous.

The Board explored with the treating team the circumstances in which the sexual activity had occurred - in relation to whether the risks that arose from that activity (to the patient's own health and safety and to others whom she might infect) were risks related to the patient's mental illness. An English author has observed, in relation to comparable provisions in English mental health legislation, that:

> *"The purpose of invoking compulsory powers is not to eliminate that element of risk in human life which is simply part of being free to act and to make choices and decisions. Rather, the purpose is to protect the individual and others from a particular and somewhat limited kind of risk - that which arises when a citizen is of unsound mind and his judgment of risk, or his capacity to control behaviour he knows puts himself or others at risk, is in consequence of this markedly impaired. The key issue is the patient's judgment and appreciation of his situation, the way in which he will use his liberty if it is restored to him and he is again free to make decisions for himself … ".* (Eldergill, *Mental Health Review Tribunals*, Sweet and Maxwell 1997 at page 728).

The Board accepted the evidence of the treating doctor that, based on his observations of the patient over many years' association, the patient's sexual behaviour occurred when she had been psychotic, unable to make judgments about her behaviour, and unable to perceive that she was being exploited by her sexual partners. The Board accepted that the patient had not made judgments to engage in unprotected sexual activity after weighing up the relative risks and benefits. Rather, the behaviour was the product of the patient's mental illness because her judgment of risk and her capacity to control behaviour that put her and others at risk was markedly impaired. Accordingly, the Board considered that the risks presented by the sexual activity to the patient's own health and safety and to others were the kinds of risks contemplated by s 26.

Case No 6: The capacity to consent to treatment

In this case the patient had a long-standing diagnosis of schizophrenia that had in the past been resistant to treatment. He was a convicted prisoner serving a long period of imprisonment and had been transferred to an authorised hospital for treatment pursuant to s 27 of the *Prisons Act 1981*. On his admission to the authorised hospital he had been made an involuntary (detained) patient and commenced on an antipsychotic medication that he had not previously received. This medication was recognised as having a number of potentially serious side - effects, and the protocols relating to its use require the patient to have blood

tests at frequent intervals as part of a monitoring process to see whether these side - effects had developed.

The treating psychiatrist informed the Board that the patient had responded very well to the new treatment and had developed considerable insight into the nature of his illness and the pros and cons of the new treatment. In particular, the psychiatrist considered that the patient was capable of consenting to the treatment that he was receiving and was, in fact, consenting to that treatment. Nevertheless, because he did not consider that the patient would receive appropriate treatment in a prison, the psychiatrist considered that the patient needed to remain as a patient in the authorised hospital – and that could only occur if he were an involuntary patient.

Because one of the preconditions in s 26 of the Act for being an involuntary patient is that the patient is either refusing to consent to treatment or is, due to the nature of the mental illness, unable to give that consent, the Board considered that the patient in question could not remain as an involuntary patient because he did not satisfy that precondition. Accordingly, the Board discharged the patient from involuntary status. In doing so the Board was conscious that the result might be that the prisoner would be returned to prison, unless administrative arrangement could be made between the prison and mental health authorities to enable the prisoner to remain in the hospital as a voluntary patient. An appeal from the Board's decision to the State Administrative Tribunal was made subsequently and remains in progress.

Case No 7: The capacity to vote

Section 201 of the Act empowers a psychiatrist to determine that an involuntary patient is not *"… capable of making judgements for the purpose of complying with the provisions of [the Electoral Act 1907] relating to compulsory voting."* If the psychiatrist so determines he/she must notify the Chief Psychiatrist who must, in turn, report to the Electoral Commissioner – who may remove the patient's name from the electoral roll. Section 203 of the Act empowers the Board to review such a determination and the Board may confirm or cancel the determination made by the psychiatrist.

On the afternoon before the polling day for the State general election in 2005 a patient at an authorised hospital contacted the Board seeking a review of a determination made by a psychiatrist that would prevent the patient voting at the election. The Board convened a panel to hear the review that afternoon and took evidence from the patient and members of the patient's treating team.

The Board was satisfied on the evidence that the patient suffered from a mental illness that involved certain delusions, but was nevertheless satisfied that the patient had a reasonable understanding of the State's parliamentary and electoral system - including the compulsory nature of voting - and an ability to nominate the electorate in which he usually resided and the name of his local member. The Board was satisfied that the patient was capable of making judgements about complying with the provisions of the Electoral Act relating to compulsory voting – and ordered that the psychiatrist's determination under s 201 be cancelled.

PART 9 COMMUNITY TREATMENT ORDERS

As mentioned in Parts 3 and 8 of this Report, before a psychiatrist can make an order that a person be an involuntary patient detained in an authorised hospital consideration must be given to whether the objectives of the *Mental Health Act 1996* would be better achieved by making the person the subject of a community treatment order ("CTO"). Many hundreds of CTOs are made each year – and some patients remain on a CTO for extended periods. An obvious benefit of a CTO is that the person can continue to live in the community rather than be detained in a hospital. However, at the same time, the person must accept the medication or other treatment specified in the CTO and will be subject to the coercive aspects of the Act should he or she not comply with the terms of the CTO.

During the year under review a number of issues relating to CTOs arose in the course of the Board's review function.

Availability of suitable accommodation

Section 66 of the Act provides that one of the matters about which a psychiatrist must be satisfied before a CTO can be made is that *"suitable arrangements can be made for the care of the patient in the community"*.

For many patients accommodation in the community will not be an issue – because they can live in their own home or with family or friends. However, a person with a mental illness will frequently require supported accommodation if he or she is to be able to live in the community and in many cases family members or friends will not be available, or able or willing, to provide such accommodation.

When mental health services in Australia were "de-institutionalised" in the past it was on the basis that adequate supported accommodation would be provided in the community to replace the institutional care that was previously the norm. Such accommodation needs to offer a range of degrees of support to patients according to their ability to look after themselves. It has often been said by observers of the mental health system that such supported accommodation has not been provided in sufficient quantities and that, as a consequence, many persons with mental illnesses who were discharged from hospital facilities in the past have been unable to find appropriate accommodation and have failed to adjust to community living. It is also said that, as a consequence, such people have frequently been returned to hospital, have fallen foul of the criminal justice system and spend considerable periods of time in prisons (which are ill - equipped to care for them), or have simply become homeless.

From the Board's perspective the issue of the lack of supported accommodation in the community is most frequently seen when reviewing the involuntary status of persons who have been detained in authorised hospitals for considerable periods of time. Members of the treating team frequently inform the Board that the patient does not need to remain as an inpatient for treatment reasons – but that, rather, the person remains in hospital only because

no suitable accommodation can be found for the person in the community. In other words, the patient could be the subject of a CTO but for the fact that suitable arrangements cannot be made for the patient's care in the community because of the absence of supported accommodation.

Many of the patients who fall into this category are eager to be discharged from hospital and are distressed that this is not possible. The patients are, due to a lack of family connections or an inability to manage their own affairs, unable to organise appropriate accommodation for themselves and are reliant on the efforts of hospital staff to make the necessary arrangements. The Board is often told that the number of beds available in hostels or other forms of supported accommodation is decreasing rather than increasing and that it is increasingly difficult for hospital social workers and other support staff to find appropriate supported accommodation in the community for inpatients who could otherwise be discharged on a CTO.

It is of concern to the Board that the objective of the Act - that persons with a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity - may be frustrated by the prolonged detention in hospital of persons who could live in the community if appropriate accommodation were available. The Board is aware of a number of initiatives announced by the Government to increase the availability of supported accommodation for persons with a mental illness and it is hoped that this will make a material difference to the numbers of patients in this position. The Board will monitor carefully progress in the achievement of those plans.

Confirmation of CTOs

Section 69 of the Act provides that (with certain exceptions) a CTO does not have effect unless, within 72 hours after it is made, it is confirmed by a second psychiatrist or, if a second psychiatrist is not "readily available", by another medical practitioner who has been authorised by the Chief Psychiatrist for that purpose.

A "psychiatrist" is defined by s 3 of the Act to mean a medical practitioner whose name is maintained in a register of psychiatrists maintained by the Medical Board of Western Australia. Section 69 of the Act empowers the Chief Psychiatrist to authorise a medical practitioner for the purposes of confirming CTOs if the medical practitioner has, in the opinion of the Chief Psychiatrist, suitable experience to decide whether a person should be the subject of a CTO.

In conducting reviews of patients on CTOs the Board became aware that on many occasions the CTO under review had been confirmed by a medical practitioner (such as a Psychiatric Registrar or a Medical Officer) who is not a psychiatrist. This occurs even though, in many cases, it appears that more than one psychiatrist is employed at the mental health clinics concerned or are employed within the public health sector in reasonably close proximity to a clinic.

Upon making enquiries the Board established that it is common practice at clinics for a patient who may become the subject of a CTO to be examined by a psychiatrist together with a medical practitioner who is not a psychiatrist - and that, for convenience, the medical practitioner present confirms the CTO rather than another psychiatrist at the clinic becoming involved in the confirmation process. In addition, the Board established that in November 1997 the then Chief Psychiatrist made an order that *"…every medical practitioner, not being a body corporate, who is registered under the Medical Act 1984 is designated as an authorised medical practitioner for the purposes of s 69 …".*

In the circumstances described above the Board was concerned that CTOs confirmed in this way may not be valid and that, consequently, the persons who were the subject of the CTOs may not be involuntary patients at all. The Board identified three questions of law that appeared relevant to the issues, and applied to the State Administrative Tribunal for the determinations of those questions. The questions are:

1. On the basis of a finding of fact by the Board that more than one psychiatrist is employed at or in reasonable proximity to a mental health clinic, whether it can be said that another psychiatrist was not readily available, as required by s 69.

2. Whether the authorisation of all medical practitioners, without any apparent consideration of their individual experience or expertise in relation to the requirements of the Act, was a valid exercise of the power to authorise conferred by s 69.

3. If the confirmation of CTOs described above was not in compliance with the requirements of s 69 – either because a second psychiatrist was readily available or because the medical practitioner who confirmed the CTO was not authorised to do so - whether the CTOs were invalid by reason of that non - compliance.

As at June 2005 the Board's application to the State Administrative Tribunal was proceeding and since that date a final hearing has occurred. The Tribunal's decision is awaited and should remove the uncertainty about the validity of the CTOs in question identified by the Board.

Documentation of CTOs

In the course of reviewing patients on CTOs the Board also became aware that in some cases the particulars required to be included in the document recording the CTO were incorrect or absent. Accordingly, the Board reviewed 42 CTO forms that were received by the Board in a two - week period in April 2005 to assess the extent to which they were properly documented. The Board accepts that the sample involved may not necessarily be a representative one, but it provided some preliminary indication of deficiencies in the documentation of CTOs.

Some of the deficiencies identified from the review sample were:

- In four cases the duration of the CTO (the Act permits a maximum of three months) was incorrectly specified.

- In nine cases the CTO form did not specify the name of a responsible practitioner who was to ensure that the patient received the treatment outlined in the CTO.

- In 11 cases the degree of specification of the treatment plan was not sufficient.

Section 212 of the Act enables the rectification of orders that suffer from formal defects in the nature of a clerical error or an error arising from any accidental omission. The Board has regarded some of the deficiencies in CTO documentation identified at review hearings as capable of being rectified pursuant to that section (such as the accidental writing of one date when a different date was intended) but has taken the view that s 212 cannot be used to rectify a deficiency such as the omission of the name of a responsible practitioner.

The Board has informed the Chief Psychiatrist of the prevalence of deficiencies of the type referred to above and has assisted the Chief Psychiatrist in formulating a notice to practitioners reinforcing the need for proper documentation of CTOs. During the 2005/06 year the Board will conduct a further survey of CTO documentation over a longer period once the decision of the State Administrative Tribunal on the questions of law referred to above has been received. The results of the survey will be shared with the Chief Psychiatrist so that remedial action, if needed, can be taken.

PART 10 CONTACT AND OTHER INFORMATION

The Board maintains a website (www.mhrbwa.org.au) that contains information about the Board and its activities, in particular in relation to the conduct of reviews of the status of involuntary patients. The website also contains previous Annual Reports, which contain additional information about the Board's activities in previous years.

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