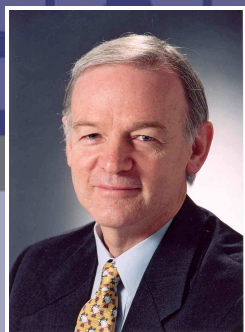


INFORM

NEWSLETTER OF THE CHIEF PSYCHIATRIST

Autumn/Winter 2009



Clinicians and decisions of the Mental Health Review Board

Mr Murray Allen- President, Mental Health Review Board

The main role of the Mental Health Review Board is to review the status of persons who are treated involuntarily under the *Mental Health Act 1996* - either as patients detained in an authorised hospital or under a community treatment order (CTO). On a regular basis (but in a relatively small proportion of the total number of reviews conducted) the Board discharges a patient from involuntary status. In the years to 30 June 2007 and 2008 respectively the Board discharged 59 and 39 CTO patients and 27 and 11 detained patients.

When conducting a review the Board must consider all the circumstances relating to the patient at the time of the review, and decide whether the criteria for involuntary status set out in s 26 of the Act are satisfied. By definition, if the Board decides to discharge a patient from involuntary status it will be because the Board has formed a different view about the criteria for involuntary status to that taken by the treating psychiatrist - because otherwise, presumably, the psychiatrist would have discharged the patient from involuntary status.

The Board is aware that, on occasions, when it has discharged a patient from involuntary status, the clinicians involved in the patient's care have disagreed with the Board's conclusions. This article outlines the options available to clinicians in such a situation.

Option 1: Seek a statement of reasons for the Board's decision

At a review hearing the Board will always announce its decision and, usually, state briefly its reasons for that decision. However, the Act (cl 15 of Sch 2) enables any party to the review to request (within 14 days of the Board's decision) the Board to give reasons in writing for the decision. Patients often request the Board to provide a statement of reasons, but it is most unusual for a clinician to do so. When the Board prepares a statement of reasons at the request of a patient it will always send a copy of the reasons to the clinician concerned.

Obtaining a statement of reasons will help the clinician understand why the Board made a particular decision, and also increase the understanding of clinicians about the matters the Board must address when making decisions on a review. This should not only assist clinicians in future review hearings but also help in making their own decisions about whether involuntary treatment of a patient is necessary or possible.

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Or visit our website:
www.chiefpsychiatrist.health.wa.gov.au



Delivering a Healthy WA

Clinicians and decisions of the Mental Health Review Board- continued

Option 2: Appeal the Board's decision

An appeal against a decision or order of the Board may be made to the State Administrative Tribunal (SAT) by the patient concerned or by any other person whom the SAT considers has a sufficient interest in the matter: s 148A of the Act. The treating psychiatrist would be such a person. The appeal involves a complete rehearing of the review of the patient's involuntary status and the SAT will make what it considers to be the correct and preferable decision about that status at the time of the appeal hearing. In certain circumstances the SAT may make an order staying the operation of the Board's decision that is being appealed, pending the outcome of the appeal: *State Administrative Tribunal Act 2004 s 25*.

Patients who are aggrieved by decisions of the Board exercise their right to appeal to the SAT regularly, but it is rare for an appeal to be commenced by a clinician.

Option 3: Make the patient involuntary again

When the Board discharges a patient from involuntary status it expects clinicians to give effect to that order: cl 16 of Sch 2 to the Act. As a general rule, the Board would not expect a clinician to make a new involuntary treatment order shortly after the Board had discharged the patient - because that would be to permit clinicians effectively to over-rule a decision of the Board to discharge a patient.

However, there may be circumstances in which it is appropriate for a psychiatrist to consider making a patient an involuntary patient again soon after a Board decision. Two general situations may arise:

a) A psychiatrist may become aware (after the Board hearing) of factual material that was not before the Board and which the psychiatrist believes in good faith would have been likely to cause the Board to arrive at a different decision. Such information might, for example, throw new light on the assessment of the risk factors relating to the patient - such as new information that the patient has recently made a suicide attempt or has assaulted another person.

b) There may have been a material change in the circumstances underlying the Board's decision. For example, the Board may have discharged a patient from involuntary status because it accepted the patient's assurances that he or she would remain in hospital as a voluntary patient and would continue to accept medication - but soon after the Board decision the patient seeks discharge from hospital and/or refuses medication.

In considering whether to make a new involuntary treatment order (detained or CTO) the psychiatrist must ask him/herself whether the sole or principal ground on which he/she relies to make the order is one that, in substance, was rejected by the Board and/or whether the new order is based solely or principally on a difference of opinion between the psychiatrist and the Board. In such situations the psychiatrist should not make a new order.

If a psychiatrist makes a new involuntary treatment order soon after a Board decision to discharge a patient, the Board would expect the psychiatrist to apply to the Board for a further review to be conducted by the Board: s 142 of the Act - so that the Board can be made aware of the circumstances that are said to justify the new order and can make a new decision about the patient's status.

Put the best case forward

As noted above, the Board will discharge a patient when it takes a different view to that of the psychiatrist about the need for involuntary treatment. If the Board is to give full weight to the opinions of the treating team it must have presented to it at the review the strongest case the team can present to justify the need for involuntary status. This will usually be achieved best if the Board is given (in a timely way) a comprehensive report from the treating team that addresses specifically (with supporting evidence) the reasons why the team believes the s26 criteria for involuntary status are met and why that status should continue. A copy of this report should be given to the patient (and any representative) a sufficient time before the hearing to enable the patient to understand its contents and prepare any response.

Non-Government Standards Monitoring Program

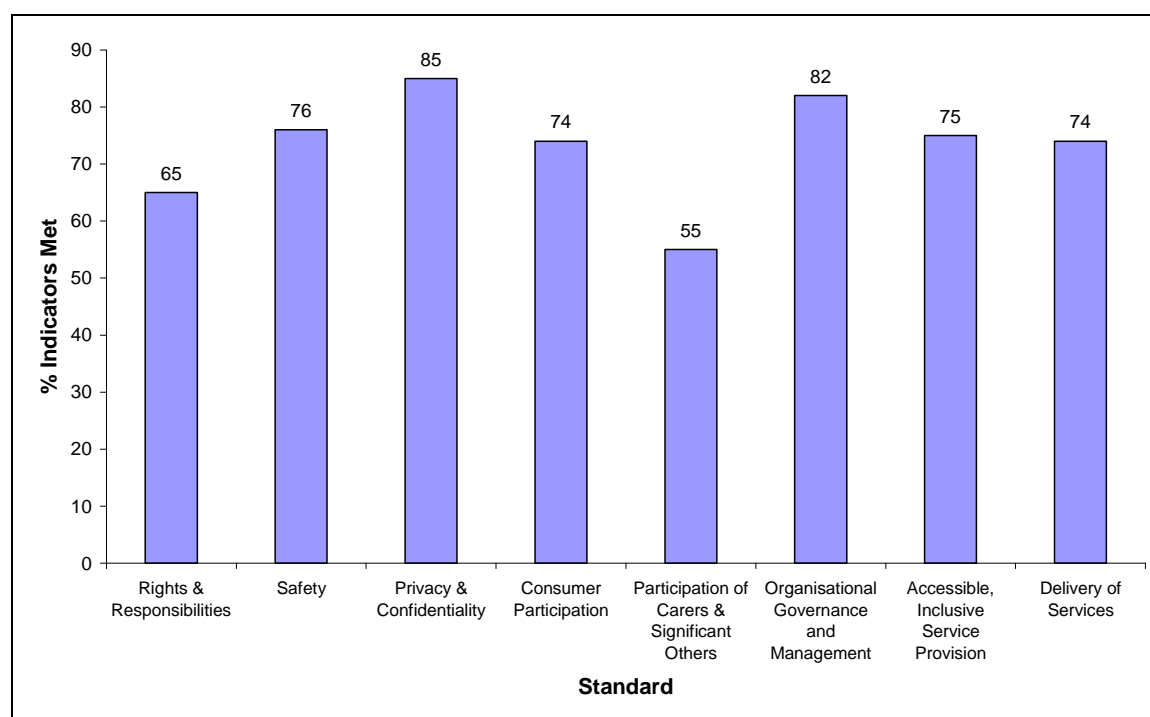
The Chief Psychiatrist has the responsibility under the *Mental Health Act (1996)* for monitoring standards of psychiatric care in community mental health facilities. For the non-government sector this responsibility is exercised through a program of monitoring based on the *Service Standards for Non Government Providers (2004)*.

The standards monitoring program for non-government organisations (NGOs) comprises two phases; a Self Assessment to be completed by all 54 agencies, and a Comprehensive Standards Review to be completed by 21 selected agencies. The Self Assessment phase was completed in 2008 by 52 NGOs, and a pilot of the Comprehensive Review methodology has been undertaken. The results are detailed below.

Self Assessment

Each agency completed Self Assessment forms against the eight service standards. As the graph below demonstrates, agencies met the majority of indicators within each standard.

Percentage of indicators met by standard:



Overall agencies demonstrated a strong commitment to protecting consumer privacy and confidentiality, including consumers in the planning and delivery of services, and in delivering services in a way that upholds and promotes the dignity and respect of the consumer. Areas for improvement are focused around formalising what are often current practices into policies and procedures, and the development of staff training programs across areas such as occupational health and safety, awareness of diversity and risk management.

A report summarising the data from each standard has been sent to all agencies.

The Self Assessment is required to be completed on an annual basis and the 2009 round will commence in April.

Community Treatment Orders (CTOs)

Deborah Colvin, Head of the Council of Official Visitors highlights ten concerns expressed by consumers

1. Not really understanding how the CTO works, how long it will apply for, or their rights (this includes: unclear wording of the CTO order so the patient does not know what they have to do or not do to comply; a patient wrongly being told they had to do everything the doctor said including stay in a private hospital and not leave the ward; and informing long term CTO patients, as medical teams seem to assume they know their rights);
2. Not knowing whether their CTO has lapsed or not - in particular there is confusion over extensions of the CTO - staff do not discuss the CTO or make clear what is happening or going to happen;
3. Mental Health Review Board (MHRB) hearings - no-one turning up from the clinic; not being given a copy of the doctor's report to the MHRB before the hearing and/or not having it discussed with them by the doctor before the hearing;
4. Having clinic staff (and sometimes police) turn up at their door without warning and/or taking them off to hospital (sometimes shortly after they have seen the doctor at the clinic and without the clinician having discussed their concerns with the consumer); other times asserting the consumer had missed an appointment when they had a legitimate reason or there was a genuine misunderstanding or mistake;
5. Threats of being sent to an Authorised Hospital (with the added fear they will be picked up by police in a marked car and embarrassed in front of neighbours);
6. Not listening to the patient and not trying other or new methods of treatment and therapy - particularly long term CTO patients who tend to be put into the "too hard basket";
7. Lack of ready or timely access to their psychiatrist, services like psychologists and second opinions;
8. Turning up at the clinic for the first time and not knowing the staff or the management plan - and sometimes turning up when the clinic know nothing about them either;
9. Having to go to a particular clinic when there is one closer to home and inability to change doctors if they don't get on well with the one allocated;
10. Conversely, treating clinician and clinic staff turn-over - having to tell their story over and over again - either due to staff turn-over or just because they get bounced around from person to person in the treating team.

Chief Psychiatrist's comment:

Although a patient on a CTO is an involuntary patient under the Mental Health Act 1996, the success of a CTO depends primarily on the therapeutic relationship between the consumer and staff providing the community mental health service, so every effort should be made to develop and sustain these important relationships.

Mental Health and Firearms licences

Firearms and licences for firearms are regulated by the *Firearms Act 1973* (Firearms Act). At times the issue has arisen about whether we can provide information to the police about a mental health consumer who possesses a firearm or respond to a request from the police about a firearms licence application.

As there is no central process or division in the Department of Health to which the police can be directed regarding queries about the fitness of applicants to hold a firearms licence, queries will often come directly to mental health clinicians.

Duty of confidentiality

Health care staff have a duty of confidentiality not to disclose confidential patient information without the patient's consent. These duties are prescribed under the common law and the *Mental Health Act 1996* (MHA). The MHA and the Firearms Act provide some exceptions to this duty.

Relevant exceptions to the duty of confidentiality- In the context of firearms licence applications, there are two relevant exceptions to the duty of confidentiality in the Firearms Act.

1. Section 18 - Certificate from medical practitioner

Section 18 of the Firearms Act provides that the Commissioner of Police must ensure that, for the purpose of forming an opinion as to whether an applicant is a fit and proper person to hold a licence, if there is any apparently reliable indication that the applicant may not meet the standards of mental or physical fitness, sufficient evidence must be provided to satisfy the Commissioner that the person does meet those standards. The Commissioner may require a certificate from a medical practitioner to the effect that the applicant has been examined and has not been found to have any physical or mental condition that could result in the person being considered not a fit and proper person to hold a licence. A medical practitioner is not compelled to provide such a certificate. If a medical practitioner provides the Commissioner with a certificate, the Commissioner may request from the medical practitioner any further information that the Commissioner considers to be relevant. If a medical practitioner gives the Commissioner further information in good faith as requested, there is no breach of the duty of confidentiality.

2. Section 23B - notification by health professionals

Section 23B of the Firearms Act permits a health professional to inform the Commissioner if the health professional is of the opinion that, because of a patient's physical, mental or emotional condition, it is not in the patient's interest or the public interest for the patient to hold a firearm or ammunition to which the patient is believed to have access.

Medical practitioners and registered nurses may also inform the Commissioner when a person is seeking or has sought medical assistance for an injury which may have been caused by a firearm or ammunition.

Summary

In summary, the police may approach a health professional for information as to whether a patient should or should not hold a firearms licence. It is not a breach of confidentiality if the health professional provides such information to the police pursuant to the exceptions in the Firearms Act but the health professional is not compelled to do so. Although there is no obligation to provide the information, health professionals should remember that it is an offence for a person to take active steps to prevent or obstruct the discovery or investigation of an offence.

A patient may expressly consent to the disclosure of their confidential information. The police may provide the health professional with a signed consent form as evidence that the patient has consented to the disclosure of the information. Health professionals should be clear on the scope of the consent and ensure that the disclosure is only made to the appropriate organisation or individual and for the purpose specified in the consent form.

Health professionals should contact Legal & Legislative Services if they are unsure about whether to disclose confidential information to individuals or organisations not involved in a patient's care.

Providing information to the Mental Health Review Board

Mr Murray Allen- President, Mental Health Review Board

The *Mental Health Act 1996* and its regulations require the Mental Health Review Board to keep certain particulars about every person who is treated as an involuntary patient. The particulars concerning each involuntary patient are specified to be:

- The name, address and date of birth;
- Details of any orders made under s49(2)(a) (initial detention order); s 49(3)(a) or s50 (continuation of detention orders); s70(1) (order for detention when a CTO is revoked); or s78 (discharge from involuntary status);
- Details of any CTO made or revoked, and any variation, extension or breach of a CTO;
- Any periods of leave of absence granted or any absence without leave;
- Details of any reports made under s115(b) (emergency psychiatric treatment); s120(d) (seclusion of a patient); or s124 (use of mechanical bodily restraint);
- The date a patient is released from detention in an authorised hospital or ceases to be an involuntary patient;
- The date and cause of death if any involuntary patient dies.

The Board relies on hospitals and clinics to provide the information required in a timely way - so that it can be used in the scheduling of reviews that the Board is required to conduct. Instances have occurred where information about an involuntary patient has not been provided to the Board, with the result that the patient concerned has not had a review of involuntary status at the times required by the Act.

Recently, problems have also arisen when a patient has been placed on a CTO where the supervising psychiatrist is a private practitioner who is not employed within the public mental health system. On occasions the Board has not been provided with information about the CTO - particularly extensions or the making of new CTOs. If a patient on a CTO is referred to a private psychiatrist then it is important that the psychiatrist is aware of the need to provide information to the Board.

The information (most of which is contained on the forms made under the Act) can be provided to the Board by way of Facsimile, Email or Hard copy sent by ordinary mail or special delivery (provided that it arrives at the Board in a timely way).

The Board's preference is to receive the information by facsimile. **It would be greatly appreciated if all hospitals and clinics (and private psychiatrists involved in the treatment of involuntary patients) would check their current administrative arrangements to ensure that appropriate procedures are in place to ensure that all necessary information is provided to the Board.**

If any hospital, clinic or practitioner has queries regarding providing information to the Board then contact should be made with Lisa Glass at the Board on 9219 3131 or by emailing lisa.glass@health.wa.gov.au. Alternatively, advice can be obtained from the Office of the Chief Psychiatrist.

Inpatients Rights and Legal Representatives

Sections 166 to 177 of the *Mental Health Act 1996* (MHA) detail an inpatients rights in regard to having visitors, sending and receiving mail and receiving and making phone calls. While the MHA recognises these rights it also permits a restriction or denial of these rights if the psychiatrist considers it to be in the interest of the person to do so.

The view of the Chief Psychiatrist is that a restriction or denial of these rights may be appropriate however should not apply if the patient wishes to contact or be contacted by their legal representative. The right to legal representation is recognised in the MHA and the United Nations Principles for the Protection of Persons with Mental Illness (1991) and the ability of the patient to contact or be contacted by their legal representative should only be withheld at the request of the legal representative.

Delivering a Healthy WA

The Chief Psychiatrist's Clinical Governance Review Program

The *Mental Health Act 1996* prescribes the Chief Psychiatrist with the responsibility of monitoring the standards of psychiatric care provided throughout the State of Western Australia. In order to meet this responsibility the Chief Psychiatrist has established a process whereby clinical service delivery of mental health services are to be systematically reviewed.

Across WA there are a total of 32 public mental health services, each of which will undergo a Clinical Governance Review. In addition, the Chief Psychiatrist also conducts Clinical Governance Reviews of private facilities, at the request of the organisation.

The Clinical Governance Review Process is as follows:

- Pre-review planning and data collection commences 6 months prior to the review date.
- Site visit - usually lasting one week.
- First draft CGR Report is produced and sent to the service.
- The service responds to the report by completing an Action Plan to address the recommendations made
- Full Clinical Governance Review Report (incorporating service response) is prepared. The report is acquitted by the Chief Psychiatrist and sent to the Director General of Health, Area Health Director, Area Mental Health Director and Service.
- Progress audits are conducted at the service three monthly following receipt of the CGR Report.
- Once all recommendations have been achieved, a final CGR Report is provided to the service.
- Completion of the Clinical Governance Review Process

To date, a total of eight public and one private mental health services have completed the full Clinical Governance Review cycle.

An additional five mental health services are currently in the progress audit phase, and reports are currently being prepared for a further five services.

Planning is underway for three further reviews this year. A copy of the timetable is available on the OCP website.

If you have any queries about the Clinical Governance Review process, please contact the Co-ordinator of Standards Monitoring, Dr Theresa Marshall at theresa.marshall@health.wa.gov.au.

The Office of the Chief Psychiatrist employs clinicians from the public mental health services to be part of the Clinical Governance Review teams. If you are interested in participating in a Clinical Governance Review, please email an expression of interest, briefly outlining your clinical experience, to andrea.kersten@health.wa.gov.au.

Delivering a Healthy WA

Driving and mandatory reporting to the Department of Planning and Infrastructure

The West Australian Department of Planning and Infrastructure require mandatory reporting by patients with a number of illnesses where their condition may adversely effect their ability to drive. This requirement now applies to every State and Territory in Australia.

The types of illnesses include people suffering from mental illnesses such as depression, schizophrenia, bipolar disorder or other psychosis. The issues relate to a patient's perception, judgement, response time and general physical capability. There are a number of physical conditions such as diabetes, epilepsy, heart conditions, eye problems and sleep disorders which also apply.

It is expected that people will self report any condition and the website details the options available to the patient and the Department to manage the issues in the safest way for the person and other road users. Failure to report a medical condition is an offence which carries a \$500.00 fine. If a patient does self-report a medical practitioner may be asked to provide a report about the medical condition.

Mandatory reporting does not apply to medical practitioners, however the Department of Planning and Infrastructure recommends that if a patient refuses to self-report that the medical practitioner inform the Department.

Reporting does not mean automatic suspension of a driving licence, however conditions may be put in place to reduce the risk of an accident such as medication must be taken, or driving only done in the day time or driving only an automatic car.

Reporting can be by e-mail to MedicalMandatoryReports@dpi.wa.gov.au or by mail to Attention - Mandatory Reporting Team, Department for Planning and Infrastructure, GPO Box R1290, Perth, WA 6844. For further enquiries visit the website

<http://www.dpi.wa.gov.au/licensing/yourlicence/15753.asp> or phone 1300 852 722.

Authorised Mental Health Practitioner (AMHP) Corner

The Register of AMHPs in Western Australia indicates that there are over 500 AMHPs within services in WA. Many of these AMHPs are probably not active in the role due to change of position, doing a special project or even promotion. If you are one of these AMHPs and it is unlikely you will be using your powers in the foreseeable future please contact me and I will remove your name from the Register. We really want to keep the Register for those AMHPs who are in roles where these powers can be used. If you are taken off the Register at any time you can be re-instated without having to redo the training.

According to the returned notifications in 2008 AMHPs did 5923 assessments under section 29 of the Mental Health Act 1996. On 483 occasions a Form 1 was completed and on 352 occasions a Form 3 was completed. I note it was more successful getting notifications of activity using just an e-mail format rather than a Form and will continue that in 2009.

Relationships with the police and use of a Form 3 have for some AMHPs been difficult over the last year. A new police liaison officer, Inspector Brian Cunningham, has been appointed and in conjunction with work being done by the Mental Health Division and the Nurse Director of Patient Bed flow with a Assertive Patient Flow and Bed Demand Management policy some of these difficult situations will be better managed in 2009. Approximately 60 Custody Officers have been employed at the Perth Watch House. These officers are designated as Special Constables and therefore have the authority to transport a person referred on Forms 1 and 3. In the future they may be involved in police transports under the Mental Health Act 1996 as police officers are at present.