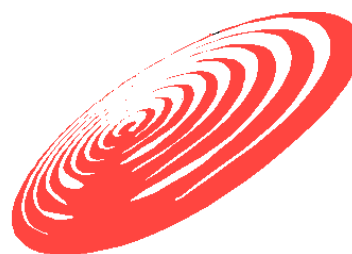
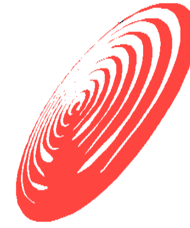


Annual Report 2012

Mental Health Review Board
Western Australia



MENTAL
HEALTH
REVIEW
BOARD

The Honourable Helen Morton MLC
Minister for Mental Health
7th Floor Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Minister

I have pleasure in submitting to you a report from the Mental Health Review Board for the year ended 30 June 2012. 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

Michael Hawkins
PRESIDENT

10 October 2012

CONTENTS

PART		PAGE
1	Mental Health Review Board – Roles and Functions	1
2	Membership of The Board	2
3	The Review of Involuntary Patients	4
4	Statistical Information about Reviews	9
5	Patient Attendance and Representation at Reviews	13
6	Applications to The State Administrative Tribunal	16
7	Other Matters	18
8	Board Decisions – Case Studies	20
9	Community Treatment Orders	26
10	Contact and Other Information	28

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

The Board is an independent quasi-judicial tribunal established under Part 6 of the *Mental Health Act 1996.* It consists of a President and such other members as are appointed by the Governor on the recommendation of the Minister for Mental Health, and must include at least one psychiatrist, at least one legal practitioner, and at least one person who is neither a medical practitioner nor a legal practitioner. Details of the membership of the Board in the year to 30 June 2012 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 and further information about this function and the Board's performance of it are 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 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 Mental 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 a second psychiatrist does not approve a recommendation by another psychiatrist that the therapy be performed: s 106.

- 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.

PART 2: MEMBERSHIP OF THE BOARD

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 lawyer and a community member: s 129.

The year under review was one of change in the composition of the Board with an influx of 22 new sessional members who were appointed on the 3rd May 2011 but who did not commence sitting until after the 30th June 2011, the resignation of Dr Neville Hills in February 2012, Mr Murray Allen's resignation as President with effect from the 4th March 2012, the appointment of Mr Michael Hawkins as President with effect from the 5th March, and in May the re-appointment of Dr Ann Bell and the appointment of Dr Daniel de Klerk as members with qualifications as psychiatrists. These changes mean that the Board finished the year with 43 sessional members plus a President, and comprised 21 members who are neither psychiatrists nor lawyers, 9 psychiatrists, and 14 lawyers. In terms of gender, 20 are women and 24 are men.

The other significant change was that on the 30th June 2012 the Department of the Attorney-General ceased to be responsible for the supply of administrative support to the Board. That responsibility now vests in the Mental Health Commission. The Board takes this opportunity to express its appreciation for the friendship and administrative support provided by the members and staff of the State Administrative Tribunal between 1st January 2005 30th June 2012.

During the year ending 30 June 2012 the following persons sat as members of the Board.

President	Mr Murray Allen (to 4 March 2012)	Mr Michael Hawkins (from 5 March 2012)
Psychiatrist Members	Dr Adam Brett	Dr Hugh Cook AM
	Dr Kevin Dodd	Dr Neville Hills
	Dr John Penman	Dr Nada Raich
	Dr Bryan Tanney	Dr Anthony Zorbas
Community Members	Mr Alan Alford	Ms Kerri Boase-Jelinek
	Rev Rodger Bull	The Rt Revd Michael Challen AM
	Ms Donna Dean	Mr Stuart Flynn
	Mr John Gardiner	Professor David Hawks AM
	Ms Barbara Holland	Mr John James
	Ms Manjit Kaur	Ms Lorrae Loud
	Ms Lynne McGuigan	Mr David Rowell
	Ms Maxinne Sclanders	Ms Leone Shiels
	Ms Josephine Stanton	Mr Anthony (Gerry) Warner AM
	Ms Ann White	The Hon. Keith Wilson
Lawyer Members	Mr Ryan Arndt	Ms Kathryn Barker
	Ms Harriette Benz	Mr Peter Curry
	Ms Magdeline Fadjiar	Mr Tony Fowke AM
	Mr Michael Hawkins	Ms Hannah Leslie
	Mr Michael Nicholls Q.C.	Ms Anne Seghezzi
	Mr Daniel Stepniak	Ms Merranie Strauss
	Ms Jennifer Wall	Ms Rachel Yates

Psychiatrists Dr Ann Bell and Dr Daniel de Klerk were appointed to the Board in May 2012 but due to professional commitments were not able to sit on the Board before the 30th June 2012.

During the year to 30 June 2012 the terms of appointment of Mr Murray Allen (who was President of the Board from 1st January 2005 until the 4th March 2012) and Dr Neville Hills (first appointed as a member with qualifications as a psychiatrist on the 22nd November 2005) concluded. The Board benefited greatly from their work and dedication as members.

Board members are entitled to such remuneration and allowances as the Minister for Mental Health from time to time determines. In May 2012 the Minister made a determination that revised the remuneration of members for sessional sitting fees. The previous determinations had been made in December 2000 and May 2005.

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, which, in summary, requires that:

- the person has a mental illness requiring treatment;
- the treatment can be provided by detention in an authorised hospital or by a CTO, and needs to be so provided in order to avoid certain types of risks, including risks to the health or safety of the person or any other person (including certain types of self-inflicted harm);
- the person has refused to consent to the treatment or, due to the nature of the mental illness, is unable to consent to the treatment;
- the treatment cannot be adequately provided to the person as a voluntary patient.

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 in respect of the person: s 65. A CTO is not to be made unless the psychiatrist is satisfied of the matters set out in s 66, including whether:

- treatment in the community would be inconsistent with the objectives of avoiding the types of risks set out in s 26; and
- 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) Periodic 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’s involuntary patient status commenced: 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 periodic review***.

For the purposes of determining when a person commences a period as an involuntary patient and the timing of periodic 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, the person is taken to have been continuously an involuntary patient despite that gap.

When conducting a periodic 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 (whether detained in an authorised hospital or on a CTO) 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 and from that creates a database containing information concerning each patient. The 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*, 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 if 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 provide appropriate access 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 audio-visual conferencing 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 audio-visual facilities at

20 regional locations from Wyndham to Esperance involving 125 reviews (117 in the year to 30 June 2011).

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. Audio-visual conferencing 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 audio-visual conference 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 is 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, 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 18 reviews were scheduled involving interpreters in 12 languages, namely Vietnamese (3 reviews), Croatian (2), Italian (1), Somali (2), Auslan (1), Arabic (2), Persian (1), Hokkien (1), Serbian (2), Burmese (1), Indonesian (1) and Aboriginal (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 audio-visual conference. 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. However on a number of occasions the physical facilities and the level of co-operation and assistance provided fell 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 not independent.

- On many 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.

The Board is well 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 made, 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 directly affect the dignity and comfort of patients and the consideration due to them at hearings.

Regrettably, because the Board does not know the availability of and other commitments of the medical team treating each patient, the Board is not able to take those factors into account when it schedules reviews. The Board has attempted to mitigate the difficulties that this causes at the two major authorised hospitals by offering to send the hospitals rolling lists of patients in respect of whom a review must be held within the following four to six weeks, and giving the hospitals the opportunity to draft review schedules which take into account the other commitments that members of the treating teams have. Due to a lack of administrative staff at the hospitals they have not been able to take advantage of the offer. The staff at Graylands Hospital, however, organise the timing of and venues for reviews on the days that the Board attends the hospital, and all reviews at Fremantle Hospital of patients on a CTO are now scheduled to take place in the morning so that if the list collapses for any reason the reviews scheduled for in-patients can be brought forward. This means that the Board now attends Fremantle each fortnight for a day rather than each week for one half a day, with consequential efficiencies in the scheduling of reviews at other venues. Another benefit to Fremantle Hospital is that the Board now only occupies a room which is much in demand for other purposes, once a fortnight instead of weekly.

PART 4: STATISTICAL INFORMATION ABOUT REVIEWS

During the year to 30 June 2012, 2955 persons commenced periods as involuntary patients as a result of orders being made that they be detained in an authorised hospital (2626 persons) or by the making of community treatment orders (CTOs) (329 persons). These represent an overall decrease of 3.5% over the previous year's corresponding figures, with decreases of 2.4% for detained patients and 11.3% for CTO patients. In the same period 516 persons who had previously been detained in hospital were discharged from hospital on a CTO and 298 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: Orders Commencing/Continuing Periods as Involuntary Patient

	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Involuntary status *commenced* by orders:								
• detaining in hospital	2638	2535	2513	2486	2397	2688	2690	2626
• new CTO	350	328	317	255	295	339	371	329
Total	**2988**	**2863**	**2830**	**2741**	**2692**	**3027**	**3061**	**2955**
Involuntary status *continued* by orders for:								
• revocation of CTO and readmission to hospital	158	217	184	171	141	189	95	122
• CTO on discharge from hospital	622	623	510	516	546	569	552	516
• extending a CTO	399	339	232	284	331	319	280	298
Total	**1179**	**1179**	**1017**	**971**	**1018**	**1077**	**895**	**936**

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 eight years approximately 57% 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 57% of those patients will be discharged in that period. However within the initial 28 day period patients can, and many do, request reviews and reviews are held on the first available date.

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

	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Number commencing as detained patients	2638	2535	2513	2486	2397	2688	2690	2626
Number discharged outright in 28 days	1586	1416	1361	1393	1329	1552	1590	1579
Discharge rate (%)	60.1	55.8	54.2	56	55.4	57.7	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 held in the year under review (1914 and 1135 respectively) compared to previous years.

Table 4.3: Numbers of Reviews Scheduled and Held

	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Total reviews scheduled	1826	1866	1948	1934	1922	1846	2085	1914
Total reviews held	1203	1162	1171	1101	1144	1123	1242	1135
Percentage Held	65.9	62.3	60.1	56.9	59.5	60.8	59.6	59.3

The 1135 reviews held in the year fell into the categories shown in Table 4.4

Table 4.4: Numbers and Types of Reviews Held – 2011/12

	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 held	**1135**	145	294	140	48	326	182

As indicated in Table 4.3, 779 reviews were scheduled but not held during the year. This represents 40.7% 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 for 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 – 2011/12

Reason	Number
Patient no longer involuntary	526
Patient discharged from hospital on a CTO	31
Cancelled at psychiatrist's request	75
Patient transferred between hospitals	25
Withdrawal of request for a review	11
Cancelled at request of patient or representative	58
CTO revoked and patient readmitted to hospital	14
Cancelled at Board's request	17
Other reason for cancellation	22
Total cancelled	**779**

In the case of patients discharged from an authorised hospital in the metropolitan area on a CTO, if the patient lives in the metropolitan area and hence has the opportunity to attend the hearing, the Board will usually continue with the review hearing and not cancel it. 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 (whether detained in hospital or on a CTO) 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 made in the period between the Board setting a date for the review and the date of the hearing that would have taken place but for the patient's discharge in the meantime.

As shown in Table 4.6, in the year under review the Board discharged 47 patients from involuntary status. Twenty of the forty-seven were patients detained in hospital and twenty-seven were patients on a CTO.

Table 4.6: Patients Discharged from Involuntary Status by MHRB

	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Total reviews completed	1162	1171	1101	1144	1123	1242	1135
Patients discharged from involuntary status							
- detained in hospital	13	27	11	25	25	32	20
- on CTO	36	59	39	32	25	26	27
Total	**49**	**86**	**50**	**57**	**50**	**58**	**47**
Percentage Discharged by MHRB	4.5	7.3	4.5	5.0	4.5	4.7	4.1

Reasons for Decision

In the vast majority of cases the Board announces its decision on the matters to be determined in a review at the end of the hearing. Only very occasionally does the Board reserve its decision about a matter - although it has the right to do so. When announcing its decision at the end of a hearing 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 made its 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 review proceedings makes a request for such 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 application to review 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 in 35 matters.

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

04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
58	36	31	25	34	26	24	35

PART 5: PATIENT ATTENDANCE AND REPRESENTATION AT REVIEWS

At a review hearing any party to the proceedings may appear personally (unless the Board considers the personal appearance of a person 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 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 (detained in hospital and on CTOs) who attended their review hearings in 2011/12 compared with previous years - and shows a small increase in the attendance rates for patients on a CTO 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

	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Total reviews completed	1162	1171	1101	1144	1123	1242	1135
Total reviews - detained patients	519	599	593	588	554	654	579
• Patient attended	446	513	507	499	484	569	477
• Patient attendance rate (%)	85.9	85.6	85.5	84.9	87.4	87	82.4
Total reviews – CTO patients	643	572	508	556	569	588	556
• Patient attended	304	216	203	234	203	194	228
• Patient attendance rate (%)	47.3	37.8	40	42.1	35.7	33	41
Total Patient attendance	**750**	**729**	**710**	**733**	**687**	**763**	**705**
Overall patient attendance rate (%)	64.5	62.2	64.5	64.1	61.2	61.4	62.1

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 2011/12.

The Mental Health Law Centre does not charge patients a fee for representing them, and the Board ensures that brochures publicising the Law Centre are sent to every patient who is due to be reviewed by the Board. Despite that publicity, the level of representation by Official Visitors overall was significantly higher overall than the level of representation by lawyers from the Mental Health Law Centre. When reading the Table, please note that some patients were supported by or represented by an Official Visitor as well as a lawyer and/or a person close to the patient, such as a family member.

Table 5.2 Patients Represented or Supported at Review Hearing – 2011/12

	Detained in Hospital			CTO			Total Rep
	Requested Review	Initial Period Review	6-month Period Review	Requested Review	Initial Period Review	6-month Period Review	
Mental Health Law Centre	47	19	10	15	9	5	105
Council of Official Visitors	89	91	69	13	5	4	271
Spouse, partner, family member	25	36	12	7	23	20	123
Total Reviews Held	**145**	**294**	**140**	**48**	**326**	**182**	**1135**
Mental Health Law Centre attended	32.4%	6.5%	7.1%	31.3%	2.8%	2.7%	9.3%
Council of Official Visitors attended	61.4%	31%	49.3%	27.1%	1.5%	2.2%	23.9%
Spouse, partner, family attended	17.2%	12.2%	8.6%	14.6%	7.1%	11%	10.8%

*Note: In 2010/11, the Mental Health Law Centre and the Council of Official Visitors represented patients at respectively 84 (6.8%) and 242 (19.5%) of the 1242 reviews held.

Representation and Support for Children and Adolescents at Hearings

Table 5.2 includes data in respect of all patients, including children and adolescents. The Board makes every endeavour to hold the reviews within 10 days of the date upon which the child or adolescent is made an involuntary patient. During the year 71 reviews were scheduled to be held in respect of patients who were less than 18 years old. Forty-four of the patients were discharged before the reviews were held. Of the twenty-seven patients who remained involuntary for more than 10 days, the Council of Official Visitors represented six

and the Mental Health Law Centre represented two (one of whom was also represented by an Official Visitor). Family members were present at the reviews of only seven children or adolescents. That is a disheartenly low number.

PART 6: APPLICATIONS TO THE STATE ADMINISTRATIVE TRIBUNAL

Applications for Review of Decisions of the Board

Prior to 1 January 2005 a person who was 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.

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 review by the State Administrative Tribunal (the Tribunal). No fees are payable on the filing of an application for a review of the Board's decision and the application can be instituted by the use of a single form. These easier and cheaper procedures initially resulted in an increase in the number of applications for the review of decisions of the Board being lodged with the Tribunal. The Board welcomed this development because it offers the possibility of the Tribunal determining important questions of law that can arise in Board proceedings.

When the Tribunal reviews the Board's decisions it must be constituted in the same way as the Board was - ie 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 the hearing afresh and is not confined to matters that were before the Board. It may consider new material, and the purpose of the Tribunal hearing is to produce the correct and preferable decision at the time the Tribunal makes its decision. The logic of this is that if the Tribunal could only look at the evidence about the patient as the patient was when the Board made its decision and could only decide whether or not the Board had made the right decision, any patients whose health had improved in the meantime would continue to be detained as an involuntary patient if the Tribunal found that the patient was mentally ill as at the date that the patient was reviewed by the Board. That result would not be in the patient's best interest, and so the Tribunal makes its decision on the merits as they are as at the date of the hearing by the Tribunal.

Persons who are dissatisfied with a decision of the Tribunal may appeal that decision to the Supreme Court on the grounds that the Tribunal erred in law or fact (or both), acted without or in excess of its jurisdiction, or for any other sufficient reason.

The number of applications lodged with the Tribunal for a review of decisions of the Board and the outcomes thereof in the year ending 30 June 2012 are listed below. So too is the number of appeals pending in the Supreme Court from decisions made by the Tribunal.

- 1 appeal was pending in Supreme Court at 30 June 2012
- 12 Applications were lodged with Tribunal in 2011/2012
- 13 Applications were finalised prior to 30 June 2012 (including applications lodged before 1 July 2011 but not finalised until after 1 July 2011)
    - (12 Withdrawn/Dismissed without hearing)
    - (1 Patient Discharged from Involuntary Status by SAT)
- 1 Appeal to the Tribunal was awaiting a decision as at 30 June 2012

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. Applications can only be made if the Board has commenced a review hearing but has not made its decision. The Board did not make any application to the Tribunal during the year ending 30 June 2012.

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 is defined by the Act to mean *sole confinement in a room that it is not within the control of the person confined to leave*. A patient in an authorised hospital 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 employed at an authorised hospital, but the patient need not be an involuntary patient at that hospital. Authority for seclusion can only be given 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.

It should be noted that the employment of seclusion and mechanical bodily restraint 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 the events referred to. In addition there is, inevitably, considerable overlap between the ways in which certain events can be characterised by the hospitals concerned. 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 two types of management of patients. The total number of the two 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 (Involuntary Patients)

	2010/2011	2011/2012
Seclusion of Patients	1148	1039
Mechanical Bodily Restraints	2	2
Emergency psychiatric treatment	15	22

The Board finds the data 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, which also has the authority to enquire into such matters. The Board has not, in recent years, received a large number of complaints.

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 or not the requirements set out in 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 the psychiatrist is satisfied that all of the requirements set out in s 26 of the Act 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). In addition, 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. In accordance with s 137 of the *Mental Health Act*, the Board primarily has regard to the psychiatric condition of the patient and considers the patient's medical and psychiatric history and social circumstances. 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

In this matter the patient was on a community treatment order and did not attend the review. The report provided to the Board was slightly less than one page long. The patient was described as a 37-year-old gentleman with a history of drug induced psychosis, polysubstance abuse, and antisocial personality disorder. The author of the report wrote that the author had not met the patient, and that the report was based on observations noted in the hospital file.

The patient had had multiple admissions to hospital for psychotic episodes, the first of which was for drug induced psychosis. The patient was described as a martial arts expert with a well documented history of aggression and violence, including assaults on fellow patients. Threats to kill nursing staff had been made. He had a history of overdose which resulted in a seizure. He was described as having limited insight into his substance abuse and that he continued to abuse illicit substances despite its consequences on his mental health. The patient did not attend medical appointments regularly, and the author thought that if the patient was not on a community treatment order he would disengage with mental health services and refuse all treatment. In the report writer's opinion the patient would be a significant risk of aggression and violence towards others, and a risk to himself given a previous suicide attempt, if he was not the subject of a community treatment order.

Neither the patient nor any member of the treating team were present when the Board commenced the review.

The Board was faced with the fundamental difficulty of deciding whether or not the patient had a mental illness, because under Section 4 of the Act a person does not have a mental illness by reason only of the fact that the person takes drugs or alcohol. The author of the report was located, and called before the Board. A more detailed history was obtained and the Board decided that the patient suffered from disturbance of thought, mood, and perception that impaired the patient's behaviour to a significant extent well after the period during which any drugs or alcohol may have affected the patient, making it more probable than not that the patient was mentally ill. The Board determined that the patient should remain the subject of the community treatment order. It also provided the author of the report with a redacted copy of an example of a well written report which contained all the material relevant to each of the factors that the Board must take into account in deciding whether or not an involuntary patient order should continue to have effect.

Case No 2: Whether there was a risk of self-inflicted harm

This case involved a middle-aged grandmother who lived in a regional centre and was active in her local church. She was not only a regular churchgoer, but also worked at the church. She was on a community treatment order, but was not compliant with her medication. When unwell, she developed a fixation with the priest and would visit him, undressing in the street whilst making her way to see him.

Section 26 relevantly is to the effect that a person can be an involuntary patient only if treatment is required in order to protect a person from self-inflicted harm, including *(b) lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships;* and *(c) serious damage to the reputation of the person.*

The patient did not attend the hearing, but a member of the treating team who knew the patient well took part. Based on answers to questions that the Board asked, and taking into

account the contents of the written report that had been provided, the Board formed the opinion that the community treatment order should remain in place.

Case No 3: Whether risk of harm greater if patient remain an involuntary patient in an authorised hospital

The patient was reviewed by the Board whilst he was detained in the Frankland Centre, located in the Graylands Hospital grounds. The Frankland Centre is a high security area. A feature of the case was that whilst the patient was subject to an involuntary treatment order under the Mental Health Act, he had been remanded by a court to the same facility pending the determination of criminal charges against him or further order of the court. This meant that regardless of the Board's decision, pending further court orders the patient would remain legally bound to remain at Frankland Centre. The patient's lawyer argued that if the Board found that the patient should not be an involuntary patient in an authorised hospital, the patient could ask the court for bail, alternatively for an order that he be remanded to a prison rather than being held in the Frankland Centre pending trial.

An issue that was raised was whether the Board should continue with the hearing, as in the absence of a court order the patient would remain at Frankland Centre irrespective of the Board's decision. The Board decided that it should continue with the hearing because the involuntary patient order could still impact substantially upon the patient’s freedom to choose whether or not to accept treatment in that whilst the order remained in place the patient could be compelled to take treatment regardless of whether or not he consented to it.

It was common ground between the treating team and the patient's lawyer that the patient was mentally ill. The patient disputed that the diagnosis suggested by the doctor was correct. That dispute was irrelevant, because under Section 4 of the Mental Health Act a person is defined to have a mental illness *if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgement or behaviour to a significant extent.*

As the Board noted, it is clear from that definition that because the definition is based on behaviour there is no requirement for a person to have a settled mental health diagnosis before the person can be made an involuntary patient.

A difficult aspect of the case was that the doctor submitted that the patient and other patients and staff were to some extent exposed to greater risk of harm by the fact that the patient was being treated in the restrictive environment that exists at the Frankland Centre. The basis for the submission was that the patient's primary response to perceived threats had previously been to escape or otherwise avoid conflict, but because the patient was confined to a locked ward at Frankland Centre, the patient did not have the ability to flee from real or perceived dangers and so his safety and the safety of others was to some extent more at risk than if the patient was in a less restricted setting.

The thrust of the submission was that the involuntary treatment of the patient in fact increased some of the risk factors that treatment under Section 26 of the Act is required to avoid. In addition, the patient's lawyer argued that the environment in the Frankland Centre was in some respects not therapeutic for the patient.

The doctor clarified his earlier submission and refuted any suggestion that the overall risk of harm, whether to the patient or others, was in fact increased by treatment in Frankland Centre.

The Board noted that if its decision required merely a balancing act between the increased risk to the patient and others if he was treated at the Frankland Centre, and the risk to the patient's quality of life if he were to be released into the community on bail, the Board would have had difficulty in addressing the aspect of balancing benefit and detriment. However, it also emerged that the patient was charged with making a statement which he knew to be false and which indicated a threat. The doctor's understanding was that the patient had led police to believe that he possessed a gun and intended to use it, with the result that a siege situation developed involving a large number of police and the Tactical Response Group. The Board found that the potential for harm represented by a siege situation tipped the balance in favour of finding the treatment was required to protect the patient and potentially other people from serious harm.

The Board then considered whether there was a less restrictive means of providing adequate treatment then by continued detention in the Frankland centre.

The doctor submitted that was the first time that the patient had been given comprehensive treatment for his mental illness, and that it was too early to know how he was likely to respond to the treatment or what further treatment may be required. He noted that although there was some mental health support available at Hakea Prison, it would be far less comprehensive than the support available in the Frankland Centre.

Insofar as release into the community on bail and on a community treatment order was concerned, the evidence was that the patient was homeless.

The Board accepted that in light of the difficulties and inadequacies surrounding treatment either in prison or the community, treatment could not adequately provided in a less restrictive manner than if the patient remained an involuntary patient in the Frankland Centre.

Case No 4: Whether a juvenile should remain detained over Christmas

A number of the patients (including juveniles) reviewed by the Board experience psychosis after taking illicit drugs or smoking marijuana, particularly marijuana that has been growing hydroponically.

Some of the more difficult reviews that the Board conducts concern juveniles from remote or regional areas who have been made an involuntary patient and brought into Perth for treatment. They are far from home and culture and, because of distance, are without the support of their family.

One patient reviewed by the Board was a young aboriginal female who had had no previous psychiatric history but was admitted with a cluster of symptoms reflective of psychosis and complex post traumatic stress disorder. There was a suspicion of substance misuse prior to her admission. The patient had had exposure to significant family violence at young age, and after her parent's marriage failed, lived with her mother for some time before she became a border at school where she excelled academically and athletically for a while. She left that school and went to a day school where she struggled academically. Her mother told the treating team that the patient had been abducted by an older man and sexually assaulted on a number of occasions, and the mother said that the patient had become increasingly violent and aggressive towards her since then. As a result, the patient went to stay with an aunty for about four weeks prior to admission, and there was the suspicion that substance misuse and exposure to culturally sensitive information during that stay caused the patient added confusion.

On admission, the patient presented with delusions of misidentification and was insistent that her mother and family members had been replaced by imposters. The patient also believed that others had stolen her eyes and brain and voice box. Initially, because of her paranoia, she refused a physical examination.

The Board reviewed that patient 24 days after she had been admitted to hospital. On the date of the review the patient was still at risk of relapse of her psychotic illness, and on the morning of the review had threatened to shoot the treating doctor. That was seen by the doctor as reflective of a person with poor coping strategies at a time of distress.

During the review, the patient denied that she was mentally ill and denied that she had been abducted by an older man. She said that he had been and was her boyfriend and she wanted to live with him.

The Board decided that the patient should remain in hospital as discharge in the early stages of her recovery could lead to relapse, and because she was vulnerable to exploitation. Eleven days after the review she was discharged on a community treatment order which expired 3 months later. One month after the CTO expired the patient was admitted to hospital as an involuntary patient because she had suffered a relapse and, because of her aggressive behaviour, for her own protection needed to be in a secure environment. She was treated in hospital for a further month and then discharged. The patient has not been the subject of an involuntary patient order since then.

PART 9 COMMUNITY TREATMENT ORDERS

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 will be subject to the coercive aspects of the Act should he or she not comply with the terms of the CTO.

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. As might be expected, 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 be of varying kinds, offering 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, accordingly, 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 reviewed by the Board 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 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.

PART 10 CONTACT AND OTHER INFORMATION

The Board has a website (www.mhrbwa.org.au) which 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. The website is badly in need of an over-haul, and steps have been taken for that to be done.

The Board's current contact details are as follows:

Address: Level 4, 12 St Georges Terrace, Perth

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Telephone: (08) 9219 3162

Facsimile: (08) 9219 3163

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In late October 2012 the Board will be relocated to Level 2, 681 Murray Street, West Perth.