mental health tribunal western australia

Guidance Notes

Medical Report

For use in Mental Health Tribunal review proceedings under the *Mental Health Act 2014* (WA)

FAMILY NAME
Click here to enter text.
GIVEN NAME
Click here to enter text.
ADDRESS
Click here to enter text.
DATE OF BIRTH
Click here to enter a date.
HEARING DATE
Click here to enter a date.

UMRN
Click here to enter text.
CMHI
Click here to enter text.
GENDER
Choose an item.
REPORT DATE
Click here to enter a date.

Complete all information as indicated.

Report author: Click here to enter text.

Mental Health Service: Click here to enter text.

Medical Officer/Registrar: Click here to enter text.

Date of current admission to service: Click here to enter a date.

Date current treatment order made: Click here to enter a date.

Position: Click here to enter text.

Supervising Psychiatrist: Click here to enter text.

Case Manager: Click here to enter text.

Patient Status: Choose an item.

Date current treatment order ends: Click here to enter a date.

The patient is entitled to a copy of this report. Please provide a copy to the patient at least 72 hours before the hearing.

If the psychiatrist believes the patient should not access the report, please complete Form 12B Record of Refusal of a Patient's Request to Access Documents. Provide a copy of the Form 12B to the patient as well as the Tribunal at least 72 hours before the hearing.

If the psychiatrist believes the patient should access a redacted copy of this report, please also provide a copy of the redacted report to the patient as well as the Tribunal at least 72 hours before the hearing.

PRELIMINARY MATTERS

1. If the patient is of Aboriginal or Torres Strait Islander descent, has assessment and treatment been provided in collaboration with an Aboriginal or Torres Strait Islander mental health worker or a significant member of the patient's community? (You may be asked to elaborate at the hearing). Be prepared to discuss your reasons if you choose this option	Collaboration is not practicable or appropriate (be prepared to discuss reasons at hearing)
2. If the patient requires an interpreter for the hearing, specify language.	Click here to enter text.
3. If the patient has a Guardian appointed under the *Guardianship and Administration Act 1990*, provide the name and contact details of the Guardian.	Click here to enter text.
4. Is the patient aware of the free assistance available from the Mental Health Advocacy Service and the Mental Health Law Centre?	Yes
5. Is the patient aware that family members and other supporters may attend the hearing? Please note if the patient objects to their attendance. The patient should notify the Tribunal of their objections in advance where possible.	Patient's objection has been forwarded separately to the Tribunal

THE PATIENT

6. Provide a summary of relevant background and social circumstances. Include matters such as family and childhood issues, education, employment history, finances, relationships, accommodation and social support.

The Tribunal needs to be provided with background information about the patient. ***The Tribunal members no longer access the patient's medical file or review the reports from previous hearings in most matters. The psychiatrist should include in this report all relevant background information that the Tribunal will need to make a decision.*** *When you write your next report for the patient, you can copy and paste this information into the new report and update to include any new relevant background information.*

HINT: *when handing over a patient to a new psychiatrist, include a word version of your most recent Tribunal report using this template. If you are accepting the patient, ask the previous psychiatrist for a word version of her or his last report using this template (unfortunately the Tribunal cannot provide you with this). This will give the new psychiatrist (or you!) a completed template for the patient to save as a first draft of the next report. This will save considerable time. If you do this, you are responsible for updating the information to ensure the report is current as at the next hearing date. Please don't submit the earlier report without the appropriate changes.*

7. Outline the circumstances surrounding the current admission and treatment.

This is important to the Tribunal because it helps us understand the context of the patient's treatment. Were they initially voluntary and became involuntary later? Were they brought in by police or did the patient self-present? Knowing how unwell the patient was before s/he received treatment is important information for the Tribunal.

8. What is the current diagnosis?

The Act requires a 'mental illness'. Tell us what the diagnosis is. Is it well-established? Has the patient requested a second opinion to confirm the diagnosis?

9. Describe previous involvement with mental health services, base line functioning prior to the recent decline, any relevant substance use, medical and forensic history not already addressed.

Once again, without access to the patient's file, the Tribunal won't know this. For patients who have already had a hearing, you can cut and paste this from the previous report and update where necessary.

10. Please include a list of the patient's current medications.

Self-explanatory. This is primarily for our psychiatrist members.

CRITERIA FOR AN INVOLUNTARY TREATMENT ORDER

MHA ss 25(1)(a) and 25(2)(a): That the person has a mental illness in need of treatment.

MHA s 6(1) provides that a person has a mental illness if the person has a condition that:

- is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and
- significantly impairs (temporarily or permanently) the person's judgment or behaviour.

Exclusions in MHA s 6(2) and s 6(3).

11. Provide examples of how the patient's symptoms reflect a disturbance of thought, mood, volition, perception, orientation and/or memory and how it significantly impairs their judgement or behaviour.

The Act requires not just a mental illness, but a mental illness which is characterised as above. It is a two-part test:

- *the disturbance of thought/mood/volition/perception etc; AND*
- *the significant impairment of judgment/behaviour.*

*What we are looking for here **is how the symptoms manifest in this patient when untreated**: some facts (ie descriptions of their symptoms and how the symptoms impact on their judgment and behaviour) to satisfy the Tribunal of this. Include examples of how the symptoms actually interfere, not just how they potentially interfere.*

MHA ss 25(1)(b) and 25(2)(b): That, because of the mental illness, there is —

(i) a significant risk to the health or safety of the person or to the safety of another person; or

(ii) a significant risk of serious harm to the person or to another person; or

(iii) [*for CTO ONLY*] a significant risk of the person suffering serious physical or mental deterioration.

12. Describe any current significant risk to the health or safety of the person or safety of another or significant risk of serious harm to the person or another.

"Health or safety' and 'serious harm' are two different categories.

Health or safety is usually about physical matters.

Serious harm can be physical, but in some cases, it may be psychological, economic, social, etc. Serious harm in other legal contexts means harm that is permanent or endangers life, but the Mental Health Act does not define it in this context. Please consider applying to the State Administrative Tribunal for an administration order if the harm is financial, as this may be considered a less restrictive option than an involuntary treatment order.

If the risk is to another person (not the patient) then it must be to the 'safety' of the other person (not their health) or it must be a risk of serious harm.

The risk level must be significant – higher probability of occurrence than possible.

The risks must be current as at the day of hearing.

Example: a person who is disinhibited and walks the streets naked is potentially at risk to health (could suffer exposure) or safety (could be assaulted) but is also potentially at risk of harm (social embarrassment or reputation etc). To qualify, though, the harm needs to be serious – this depends on context. Is this a public figure? Is it a very small town? Are they damaging relationships which interfere with their ability to remain at home?

13. For community treatment orders only, outline any significant risk of the person suffering a serious physical or mental deterioration.

This is a less onerous test that applies to CTOs only. Use this category if risk of deterioration is the most significant risk arising. Examples of previous attempts at being voluntary, relapse history, etc are often helpful.

MHA ss 25(1)(c) and 25(2)(c) MHA: That the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself.

Note: To determine capacity the Tribunal must be satisfied that the person has the capacity to:

- understand the things that are required under section 19 to be communicated to the person about the treatment; and
- understand the matters involved in making the treatment decision; and
- understand the effect of the treatment decision; and
- weigh up the above factors for the purpose of making the treatment decision; and
- communicate the treatment decision in some way.

14. When was capacity last assessed?	*Tell us when capacity was last assessed. It should have been done very recently (particularly if capacity is fluctuating) or there may need to be an adjournment. This is because the Act requires the Tribunal to know as at the date of hearing what the patient's condition is.*

15. Is the patient currently able to understand the information required to be communicated to them about diagnosis and treatment? If not, why not?

This question refers to section 18(a) of the Act and is about the patient's ability to understand the information that must be disclosed under section 19 to provide informed consent. Section 19 requires a 'clear explanation of the treatment' which has enough information to enable the patient to make a balanced judgment. It must include alternative treatment options, and risks of treatment. You should articulate what you have told the patient (and when you told them) and whether they appeared to understand.

This question is not about whether the patient accepts they are unwell or appreciates the need for treatment, but rather their ability to understand what you are saying to them about the treatment options. This includes cognition, but may also include hearing, language, behavioural or emotional dysregulation etc. Where possible please try to distinguish between the cognitive deficits which arise from the mental illness and cognitive deficits which arise from other causes.

16. Is the patient capable of understanding the matters involved in making a treatment decision? If not, provide examples of how symptoms impede the patient from being able to understand the matters involved in making a treatment decision.

This question refers to section 18(b) and (c) of the Act and is about the patient's ability to understand all other matters involved in making the treatment decision. This includes the nature of the illness, the need for treatment and the effect of the treatment on the illness, the effect on the patient of refusing treatment in both the short and long term, and any other relevant matters. It is much broader than question 15, so please do not respond 'see 15'. Please also avoid using the shorthand 'patient lacks insight'. Instead, provide detail as to how the patient's level of acceptance of the illness (or other perceptions) impact upon the treatment decision.

17. Is the patient able to weigh up the relevant factors for the purpose of making a treatment decision? If not, give examples of how their ability is compromised.

This question refers to section 18(d) of the Act, which is about the ability to weigh and balance the factors referred to in section 18(a)-(c) (and to retain this for long enough to make a reasoned decision and comply with it). It is primarily about any impairments of reasoning arising from the illness. Give examples.

18. Is the patient able to communicate the treatment decision in some way (even if limited)? If not, why not?

In most cases, the patient will be able to communicate in some way, unless they are completely non-verbal or unconscious.

MHA ss 25(1)(d) and 25(2)(d) MHA:

- *FOR INPATIENT TREATMENT ORDER ONLY*: That treatment in the community cannot reasonably be provided to the person.
- *FOR CTO ONLY*: That treatment in the community can reasonably be provided to the person.

19. Can treatment be reasonably provided in the community? If not, explain.

The question concerns the supports which are available to the patient in the community and whether they are sufficient to support community treatment. Is a community psychiatrist available and willing to treat the patient? Do the risks/safety issues identified in question 12 prevent community treatment? Be specific.

MHA ss 25(1)(e) and 25(2)(e): That that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making the order.

20. Can the patient be treated in a less restrictive way at this time? If not, why?

If the patient is on an CTO, address why the patient cannot be a voluntary patient.

If the patient is on an inpatient order, address why the patient cannot be on a CTO.

This question is NOT about why the patient needs to be on one type of treatment as opposed to another (such as depot versus tablets), as the Tribunal does not make treatment decisions. Nevertheless, the members may ask about alternative treatment options where relevant (for example, they may want to know whether a depot treatment might facilitate a CTO or voluntary status).

OTHER MATTERS TO WHICH THE TRIBUNAL MUST HAVE REGARD (Not otherwise detailed above) (MHA s 394)

21. What are the patient's wishes (to the extent that it is practicable to ascertain those wishes).

Here we are looking for the patient's view – please ask the patient and document here, particularly if you don't expect the patient to attend the hearing.

22. What are the views of any carer, close family member or other personal support person of the involuntary patient.

Same as above, but for family and carers.

TREATMENT SUPPORT AND DISCHARGE PLANNING (MHA ss185-188)

23. Describe the person's current stage of recovery and plan for discharge (attach a copy of the current signed TSDP to this report).

Please update the TSDP before every hearing and attach the TSDP to the medical report. The Tribunal has the statutory power to review the TSDP and to ensure that it is compliant with the matters detailed below.

Please note that the Tribunal expects to see a compliant TSDP in every matter and has the power to recommend that patient's psychiatrist (not merely the HSP) review the TSDP.

The Tribunal also has the power to issue the patient's psychiatrist (not merely the HSP) with a compliance notice under section 423 on its own initiative. If the Tribunal does so, your name must be published in the Tribunal's annual report in accordance with section 426 of the Act.

TSDP Requirements

Section 185 requires that every patient have a TSDP. ***It is the statutory responsibility of the patient's psychiatrist to ensure*** *that the treatment, support and discharge plan for the patient —*

> *(a) is* ***prepared as soon as practicable*** *after the patient is admitted by the hospital or the community treatment order is made; and*
>
> *(b)* ***is reviewed regularly****; and*
>
> *(c)* ***is revised as necessary****.*

The requirements are different for inpatients and community patients.

For inpatients, treatment, support and discharge plan for a patient must outline —

> *(a) the treatment and support that will be provided to the patient while admitted by the hospital; and*
>
> *(b) the treatment and support that will be offered to the patient after the patient is discharged by the hospital.*

For community patients, the treatment, support and discharge plan must outline —

> *(a) the treatment and support that will be provided to the patient under the community treatment order as set out in that order; and*
>
> *(b) the treatment and support that will be offered to the patient when the patient is no longer under the community treatment order.*

The Chief Psychiatrist's Guidelines for the preparation, review and revision of treatment, support and discharge plans also requires as follows:

2.4 The patient's psychiatrist must also ensure that the following people are involved in the creation of the plan when appropriate:

> *2.4.1 The patient - who must always be involved (this also applies to a patient who is a child). Where a patient is temporarily unable, or is unwilling, to be fully involved in the process, repeated valid attempts will be required to engage the patient in dynamic, meaningful and individually relevant planning. These attempts must be documented.*
>
> *2.4.2 If the patient is a child or required to have a guardian (or any person authorised by law to consent on person's behalf) then these people must be involved in the development of the plan and also require a copy of the plan.*
>
> *2.4.3 The patient's personal support persons (Unless it is not appropriate to supply this information due to risks or concerns under sections 269(1), 288(2), 292(1)).*
>
> *2.4.4 The psychiatrist must take a number of reasonable steps to ensure that the patient's personal support persons are contacted and included – and these steps must be filed in the clinical notes if the contact attempts are not successful.*
>
> *2.4.5 If the patient is of Aboriginal or Torres Strait Islander descent, then significant members of the patient's community (including elders and traditional healers) and Aboriginal or Torres Strait Islander mental health workers must be consulted and included wherever possible. (s.189)*
>
> *2.4.6 If the patient is from a culturally and linguistically diverse population, every effort must be made to address any language and cultural issues that may negatively impact on the person's ability to be consulted in developing*
>
> *treatment, support and discharge plans. This may involve including interpreters or members from the patient's community to assist with the development of the plans.*
>
> *2.4.7 The psychiatrist should also ensure that any other appropriate persons or bodies (organisations) are involved in the treatment, support and discharge plans – for example the psychiatrist will involve relevant community clinical and other mental health services to ensure collaboration and support for the person on a CTO or for someone about to be discharged from an authorised hospital.*
>
> *2.4.8 A record of the plan, involvement of any persons above and a record of attempts made to contact the personal support persons must be filed in the person's clinical notes. (s. 188)*

2.5 The physical health treatment needs of the patient should be considered when developing the plans and included in the treatment plans if there are physical conditions which need to be monitored or addressed.

SIGNATURE OF THE REPORT'S AUTHOR

How long have you known the patient? Click here to enter text.

Signed by: Click here to enter text.

Name: Click here to enter text. Position: Click here to enter text. Date: Click here to enter a date.

CONFIRMATION OF REPORT BY SUPERVISING/TREATING PSYCHIATRIST

If you are the supervising psychiatrist, please supply the date of your last review in accordance with sections 118 and 119 of the Act? Click here to enter a date.	Signed by: Click here to enter text.
I have reviewed and confirm the accuracy of this report.	Signed by: Click here to enter text.

Please consider if there are any significant safety issues for the Tribunal Hearing and contact the MHT Registry on (08) 6553 0060 to discuss as required.

Please email your report to: registry@mht.wa.gov.au

If you have any queries, please telephone the Registry staff on (08) 6553 0060