



MENTAL HEALTH REVIEW BOARD

WESTERN AUSTRALIA

HANDBOOK

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Foreword

The Mental Health Review Board was established under Part 6 of the *Mental Health Act 1996 (the “Act”)*. The objects of the Act are:

- (a) *ensuring that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference of their rights and dignity;*
- (b) *ensuring the proper protection of patients as well as the public; and*
- (c) *minimising the adverse effects of mental illness on family life.*

The role of the Mental Health Review Board (“the Board”) is critical in ensuring the objects of the Act are met. The Board provides involuntary patients, whether detained in an authorised hospital or subject to a Community Treatment Order in the community with a speedy, informal and fair means of having their involuntary status reviewed, either upon request or periodically.

The establishment of the Board under the Act also embodies Principle 17 of the United Nations document ‘*Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*’ (1991). Principle 17 requires that involuntary detention be reviewed at reasonable intervals by a body that is judicial or otherwise independent, assisted by qualified mental health practitioners. The United Nations principle also requires that the review body’s procedures be simple and expeditious and that there be a right of appeal to a higher court against a decision.

There were a number of reasons behind the decision to publish *Handbook 2000*, the Board’s inaugural policy handbook. The goals of the original Handbook included:

- articulating the way in which the Board goes about its task of reviewing the involuntary status of patients; and
- being open and accountable to the Board’s ‘client base’, which includes mental health consumers, carers, service providers, advocacy groups, non-government organisations, the Health Department, the Minister, and the general community.

Feedback has been received from various sources since publication and in early 2001 further feedback was sought from interested persons and groups. I thank all persons who took the time to provide feedback to the Board. This revised edition of the Handbook takes account, where possible, of the feedback received and is intended to provide a clear guide to how the Board seeks to meet the responsibilities given to it by the Act.

In an area as dynamic and complex as mental health, new situations will inevitably emerge which will require new responses. I therefore request feedback in relation to matters in this Handbook or those matters that observers

consider should be included in the Handbook but have not been. The feedback will be considered for inclusion in future editions of the Handbook, which will be published as the need arises.



Neville Barber
PRESIDENT



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1.0 – OVERVIEW OF THE BOARD

1.1 Establishment of the Board

The Board is an independent review body established under Part 6 the *Mental Health Act 1996* (the “Act”). Board members are required to be legal practitioners, psychiatrists and persons who are neither legal practitioners nor psychiatrists. (s.126(2)) The Board also has a staff including a Registrar and such other officers as are necessary to assist with the performance of the Registrar’s functions. (s.22) Currently, staff include a Registrar, Executive Officer and Personal Assistant.

1.2 Purpose of the Board

The Board’s primary statutory purpose is to review involuntary patients, in accordance with the Act. For each review, the three members comprise a legal practitioner, a psychiatrist, and a ‘community member’- a person who is neither a legal practitioner or a psychiatrist. (s.129(5)) Each three member Board acts independently when reviewing a patient’s involuntary order though the process of review is generally the same for all reviews. In conducting reviews, the Board reviews the decision of a psychiatrist to order or maintain the involuntary status of a patient.

In making a determination upon a review, the Board applies the same legislative criteria as the psychiatrist when he or she makes a person an involuntary patient under the Act (*primarily considering ss.4 and 26*). The Board is also to have regard primarily to the psychiatric condition of the person concerned and is to consider the medical and psychiatric history and the social circumstances of the person. (s.137)

1.3 Powers of the Board

The Board’s decision whether to continue or discharge the involuntary status is based on reviewing whether the patient has a mental illness as defined in the Act and whether the criteria of the Act for involuntary status have been satisfied and continue to be satisfied.

The Board’s powers on carrying out a review are set out in section 145. Section 145(1) provides:

Subject to this Act, the Board may determine any matter coming before it for consideration and may make such order in respect of a matter as it thinks appropriate.

The wording of section 145(1) is not specific. It is apparent that the Board has the capacity to maintain the involuntary status of a detained involuntary patient or a patient subject to a Community Treatment Order (“CTO”). In addition, section 145(2) specifically enables the Board to:

- (a) order that a person is no longer an involuntary patient (*s.145 (2)(a)*);
- (b) order that a CTO be made in respect of a person, giving such directions, if any, as it thinks fit in relation to the terms of the order if it is satisfied that the requirements for the making of a CTO have been established (*s.145 (2)(b)*); and
- (c) if the person is subject to a CTO, vary the order, and give such directions in relation to the order as it thinks fit (*s.145 (2)(c)*).

The inclusion of the words “subject to this Act” in section 145(1) provides a limitation on what could otherwise be construed to be its unlimited powers. The words ‘subject to this Act’ require consideration to be given to the other parts of the Act, most relevantly Part 2 (Administrative provisions, including the powers of the Chief Psychiatrist); Part 5 (Treatment), Part 7 (Protection of patient’s rights) and Part 9 (Council of Official Visitors).

As necessary, the Board may also:

- (a) suspend the operation of any relevant order, or restrain the doing of anything, or anything further, under any relevant order, until the application has been determined, or the review concluded (*s.143*);
- (b) at any time, carry out a review of the case of any involuntary patient if it considers it appropriate to do so because of any report or complaint it receives or for any other reason (*s.144*);
- (c) in relation to electroconvulsive therapy where the recommendation of the treating psychiatrist is not approved by another psychiatrist, the Board may recommend an alternative treatment, transfer the responsibility for treating the person from the treating psychiatrist to another psychiatrist or order that the person is no longer an involuntary patient (*s.106*);
- (d) where there is a restriction or denial of entitlement under section 169 of the Act and an application has been made by a patient or any other person who in the opinion of the Board has a proper interest in the matter, the Board may review the restriction or denial of entitlement order and may confirm, cancel or vary such an order (*s.170*); and
- (e) where a determination has been made under section 201 by a psychiatrist that a patient who is enrolled as an elector under the *Electoral Act 1907* is not capable of making judgements for the purpose of complying with the provisions of that Act relating to compulsory voting, the patient or any other person whom the Board considers to have a proper interest in the matter may apply to the Board for a determination, and the Board may confirm or cancel the determination (*s.203*).

1.4 Objectives

The following objectives are critical to the way in which the Board conducts its reviews.

The Board will in each review seek to ensure that:

- (a) maximum respect and dignity is given to the patient being reviewed (and to family members when they are present) and to all other participants in the review;
- (b) respect is accorded to members of the treating team, acknowledging their general competence and concern for the patient;
- (c) active steps are taken to avoid or at least minimise patient distress occasioned by the review;
- (d) consistency is maintained and optimised in its processes, in order to facilitate patient and mental health service understanding of the Board and its statutory obligations and requirements;
- (e) the efficiency and timeliness of each review is optimised, in order to balance:
 - (i) the need to properly review the order pertaining to each patient; and
 - (ii) the need to minimise patient distress and discomfort caused by the review process itself.

1.5 Other Duties of the Board

- (a) The Minister for Health may direct the Board to enquire into any matter to do with the administration of the Act. (*s.147*) The Board is to report to the Minister on the results of an enquiry that it is directed by the Minister to carry out, and may report to the Minister on any other matter that it thinks should be considered by the Minister. (*s.148*)
- (b) 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*)
- (c) The Chief Psychiatrist may report to the Board on matters concerning the medical care or welfare of involuntary patients. (*s.10(d)*)



2.0 – THE GENERAL PROCESS FOR A REVIEW

The Board generally conducts its reviews in the following way:

- (a) The members of the Board review the contents of the medical files applicable to the patient and any report prepared in relation to the patient prior to the commencement of the review.
- (b) The Board's preference is for any report provided to it to also be made available to the patient and/or discussed with the patient prior to the review. Generally, this both shortens and improves the review itself.
- (c) The patient is entitled to relevant information to be able to respond to the matters raised by the treating team if he or she wishes to do so. This information can be provided in writing (by a report) or orally at the review itself.
- (d) If the Board is advised that there are good reasons why some information should not be provided to the patient (consistent with section 161), the Board considers those reasons and makes a decision about what information is made available for the purposes of the review. If any information is restricted, the Board ensures that the patient has sufficient information to respond appropriately to the relevant issues, primarily whether or not the criteria for involuntary status are or continue to be satisfied.
- (e) The review commences with introductions and an explanation of the purpose and process of the review. In most instances the patient and treating team member will be present from the commencement of the review. In some circumstances, particularly upon request by the patient, the patient may present an outline of his or her submissions at the commencement of the review in the absence of the treating team member.
- (f) After the short introductory phase, the treating or supervising psychiatrist or other member of the treating team provides further comment, where necessary, on the provided report, the patient's progress and treatment plan, and the need for continuing involuntary status. Board members, and/or the patient/ patient's representative may question the treating team member on issues arising from the report or comments. Although it is preferable where possible for the psychiatrist to personally attend the review, the Board accepts that this is not always practical and therefore accepts that in some instances the necessary information may be provided by telephone or by other members of the treating team.
- (g) The patient is given the opportunity to respond to the issues raised

by the treating team member and may introduce information by calling other persons. Board members are able to speak with the patient about his or her views, even if the patient is represented.

- (h) Once all relevant information has been provided, final comments will be sought from the patient or his or her legal representative, and the member of the treating team. The Board then adjourns.
- (i) The Board considers the information available to it and makes a decision about whether or not the involuntary status should be continued.
- (j) The Board then invites the patient back into the review room to advise him or her of the decision and provide him or her with a copy of the decision sheet. Where the patient is represented, a copy of the decision sheet should be provided to the patient's representative.
- (i) If a patient has notice of the review but does not attend it, the Board may conduct the review in the patient's absence. Where this occurs, a copy of the decision made by the Board will be posted to the patient.

2.1 Involuntary status

In a similar way to a psychiatrist considering an involuntary order, the Board has to consider the statutory criteria in the Act for involuntary status. Section 26 of the Act provides the statutory criteria which must be satisfied if a person is to be an involuntary patient, either detained in an authorised hospital or subject to a CTO.

The first requirement of section 26 is that the person has a "mental illness" requiring treatment. The term "mental illness" is defined in section 4 of the Act. To satisfy the definition, the person concerned has to suffer from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent. Relevant exceptions also apply. (*s.4(2)*)

The second requirement of section 26 is that the treatment can be provided through detention in an authorised hospital or through a CTO and is required to be so provided in order to achieve one of three things which are described in section 26(1)(b). These matters relate to protection of the health or safety of the patient or of other people (*s.26(1)(b)(i)*); the protection of the patient from certain self-inflicted harm (elaborated upon in section 26(2)); and to prevent the patient from doing serious damage to property. (*s.26(1)(b)(iii)*)

The third requirement of section 26 is that the patient has refused or, due to the nature of the mental illness is unable to consent to, the treatment.

The fourth and final requirement of section 26 is that 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.

2.2 Standard of proof

The provisions of the Act should be strictly complied with before the detention or continued detention of an involuntary patient is permitted: **M. v. Mental Health Review Board**. (*unreported Supreme Court decision number 990093 of 1999*). This principle has now been endorsed in **EO v Mental Health Review Board** (Supreme Court decision [2000] WASC 203) as also being relevant for CTOs.

2.3 Order for further information following reviews

On rare occasions, the Board may determine that the patient meets the requirements of involuntary status but may consider it appropriate to continue to have an interest in the patient's progress. Such instances may include the following:

- (a) where the treating team have given undertakings to the Board that the patient will be discharged to a CTO within a certain period, and it needs to be established whether those undertakings have been met, and if not, why not;
- (b) where the Board's decision was the subject of extensive deliberation, and it seeks information about the progress of the patient so that it can determine whether or not it is necessary to hold a further review;
- (c) where a certain event which may have impacted upon the Board's decision on the day, for example, notification of an application for accommodation with the Disabilities Services Commission, needs to be followed through.

In such instances, the Board may seek a further report be provided to it within a specific time period.

During some reviews, some systemic issues may arise which require follow-up. (*see 5.4*) Such matters should be referred to the Registrar or the President for that follow-up to occur.

2.4 Suspending the operation of an order

A patient may apply for a review for a number of reasons as detailed in section 142 of the Act. Section 143, which allows for the Board to suspend an order until the review is concluded, operates where an application is made for a review.

If the Board when conducting a review decides to adjourn the review, it may further decide whether to suspend the operation of any relevant order or restrain the doing of anything or anything further until the application has been determined or the review concluded. (*s.143*)

2.5 Reasons for decision

Any party to a review is entitled to request and be provided with reasons for the Board's decision. The request is required to be in writing and should be received by the Board within 14 days of the review being completed. (*Schedule 2.15*)

However, where possible (and particularly if the involuntary patient order that was the subject of the review is still in existence) the Board will provide reasons even if the request is received outside of the statutory timeframe.

Consistent with the requirement of the Act (*section 132 (1)(b)*) that the legal practitioner presides at a review, it is the practice of the Board for the legal member to prepare reasons for decision. The Board has a template that is generally used for preparation of reasons.

For reasons of security and confidentiality, it is the practice of the Board for reasons to be prepared at the Board's premises. An administrative fee is paid to the legal member for preparation of reasons.

Draft reasons should be prepared within 14 days of receipt of request. The Board's goal is for reasons to be finalised and posted to the relevant parties within 21 days of request.

2.6 Transcripts of proceedings

The Act requires the Registrar to keep a record of proceedings in a form suitable for enabling a transcript of proceedings to be prepared if required. (*Schedule 2. Item 14*) Upon notification by a party of the lodgement of a Supreme Court appeal (See 2.7), the Registrar will obtain a transcript of the review and provide it to the Supreme Court.

In all other circumstances, a person requesting a transcript of a review should write to the Registrar who will make a decision on the request after considering the reasons for it. Relevant considerations for the Registrar's decision about the preparation of a transcript include the following:

- (a) whether the request is from or on behalf of a participant in the review;
- (b) whether the order to which the review relates is still in existence;
- (c) whether an appeal is being considered; and
- (d) whether the person requesting the transcript has agreed to pay the transcription costs.

The Board does not provide either the actual recording or copies of it.

2.7 Appeals to the Supreme Court

Involuntary patients who are dissatisfied with the decision of the Board may appeal to the Supreme Court against a Board's decision. Any other person who in the opinion of the Supreme Court has a sufficient interest in the matter may, with the leave of the Court, also appeal to the Supreme Court. (*s.149*)

The grounds for appeal are that:

- (a) the Board made an error in law and/or in fact; or
- (b) the Board acted outside or in excess of its jurisdiction; or
- (c) there are other sufficient reasons. (*s.150*)

The appeal must be brought within one month of the Board's decision, unless the Board or the Court are satisfied that it is just and reasonable to extend the period. (s.151)

The patient must be represented by a legal practitioner. (s.152)

While the appeal is pending the Supreme Court may suspend any decision of the Board, and also revoke any suspension. (s.153)

The Supreme Court may:

- (a) confirm, vary or quash any Board decision; or
- (b) make another decision; or
- (c) remit the matter back to the Board for re-hearing. (s.154)

The Board may state a case for the opinion of the Supreme Court upon a question of law. (s.155)

The Registrar will, in accordance with Order 65, Rule 8 of the *Rules of the Supreme Court* of Western Australia, forward to the Principal Registrar documentation relevant to the review.

Parties to the appeal who require access to documents should apply to the Principal Registrar of the Supreme Court for such documentation.



3.0 – ADMINISTRATIVE AND LEGAL PROCESSES REGARDING REVIEWS

The Board conducts both periodic and requested reviews. This section explains the administrative processes relevant to all reviews.

3.1 Periodic reviews

A periodic review is a mandatory review to be undertaken by the Board even if the patient does not request a review, and must be held by the Board within eight weeks of a patient becoming an involuntary patient provided that the patient remains involuntary. (*ss.138 & 142*) Thereafter, whilst the patient continues as an involuntary patient, the Board must further review the patient not later than six months after the preceding review. (*s.139*)

The Board is required to carry out a review as soon as practicable after the initial order is made. (*s.138(2)*) The Board is required to conduct both periodic reviews and requested reviews. (see 3.2).

When considering its obligations, the factors the Registrar is required to take into account include:

- (a) complying with the Act;
- (b) ensuring that those persons who request a review can be reviewed within a reasonable time;
- (c) allowing sufficient time for patients to obtain appropriate legal representation and generally prepare their case;
- (d) providing opportunity for the treating team to prepare the necessary reports; and
- (e) practical issues including the availability of venues, and a three member Board.

Bearing in mind these considerations, periodic reviews are generally scheduled following receipt of a Form 9 (a continuation of an involuntary order and usually made approximately 28 days after the initial order). Where a CTO is initiated in the community the review is generally scheduled after the first 28 days of the order. This means that periodic reviews generally occur in weeks 6-8 of a person's involuntary status. This approach ensures that the Board is able to schedule requested reviews within a reasonable timeframe whilst meeting its statutory obligations (and time-lines) for periodic reviews.

If the patient is discharged from involuntary status but again made an involuntary patient within 7 days, for the purposes of a review the patient's involuntary status is considered to be continuous and reviews will be scheduled accordingly. (*s.140*)

Although the status of an involuntary patient may be changed by a psychiatrist from detained status to a CTO, an initial review still needs to be scheduled within 8 weeks of the patient becoming involuntary. (s.138(1))

If a review has been scheduled and prior to the review the patient is placed on a CTO, then generally the review will continue at the scheduled date, time and venue as indicated on the Notice of Review. This policy has been implemented to ensure that the patient is reviewed within the statutory time-frame required by the Act. However, if a patient is placed on a CTO to a mental health service outside of the Perth metropolitan area, the review will be rescheduled at the rural mental health service.

If no review has been scheduled at the time the patient is discharged from detained status to a CTO then a review is scheduled at the appropriate mental health service in the community. On occasion, the review of a patient on a CTO can be problematical, given the limited time available for the patient to be seen at the clinic after the patient's discharge from hospital. This situation could be rectified by legislative amendment.

3.2 Requested reviews

An involuntary patient may request a review of his or her involuntary status. (s.142(1))

All requests for reviews must be in writing either in the form of a letter to the Board or by using the 'Application Form' which is attached to the pamphlet 'Information on the review process' available at all mental health services.

An application for review may be made by the involuntary patient, an official visitor, or any other person, such as the patient's representative, advocate or carer, who the Board is satisfied has a genuine concern for the patient. (s.142 (2)) An application may be made at any time except within 28 days after the Board has made a determination which involved a consideration of substantially the same issues. (s.142(3)) In these circumstances the application will be processed after 28 days has elapsed from the time of the earlier review.

If the request is from a person who says that he or she has a genuine concern for the patient, and there is an issue as to whether in fact this is so, the matter may be determined by the Registrar, who has the delegated capacity to enquire into that matter, or by the three member Board conducting the review.

Requests for reviews will be scheduled for review in order of the timing of their receipt by the Board if possible, bearing in mind other relevant factors, including the timing of the next scheduled attendance at a particular venue.

The Board's policy is to schedule requested reviews as soon as is practicable and if possible within 14 days of receipt of the request by the Board. However if there is limited scheduling space, periodic reviews are given precedence due to the Board's obligation to comply with the legislative timeframe for reviews.

3.3 Urgent requests for reviews

The Board accepts that on some occasions it may be important for reviews to occur within an expedited timeframe. Where considered necessary, patients (or those representing

patients) may make application to the Board for an urgent review. Applications for an expedited review will be considered on a case by case basis by the Registrar. Factors to be considered by the Registrar include:

- (a) the reasons for the request for an expedited review;
- (b) the availability of a Board to be constituted to conduct the review;
- (c) the availability of medical/psychiatric evidence;
- (d) the need for and availability of an advocate for the patient;
- (e) the number of persons at that time who are waiting for a requested review, and the equity of an expedited review in those circumstances.

The Registrar will make relevant inquiries and a determination on each request for an urgent review.

3.4 Notice of review

The Board's policy is to give as much notice as it can of a forthcoming review. This means that generally 7 to 14 days prior to a review a Notice of Review is forwarded to the patient, which gives details of the date, time and venue for the review, accompanied by an explanatory letter. If the patient is detained in an authorised hospital then a staff member is required to hand deliver this letter to the patient and sign a form confirming the service of notice (*Service of Notice of Review*). This form is placed on the patient's hospital file. Patients on CTOs are informed by Registered Post in a plain envelope sent to the address listed on the CTO and the Board receives a delivery confirmation card upon collection of the Registered Post.

The Board's pamphlet is always provided to the patient when notice of the review is given. The pamphlet gives information about the Board, how to apply for a review, how to prepare for a review and what happens at a review. The Board encourages the patient to obtain legal advice or assistance for the review as well as encouraging them to bring a relative, friend or carer to the review. An insert regarding how to obtain advice and representation is also included. Information provided to participants in Teleconference reviews also includes an insert entitled *Teleconferencing and the Board*.

The treating or supervising psychiatrist is sent a copy of the Notice of Review, accompanied by an explanatory letter. The letter asks for a written report to be prepared for the Board and indicates that the Board's preference is that a copy of the prepared report be given to and/or discussed with the patient prior to the review.

For patients detained in hospital, the Board sends a Notice of Review and letter for the patient to the relevant Ward Clinical Nurse Specialist (CNS). The CNS is requested to assist the patient attend the review. If the patient has been transferred to another ward, the CNS is requested to on-forward the letter and Notice of Review to the patient's new ward.

For patients on CTOs the Responsible Practitioner, as noted on the Form 10, is sent a Notice of Review and is also requested to assist the patient attend the review.

3.5 Length of review

Reviews are usually scheduled at half-hourly intervals but in some instances, for example, when an interpreter is attending or where there are other special circumstances, a longer review is scheduled. Half-hour scheduling does not mandate that the review must be completed in an half-hour although, generally, most reviews are completed within that timeframe. If a review goes for longer than half an hour then the next scheduled review will be delayed. All parties to a review are informed that although a specific time is indicated in the 'Notice of Review' delays may occur.

If reviews continue for longer than the time scheduled, Board members should contact the liaison person at the hospital or clinic or the Board's administrative staff so that persons attending subsequent reviews may be informed of the delay.

3.6 Withdrawal of request for review

A patient may in writing seek to withdraw their request for a review. If so, the Registrar will make a decision upon the request. If the requested review is an initial review then the review will generally continue as a periodic review at the time and date scheduled. Occasionally, due to other factors, the Registrar may decide to accept the withdrawal and cancel the scheduled review.

An application for withdrawal of a requested review following the completion of an initial review will ordinarily be accepted by the Registrar and any scheduled review cancelled, unless a periodic review is imminent.

3.7 Cancellation of reviews

The mental health service is required to notify the Board's administrative staff when a patient has been discharged from involuntary status as the review is then cancelled. If the timeframe is short this may be done by telephone or facsimile and followed up by forwarding the appropriate form.

The supervising psychiatrist, responsible practitioner and the patient are informed in the letter sent notifying them of the review that if the patient is discharged from involuntary status prior to the review that the review will not proceed.

It is the duty of the psychiatrist or other member of the treating team to ensure that the patient and any one else expected to attend the review are notified of the change in the person's status and thus the cancellation of the review.

In circumstances where the patient has a legal representative or member of the Council of Official Visitors scheduled to attend the review the Board's administrative staff will inform these persons of the cancelled review upon notification by the mental health service.

3.8 Adjournment of a review

Any party to a review may request an adjournment of a review.

Adjournments occur when a review is commenced but not completed on that day. In general

terms, it is preferable where possible for the Board to make a decision upon the information available to it on the day and thereby conclude the particular review. Adjournments will generally only be made when there is insufficient information to allow the Board to make a decision. (see 5.4.8 (b))

The Board may also adjourn a review in other circumstances. For example, it may be necessary for a review to be adjourned to obtain an independent psychiatrist opinion or an interpreter.

If a matter is adjourned prior to the substantive hearing commencing, it will be adjourned to a date to be fixed, rather than to a fixed date and may be heard by a differently constituted Board due to the practical difficulties in reconvening the Board with the same membership.

3.9 Using teleconferencing for reviews

Whenever possible, reviews outside the Perth metropolitan area will be conducted using audio-visual equipment. (*s.133*)

Letters to supervising psychiatrists, responsible practitioners and mental health managers of in-patient services regarding the review include guidelines regarding teleconferencing. These guidelines request that as well as the Psychiatrist's report, other relevant documents regarding the patient be faxed or sent by post to the Board prior to the review. Such relevant documents include, as a minimum, prior discharge summaries and case notes for the month preceding the review.

The administrative staff will liaise with the service provider to ensure that relevant available documents are provided to the Board before the review. On some occasions, essential documents may be held by another mental health service other than the mental health service then responsible for the patient. Should this become apparent, the administrative staff will request from that service those documents that are necessary for the Board to properly conduct the review.

All such documents either faxed or sent by post will be maintained on the patient's confidential file held by the Board.

A member of the Board's administrative staff will assist the Board in establishing a teleconference link with the mental health service. Usually, the teleconferencing link will be initiated by the Board.

If there is a failure with the teleconferencing equipment before or during a review the Board may commence or continue the review using a conference phone, or in matters of some complexity or special need, may adjourn the matter to a date to be fixed.

During a review the Board may require further documents held by the mental health service supervising the patient or a previous mental health service. In these circumstances the Board will request that the relevant documents be faxed immediately to the Board.

3.10 Psychiatric reports and patient access to information

Schedule 2 of the Act sets out provisions concerning proceedings before the Board. The

Board is not bound by the rules of evidence but may inform itself on any matter in such manner as it thinks fit. (*item 8*) Furthermore, it is obliged to act according to the substantial merits of the case and not adopt a technical or too legalistic an approach. (*item 7*) Each party is entitled to a reasonable opportunity to call or give evidence, to examine or cross-examine witnesses, and to make submissions. (*item 2*)

The Board is in any event subject to an overriding obligation to ensure that the proceedings and its decision, have occurred fairly. This means that patients or their representatives will ordinarily be given the opportunity to test and comment upon any documentation or other information which the Board has regard to and to make submissions on the issues to which the Board attaches significance.

Under section 160 of the Act the patient has, subject to some exceptions in section 161, an entitlement to access to and copies of material hospital records. On occasions, most of those records may be required by the Board for its deliberations; in other circumstances only a small proportion of the documentation (say, the most recent volume) may be required. In the ordinary course the Board will make a patient aware of the medical records provided to it, but the patient may believe that other records are not provided or may be of relevance to the proceedings. Accordingly, where patients believe or suspect that there is information on hospital files of relevance to any particular review, they should endeavour prior to the hearing to identify that documentation with a view to using that information to assist their case or at least alert the Board to the documentation's existence.

When arranging a review, the Board requests a comprehensive report from the treating or supervising psychiatrist. The Board's preference is for any report provided to it to also be made available to the patient prior to the review. Generally, this both shortens and improves the review itself. In circumstances when a report has not been prepared or provided to the patient, then consistent with the patient's entitlement to procedural fairness, every reasonable endeavour is made by the Board to ensure that the patient is as soon as is practicable made aware of the arguments being put for an involuntary patient's continuance so that the patient can, by the provision of information or submissions, address the issues raised.

3.11 Social reports

Although the patient's social circumstances are often incorporated into the psychiatrist's report, on some occasions an additional report may be very useful.

A social worker, the responsible practitioner or case manager may be the ideal person to describe the social systems surrounding the patient, that of the family system, the social networks and the community setting, all of which are relevant in the Board's determination about a patient's involuntary status. (*s.137*)

3.12 Information received from other sources

On rare occasions, the Board's administrative staff receive information from sources such as relatives, carers or friends, sometimes with the request (made at the end of the conversation or note) that the information be kept confidential. Such information will be

noted and placed on the patient's file. Where possible, the provider of the information will be informed of the Board's obligations to conduct reviews in accordance with the principles of procedural fairness and that it is for the Board conducting the review to make a decision about:

- (a) the extent to which it is necessary to consider the information thus provided, if at all (based upon what other information is available at the review);
- (b) how much of the information (if any) will be taken into account by the Board in coming to a decision; and
- (c) the way in which information so taken into account by the Board is provided to the patient.

3.13 Attendance of relatives, friends and carers

The Board encourages relatives and carers or others with relevant information to attend a review. Relatives, friends or carers ('significant others') may be present for the whole or part of the review at the discretion of the Board, and taking into account the patient's wishes.

In some instances, where the patient does not wish to have significant others present, the Board may request such persons to attend part of the review, provide information, be available for any questions, and then leave.

As the Board itself is not routinely provided with information on significant others, the Board requests in its letter to psychiatrists and responsible practitioners that these persons be informed of the review.

In appropriate instances, and at its discretion, the Board may adjourn a review in order to ensure the attendance of significant others.

3.14 Representation at reviews

3.14.1 Legal advocates

Patients may appear personally before the Board, unless the Board has been advised that attendance would be detrimental to the health of the patient, in which case the Board may ask that the patient be represented by an advocate or friend. (*Schedule 2.3(1)(a)*)

Patients may be represented by legal counsel, or with the Board's permission, any other person. (*Schedule 2.3(1)(b)*)

The Board should be informed in writing when a patient is to be represented by legal counsel in order that that person can be contacted regarding details of the review.

The Board understands that the involuntary patient's representation by counsel ceases after the review is completed unless advised by the patient or counsel that counsel will represent the patient at future reviews. If so advised, a notation will be made in the Case Tracking System. Counsel will be notified of further reviews whilst the patient currently remains

involuntary (that is, for the current period of involuntary status, being the uninterrupted order or series of orders before the patient is no longer an involuntary patient).

The Board may arrange for a person to be represented in proceedings before the Board if the person wishes the Board to do so. (*Schedule 2.3(2)*)

A person who does not hold a current legal practice certificate and who represents a patient at a review is not entitled to any fee for that representation. Demand for a fee is punishable by a fine of \$1,000. (*Schedule 2.3(3)*)

Costs incurred by each party are their responsibility. (*Schedule 2.10*)

3.14.2 Non-legal advocates

A non-legal advocate is a person who seeks to represent or speak on behalf of an involuntary patient at a review. An advocate does not include a relative, friend or carer who participates in the review by providing support to the involuntary patient.

The Board recognises that under the Act, Official Visitors from the Council of Official Visitors have statutory responsibility for assisting 'with the making and presentation of an application or appeal under the Act in respect of an affected person'. (*s.188 (g)*)

Where a patient requests representation by an advocate other than a lawyer or an Official Visitor, it is helpful for the Board reviewing the patient if information about the proposed advocate is provided to the Board's administrative staff prior to the review. Provision of this information expedites the Board's decision making process on the day of the review on whether to grant leave to the advocate to represent the patient.

3.15 Observers at reviews

The Board's practice is to allow observers to be present during reviews subject to the following provisions:

- (a) The attendance of an observer shall be subject to the consent of the patient. The patient shall be under no obligation to give his or her consent, and need not give any reason for not giving consent.
- (b) Observers will be limited to persons with a legitimate purpose, as determined by the Board. This will include, for example, persons engaged in training, persons engaged in relevant education and persons with a particular interest in the operations of the Board, for example, those engaged in similar operations in other States.
- (c) Persons who wish to observe a review should contact the Board's office in advance to make appropriate arrangements.
- (d) During the review, the observer shall not speak or take notes. The observer shall sit in a discrete location, preferably behind the patient, and shall not intervene in any way in the proceedings.
- (e) When the Board adjourns to decide the application before it, the observer shall

leave the room. The observer is not to discuss the review with the patient, but may return when the decision is being given.

It is very important that observers fully appreciate that all observed proceedings are strictly confidential.

Ordinarily, only one observer will be allowed to observe reviews at any given time.

3.16 Patients who do not attend a review

Each patient is informed of his or her review by letter, which includes a 'Notice of Review'. Provided that the Board is satisfied that the patient has received the Notice of Review, the review may proceed and be concluded in the absence of the patient. (*Schedule 2.1(2)*) In these instances the Board will inform the patient of the decision by post. Patients who do not attend because they are absent without leave at the time of the review will be informed when they are located.

3.17 Use of interpreters

The Board recognises the importance of interpreters in facilitating communication with patients with limited functional English language ability. The Board accepts that even though a person may speak some English, this does not necessarily mean the person understands everything that takes place at a review. In these circumstances, an interpreter can be very beneficial to the patient and the Board.

The Board relies upon others, primarily mental health service providers, for information on when an interpreter is required. Once advised that an interpreter is required, the Board's administrative staff contact the Translating and Interpreting Service to arrange for a qualified and independent interpreter to attend the review.

If at the commencement of a review the Board is advised for the first time that an interpreter is required the review may be postponed to enable an interpreter to be present.

At the commencement of the review the Board's practice is for the presiding member to outline briefly how the review will proceed and the principles for the use of interpreters, including:

- (a) the need for all proceedings to be translated to the patient;
- (b) the requirement that each speaker speaks directly to the person he or she wishes to address;
- (c) the amount to be interpreted should be short so it is manageable for the interpreter;
- (d) the interpreter should indicate by signalling when the speaker has included too much in each segment;
- (e) the interpreter should be free to question or clarify or respond to what she or he hears from the speaker; and
- (f) the interpreter should interpret what is spoken and not add or subtract content of the spoken word.

Upon request, the Board's administrative staff will also consider arranging for an interpreter for a relative, carer, or other witness of the involuntary patient, if it considered that the information to be provided by that person would materially assist the Board's decision.

3.18 Conflict of interest

'Conflict of interest' in regard to Board matters occurs when there is a previous relationship or knowledge between the Board member and the patient, excluding previous reviews, which would prevent the review from being, and being seen to be, independent. This could include (but is not limited to) the following situations when:

- (a) the psychiatrist member of the Board has previously treated the patient to be reviewed;
- (b) the patient has previously been a client of the legal member of the Board;
- (c) the patient has been or is a friend or family member of any member of the Board; and
- (d) the Board member is a member of the management committee of an organisation which has a role in advocacy at hearings before the Board.

If a potential conflict of interest is brought to the Board's attention, the Board will consider and determine whether there are legal grounds for concern, and if so, the review will be postponed and rescheduled with different members.

In certain cases it may be possible to conduct the review when there has been a previous relationship between the Board member and the patient because there is no substantive conflict of interest. This could include situations where there has been a considerable passage of time between when the relationship was current and the date of the review. In these situations the review may still proceed if the situation is explained and all parties agree with the review proceeding.

All potential conflicts of interest that become known to the Board are entered on the Board's Case Tracking System to avoid future conflict problems arising.

3.19 Publication of lists

The names of Board members sitting on a particular day are not published in advance. It is not practical to do so given the last minute changes in the constitution of the Board which are sometimes required. Also, the fact that a Board member may have previously reviewed (or not reviewed, as the case may be) a patient is not material to the decision of whether that person sits as a Board member on a particular day.

3.20 Closed reviews

A review is closed to the public unless the Board orders that it (or part of it) is open to the public. The Board may permit specified persons (who may include witnesses) to be present at a review, or may preclude persons from being present at a review or part of it. (*Schedule 2.12*)

4.0 – THE PRESIDENT AND ADMINISTRATION OF THE BOARD

4.1 The role of the President

The President of the Board is appointed under the Act. (*s.126(1)(a)*)

The President acts as the chair of any meeting of the Board at which he or she is a member. (*s.132(1)(b)*) The President is to determine the members who are to constitute the Board in any particular case. (*s.129(2)*) The President also has an administrative role under the Act. (*ss. 23 and 24*) In accordance with the Act, the President is responsible for the operation and management of the Board.

In addition, as an employee of the State, the President has the following obligations:

- (a) providing leadership and direction to members of the Board;
- (b) monitoring the effectiveness and appropriateness of the Act and related legislation, and the preparation of proposals for amendments when required;
- (c) representing the Board in public, professional and community forums in matters concerning the operation of the Board and its legislation;
- (d) ensuring that decisions of the Board are appropriately documented and are presented and maintained in a manner available for review as determined by the Act;
- (e) ensuring that effective quality control policies and procedures are in place to maintain the highest standards of decision making and client services;
- (f) liaising with various bodies operating in the mental health area and providing education about the Board's role and operations; and
- (g) providing reports to the Minister for Health about issues relating to the Board, the performance of individual Board members as part of the Board's quality assurance programme, and the Act.

4.2 The role of the Registrar

The Registrar is responsible for the administrative tasks performed by the Board and is required to keep particulars of every involuntary patient. (*s.24*)

The Registrar is also required to give effect to any direction of the President. (*s.23*)

The Board may further delegate some of its functions to the Registrar. (*s.25*)

Such delegation may be general, or as otherwise provided in the delegation. To date, the Board has generally delegated its enquiry power under section 146 of the Act to the Registrar for investigation and determination under *s.142(2)* of the Act.

4.3 The role and duties of the Executive Officer

The Executive Officer assists the Registrar with the scheduling of reviews, the scheduling of Board members in consultation with the President, and the financial administration of the Board.

4.4 Maintenance of records

Using the Board's 'Case Tracking System' database the Board maintains records on every involuntary patient in Western Australia.

The Case Tracking System further collates information on Board members and is used to prepare a variety of reports relevant to the work of the Board.

Separate to the Case Tracking System, the Board maintains records of voluntary patients and persons referred to an authorised hospital on a Form 1 or 5 and made subject to seclusion, mechanical bodily restraint or emergency psychiatric treatment.

As well as CTOs being registered on the Board's database, a CTO browser is maintained by the Board at Graylands Hospital. The browser allows for 24-hour access to information regarding whether a person is on a CTO. Enquiries about CTOs should be made to the Board during office hours and to Graylands Hospital out of office hours.

4.5 Information and assistance required from mental health services

To enable the Board to properly manage its statutory duties the Board is dependent on mental health services notifying the Board of changes in the status of patients. This notification is usually achieved by provision to the Board's offices of copies of orders indicating when patients are made involuntary, when changes in status take place and when patients are no longer involuntary. Details of the orders required by the Board are provided in Appendix 1 of this handbook.

If there is a change of status close to the time when a review is scheduled the Board's administrative staff should be immediately informed of that change by telephone.

In the metropolitan area, the Board conducts reviews at the premises of the mental health service used by the involuntary patient. To enable reviews to be conducted the Board requires a reasonable sized room furnished with a table and enough chairs for Board members and other parties, a waiting area for participants to the review, a conference/speaker phone in the review room, the file of the patient to be reviewed and access to a photocopier.

4.6 Requests for information/documentation from the Board

In accordance with the *Mental Health Regulations 1997* the Board is the recipient of information regarding an involuntary patient. Any such information/documentation received by the Board will not be distributed to any individual or agency unless exceptional

circumstances exist. Should any individual or agency require a copy of the information/documentation access should be sought from the source of the information/documentation.

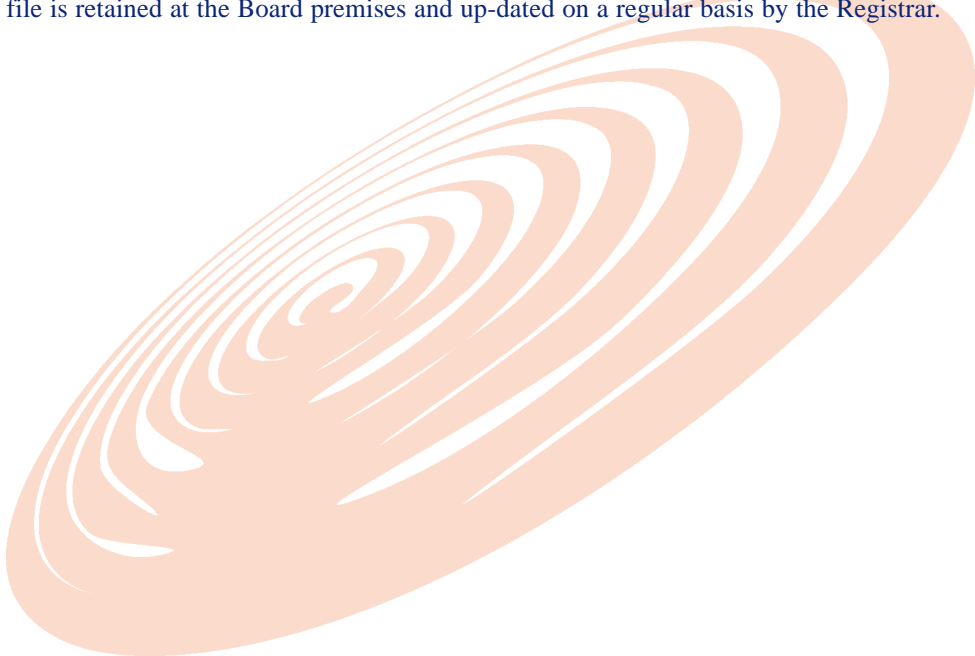
4.7 Public access to Board's Records

Section 136 of the Act states that:

'The Registrar is to prepare and make available for public scrutiny a copy of the Board's records that has been edited so as to remove anything that might identify a person who comes within paragraph (e), (f) or (g) of clause 13(1) of Schedule 2.'

The Board's records include the '*reasons for decision*' documents prepared by the Board.

The '*reasons for decision*' file is available at the Board for scrutiny by the public. Arrangements for scrutiny may be made through the Registrar. The '*reasons for decision*' file is retained at the Board premises and up-dated on a regular basis by the Registrar.





5.0 – BOARD MEMBERS

Board members are appointed in accordance with section 126(1)(b) of the Act. The Board is constituted both by the totality of its membership, and, when reviewing an involuntary patient or for the purpose of dealing with any particular matter, by groups of three members (one from each category). (*s.129(2)*)

5.1 Appointment process

Expressions of interest for appointment are sought when necessary. Following receipt of expressions of interest, the applications are assessed by a panel convened by the President.

Following an interview process by the convened panel, recommendations are made to the Minister for Health. Appointments are made by the Governor in Council on the advice of the Minister for terms not exceeding three years and members are eligible for re-appointment. (*Schedule 1*)

The Governor of Western Australia has the authority to appoint (*s.126(1)(b)*) or remove persons from the Board. (*Schedule 1*)

Psychiatrists

Psychiatrists should be medical practitioners whose names are on the roll of psychiatrists kept by the Medical Board of Western Australia. Preference will be given to those psychiatrists who are Fellows of the Royal Australian and New Zealand College of Psychiatrists or equivalent.

Legal Practitioners

Legal Practitioners must be admitted as legal practitioners in Western Australia, and have relevant legal experience.

Community Members

Community members are to be neither psychiatrists nor legal practitioners and are selected from the general public.

5.2 Induction programme

Part 1: Induction. All Board members to attend an introduction to the Board's programme, which will cover the following areas:

- (a) Welcome to the Board;
- (b) Overview of the Act;
- (c) Overview of the functions and powers of the Board;
- (d) Discussion of the policies of the Board; and
- (e) Administrative issues (scheduling, remuneration, and travel).

Part 2: Observation. New Board members are to observe reviews prior to sitting as Board members.

5.3 Personal/Professional conduct of Board Members

This code of conduct was developed from the Public Sector Standards Commission 'template' code of conduct.

5.3.1 Personal conduct

Board members are in a position of trust. Their involvement and decisions affect the rights or entitlements of involuntary patients, their families or carers, and the general public. Their decisions further impact on mental health service providers who are charged with the care of involuntary patients.

The power and obligations of the Board are derived from the Act and Regulations and members are expected to carry out their functions with professional integrity and due regard to legislation. All Board members need a clear understanding of their public duty and legal responsibilities.

Board members will:

Understand the Board's role by

- (a) gaining a clear understanding of the role and purpose of the Board as well as the statutory and regulatory requirements of members carrying out their duties;
- (b) developing an understanding of the physical, political and social environment in which the Board operates;
- (c) staying informed about all relevant activities affecting the Board; and
- (d) complying with their legal obligations in conducting reviews of individual patients.

Be involved by

- (a) attending Board meetings. Where attendance is not possible members should submit an apology to the Board's administrative staff;
- (b) participating actively and working cooperatively with fellow Board members and others to achieve agreed goals;
- (c) preparing for meetings by reading and considering any papers circulated;
- (d) being involved in quality assurance projects;
- (e) being involved in education and training activities;
- (f) keeping the President and the Board's administrative staff aware of issues that impact on the Board's functions; and
- (g) attending meetings with the President as required and in line with the Board's policy of quality assurance.

Demonstrate respect by

- (a) treating other Board members and all those who are present at a review, including the patient, family members, friends or carers, the patient's representative and mental health service provider staff with professionalism, courtesy and respect;
- (b) not improperly influencing other Board members; and
- (c) acting with consideration and in good faith.

Consult by

- (a) speaking/communicating with the President and Registrar about issues which may arise in regard to the functions and operations of the Board;
- (b) speaking/communicating with the Registrar and Executive Officer about any administrative issues.

Raise concerns by

- (a) expressing concerns to the President about decisions or actions which may be contrary to the Board's statutory duties;
- (b) disclosing any information about actual or potentially corrupt or illegal activities to the President or, if necessary, the Anti Corruption Commission.

5.3.2 External requests

Should a Board member receive a request to participate in an activity related to the Board, for example a training session or presentation to an external body, it is important that the Board member refer such requests to the President for response by the President.

5.3.3 Complaints

If a Board member receives a complaint about the Board, that complaint should be referred to the President for response. Board members are at all times encouraged to discuss any issues of concern they may have with the President or Registrar.

5.3.4 Financial issues

The *Financial Administration and Audit Act 1985* places a responsibility on Board members to ensure efficient and effective operations and to avoid extravagant and wasteful use of resources.

In relation to their role as members of the Board, Board members will not accept any fee, reward, gratuity, gift or remuneration of any kind other than sitting fees or allowances officially applicable to the Board.

5.3.5 Accommodation and travel expenses

Board members will obtain approval for travel from the President when conducting Board business or attending conferences or committees other than when attending venues for scheduled reviews.

Board members will comply with the travel conditions and guidelines set down in current government policies.

5.3.6 Entering government premises

Board members may visit the Board's premises and use government facilities and equipment at authorised hospitals or clinics. Board members should cooperate with service provider staff when using premises in hospitals or clinics for reviews. To assist staff at the authorised hospitals and clinics Board members are requested to show official recognition of their status by wearing their identification badges.

5.3.7 Use of public sector resources

All vehicles, computers, furniture and other equipment provided to the Board are managed by the Board's administrative staff for its official purposes.

Board members should:

- (a) ensure that equipment is operated in accordance with the manufacturer's specifications, is maintained in good condition and, where appropriate, stored securely;
- (b) report to the Registrar any damage or loss of Board property or equipment;
- (c) effectively and economically use Board resources, funds, time and equipment.

Official resources include, but are not limited to, motor vehicles, computers, software, photocopiers, telephones, facsimile machines, printers and any similar items of office equipment.

Any requests by an external party such as a charitable body to use Board facilities shall be referred to the President for approval.

5.3.8 Confidential information

Board members should at all times respect confidential information and maintain confidentiality.

5.4 Conduct at review

The primary function of the Board is to review the involuntary status of patients either detained in an authorised hospital or subject to a CTO. It is not within the ambit of the Board's jurisdiction to conduct a review of the total care of the patient including an historical review, a review of treatment and future plans unless any of that information pertains to the patient's involuntary status.

5.4.1 Legal member presides

In accordance with the Act, the legal member presides at a review. However, given that each three member Board operates as a single entity, it is incumbent on the legal member to ensure that each Board member is given the opportunity to participate in each review in a meaningful way.

In accordance with the Objectives of the Board as outlined in Section 1.4, the following guidelines are important:

5.4.2 Questioning

The following statements indicate the type of conduct that would ordinarily be expected of Board members when conducting reviews:

- (a) Board members may ask questions outside their area of expertise, but should be sensitive to the limits of their knowledge;
- (b) Board members should question the member of the treating team and patient only in so far as it is necessary for the purposes of making a decision as to whether or not involuntary status should be continued;
- (c) The patient should be asked concise questions and given adequate opportunity to respond and to state his or her views;
- (d) In order to minimise the possibility of the patient becoming distressed, Board members should generally avoid in-depth discussion of a patient's beliefs or delusions where possible;
- (e) Board members should carefully consider the tone and style of their questioning, particularly to the patient, and the distress persistent questioning may cause the patient;
- (f) Board members should be very cautious in exploring a person's symptomatology, as the Board is not required to undertake its own assessment of the patient but rather is required to elicit necessary information from the treating team and the patient; and
- (g) Significant repetition of questions, for example as to whether the person has a view about being an involuntary patient, should be avoided.

5.4.3 Patient's distress

It is the Board's responsibility to prevent, as far as possible, proceedings from becoming acrimonious. In some instances, this may mean that a Board member will have to conclude discussion of a matter in contention at a review.

If a patient is becoming distressed or angry at a review, the Board should do what it can to minimise this. The patient is not obliged to remain at a review, or even be at a review, though in all cases the Board encourages the patient to attend and participate in his or her review.

5.4.4 Board's decision making process

The decision of the Board is to be arrived at by consensus, with each member being given the opportunity to provide comment from his or her perspective. It is recognised that each Board member is an equal participant in the process of decision making and in the

review itself. If the Board is unable to reach a consensus, a majority decision is acceptable. In these instances written reasons will reflect both majority and minority views.

5.4.5 Conflict of roles

Board members who are employed in either the public or private health sector may only conduct reviews at services other than those with which they have a direct association.

Board members may belong to organisations and sit on committees external to the Board unless there is a direct conflict of roles between their membership of that organisation and the Board.

Board members are requested to disclose to the Registrar their membership of the management committee of any organisation that has a direct interest in advocacy before the Board. (see 3.18)

5.4.6 Reports

Board members should not read out a report at the review as this may be distressing for the patient and counter-productive to the review process. If the patient has not had access to the report prior to the review, it is preferable for the psychiatrist or other member of the treating team, to go through the report with the patient and provide a summary of its contents. A short adjournment may be necessary for this to take place.

5.4.7 Breaks during a review

If during a review, a Board member becomes concerned about the progress of a review, the Board member may request a short break to discuss the issue of concern with fellow Board members.

5.4.8 Reviews without written reports

If a Board finds in a particular review that a report has not been prepared by the treating team, it may still proceed with the review.

- (a) In these circumstances, it will be necessary for the Board to elicit sufficient information from the treating team during the review upon which it may make a decision, and to give the patient the opportunity of questioning the member of the treating team. In some circumstances, it may be possible to proceed with a review even if a member of the treating team is unavailable if the patient does not attend the review and there is sufficient information on the file from which the Board can make a decision.
- (b) If the Board is not satisfied about the information available to it, it may adjourn the review to another date to be scheduled by the Board's administrative staff. Before this decision is made, the Board members are requested to contact the Board's Registrar or Executive Officer to ensure that the review can be rescheduled within the statutory timeframe.

5.4.9 Mistakes on forms

Occasionally, a Board may notice a mistake on a form written under the Act. In these circumstances, Board members are requested to contact the Registrar. Where a mistake is established the Board may do the following:

- (a) in the light of section 212 of the Act, determine whether the mistake is one which may be rectified by reference back to the person who wrote the form;
- (b) request that the person who wrote the form provide the Board with a correct form; or
- (c) having obtained confirmation that the mistake will be rectified, proceed with the review.

5.4.10 Placing a patient on a CTO

Section 145 of the Act gives the Board some (limited) capacity to make a CTO. Sections 66 and 68 of the Act are relevant.

If the patient or counsel submits that the patient should be on a CTO and the treating team disagrees either with that proposal or its timing, the Board, before placing a person on a CTO, must be satisfied that appropriate arrangements are in place to satisfy sections 66 and 68. This may mean that the proceedings need to be adjourned to a date to be fixed. At a reconvened hearing, the Board will need to be provided with information by the patient or counsel that satisfies the relevant sections and if so satisfied may then make the CTO.

5.5 Quality assurance

It is important for the Board to continuously monitor and refine its practices to ensure that it optimally delivers its service, the review, to each involuntary patient who appears before the Board.

To this end, Board members participate in a quality assurance programme. This programme has four aspects: team discussion, critical incident reporting, management, and ongoing training and development.

5.5.1 Post-review team discussion

Following a day's reviews, Board members are requested to spend some time to reflect upon the reviews and consider any issues that arose. This process will enhance the teamwork of the Board, and enable the Board to optimise its service.

Board members are requested to provide the President with information from these sessions about systemic issues which require consideration from a broader perspective.

5.5.2 Critical incident recording

Board members are requested to maintain a Critical Incident diary, in which they will record any important incident which occurs during the course of, or pertaining to a review. Each member will then have an accurate account of incidents relevant to the Board's role

for further discussion with the President at their meetings with the President and with the whole Board at Board meetings.

5.5.3 Management

The President has a role in the maintenance of standards and consistency across the whole Board. To this end, the President will as time permits audit a selection of reviews. The President will then provide feedback to members of the particular Board which was involved in those reviews.

The President will endeavour to meet with each Board member on a biannual basis to provide a formal opportunity for mutual feedback in relation to Board issues identified by the Board member or the President.

5.5.4 Ongoing training and development

The President will in discussion with Board members determine training and development priorities. The Registrar is responsible to the President for arranging an appropriate training and development programme in the context of the determined priorities. Board members commit to this programme on an ongoing basis by virtue of their membership of the Board.

5.6 Administrative issues

5.6.1 Time commitment

As reviews are generally scheduled for the day, it is necessary for Board members to be available for the whole day, unless the Board is notified in advance and can accommodate an alternative proposal.

5.6.2 Scheduling of Board members

A blank calendar is distributed to Board members prior to the month to be scheduled. Board members are asked to complete this calendar with available dates, and then return it to the administrative staff as soon as possible. Upon receipt of this information, Board members are scheduled for the relevant month, taking into account factors including number of patients to be reviewed, the availability of Board members, the availability of members of the treating team and venues, gender issues and other matters. Scheduling of Board members is the responsibility of the President. (*s.129(2)*)

If a Board member is unable to work for the Board on a particular day for which he or she has been scheduled, the Board member should immediately contact the administrative staff so that alternative arrangements can be made. Board members should note that if they are obliged to withdraw from a review day then the most likely outcome of their unavailability is loss of employment for that day. A Board member may not make private arrangements with other Board members to change days as there are conflict issues and other matters that need to be addressed by the Board's administrative staff.

On the last working day before a review day scheduled members are contacted by the

administrative staff by phone and given details of the next day's reviews. As there may be significant changes to commencement time it is important that Board members are able to receive this information either directly or via an answering machine.

5.6.3 Duties on the review day

By arrangement with the administrative staff, Board members take the Board bag to the venue. In exceptional circumstances Board staff may take the Board bag to the venue.

The Board bag contains the following:

- (a) tape recorder and blank tapes;
- (b) extension cord;
- (c) board patient files;
- (d) evidence books for members;
- (e) copy of the Act;
- (f) copy of the Board's Handbook; and
- (g) identification badges.

Each Board member is issued with an evidence book for recording notes during the review. For reasons of confidentiality and security, these books are stored securely in the Board's office and provided to each member on the day.

Recording of reviews is required under the Act and assists in the preparation of reasons for decision. Board members are responsible for ensuring all proceedings are recorded, ie.

- (a) turning on tape recorder;
- (b) replacing tapes (tapes are one hour long and need to be turned at the end of 1/2 hour - a bleep indicates the impending time limit); and
- (c) labelling tapes clearly with patient's name and date of hearing.

If the tape recorder malfunctions it is recommended that the review be temporarily suspended so that the problem can be addressed.

Board members are responsible for ensuring that the patient and the mental health service are provided with a copy of the front side (only) of the 'Decision Sheet'. If any of the parties are not present at the review or the review is conducted via teleconferencing, the Board is responsible for indicating on the decision sheet that that information needs to be distributed and that distribution will then be undertaken by the Board's administrative staff. This also applies if photocopying of the 'Decision Sheet' is not possible.

The Board maintains a number of details regarding the outcome of a review. It is therefore important that the Board member completing the decision sheet should note the following:

- (a) the length of time the review lasted;

- (b) whether the patient was present at the review;
- (c) whether the patient was represented and by whom;
- (d) name and designation of any members of the treating team; and
- (e) name and designation of any other parties to the proceedings.

Board members are responsible for ensuring that the Board bag is returned to the Board's offices by the day's close of business. If this is not possible due to the reviews extending past 16.30 hours, then arrangements must be made with the administrative staff for the overnight secure storage of the bag.

Board members are encouraged to share tasks such as setting up equipment, completing the decision sheet and photocopying the decision sheet.

The following tasks are specifically allocated to the legal member of the Board:

- (a) to preside at the review (*s.132(1)(b)*);
- (b) to determine any question as to the admissibility of evidence, or any question of law or procedure (*s.132(1)(c)*); and
- (c) to prepare the 'reasons for decision' if requested by the patient or other party to the proceedings in accordance with Board timeframes and guidelines.

Board members should note that on the review day it may be necessary to bring forward, postpone or adjourn a review. It is recommended that any such changes should be discussed with the Registrar and where necessary other parties to the review before a decision is reached.

5.6.4 Cancellation of a review day

Occasionally because of a reduction in the number of reviews to be scheduled or the change of status of a number of patients prior to a review it is necessary for a review day to be cancelled. If this becomes necessary, a member of the administrative staff will contact the Board members concerned as soon as possible. If more than 48 hours notice is given then there is no remuneration payable for the cancelled day. If less than 48 hours notice is given, and if the Board member can demonstrate loss of income for that day, a reduced rate of remuneration is paid.

5.6.5 Transport

- (a) A Board vehicle is generally available at the Board's premises on every scheduled review day and its use is encouraged. Arrangements to use the vehicle can be made with the Board's administrative staff.
- (b) The Board does not pay a travel allowance for the use of private vehicles for Board business.
- (c) Board payment for the use of taxis will only be made in the case of emergency or accident.

5.6.6 Remuneration

Board members are paid for their services at rates set by the Minister for Health on the recommendation of the Minister for Public Sector Management. Details are available from the President.

5.7 Professional Development Strategy for Board Members

5.7.1 Background

As Board members are drawn from a variety of professional backgrounds the Professional Development Strategy needs to be multi-layered, while at the same time emphasising the core concepts of knowledge acquisition, skills development and attitudinal and behavioural aspects. The strategy stresses the importance of certain programmes which are essential for all Board members and other aspects of the programme which individuals could choose to engage with depending on an evaluation of their current professional development needs.

5.7.2 Purpose

The purpose of this professional development strategy is to maintain and improve the services the Board provides by assisting members in the performance of their duties through enhancing professional competence and expertise, facilitating development of knowledge, attitudes and skills, and promoting the pursuit of professional excellence.

5.7.3 Conferences and lectures

The Registrar will compile and maintain a list of conferences, courses and lectures that will be available in a file at the Board offices. Board members who are aware of conferences, courses and lectures which would be appropriate for other Board members should inform the Registrar so they can be added to the list.

Board members are encouraged to attend appropriate external courses, conferences and lectures. Financial support may be approved by the President in the context of the overall professional development strategy.

Board members and administrative staff who attend courses and conferences will be required to complete an evaluation form and provide a short report which can be shared with other Board members and staff.

5.7.4 Information resources

Articles: The Registrar compiles and retains at the Board's offices a selection of articles of interest to Board members.

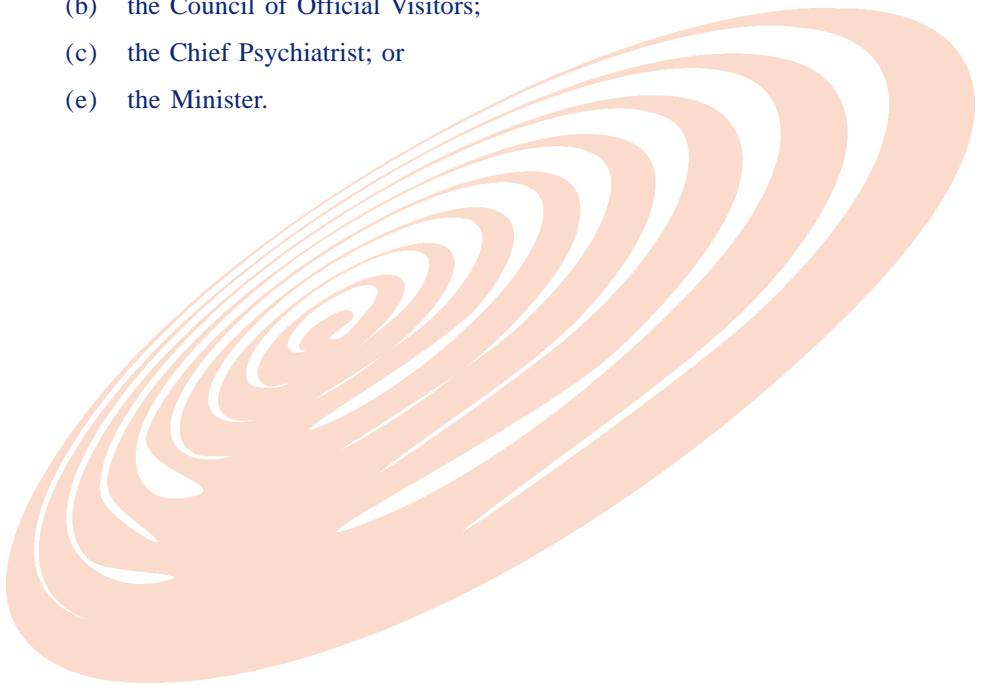
Books: Board members can access the Psychiatric Services Library at the Graylands campus. In addition, the Board purchases the most relevant texts which are retained at the Board's offices for use by Board members.

5.8 Systemic issues

In the context of the Board, systemic issues are those mental health issues that are broader than the Board's quasi-judicial role in reviewing individual patients but which may come to the attention of the Board during reviews or be brought to the attention of the Board's administrative staff by any individual or agency. In either of these situations, those issues should be reported to the President as soon as possible for further consideration and action.

Upon receipt of information about systemic issues (not related to individual patients), the President may refer the issue to:

- (a) the person in charge at the service provider;
- (b) the Council of Official Visitors;
- (c) the Chief Psychiatrist; or
- (e) the Minister.



6.0 – INFORMATION STATEMENT IN RELATION TO THE FREEDOM OF INFORMATION ACT 1992

The *Freedom of Information Act 1992* defines a court to include a tribunal, therefore the Board is a court within the meaning of that Act. Clause 5 of the Glossary of that Act provides: “A document relating to a court is not to be regarded as a document of the court unless it relates to matters of an administrative nature”. There are a number of documents in patients files, held by the Board which are not of an administrative nature and therefore not subject to the *Freedom of Information Act 1992*.



APPENDIX 1

Provision of copies of orders by mental health services

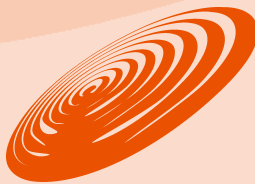
Copies of the following orders must be forwarded to the Board from mental health services as soon as possible after being made-

- (a) The making of an involuntary patient order (Form 6);
- (b) Transferring a patient from one authorised hospital to another (Form 7);
- (c) Making a patient no longer an involuntary patient (Form 8);
- (d) Allowing either a Form 6 or 9 to lapse (Form 8);
- (e) Allowing a Form 10 to lapse (Form 8);
- (f) Continuing an involuntary patient order (Form 9);
- (g) Making a Community Treatment Order (Form 10);
- (h) Revoking a Community Treatment Order (Form 11);
- (i) Extending a Community Treatment Order (Form 12);
- (j) Varying a Community Treatment Order (Form 12);
- (k) Notice of Breach of Community Treatment Order (Form 13);
- (l) Notice of Order to Attend (Form 14).

A psychiatrist who has been requested to give a second opinion in relation to a request by a patient as to whether a CTO should have been extended is to provide to the Board a copy of the request. (*s. 76 (6)*) Information regarding the outcome of a second opinion assessment is also required. If a second opinion was not provided within the 14 day timeframe the Board must be informed as the extension of the CTO has no effect or no further effect.

In addition, the *Mental Health Regulations 1997* require mental health service providers to forward the following information to the Board:

- (a) Details of any report regarding occasions of seclusion (*s.120*);
- (b) Details of occasions of any emergency psychiatric treatment (*s.115*);
- (c) Details of occasions of any mechanical bodily restraint (*s.124*);
- (d) Details of any periods of leave and periods of absence without leave; and
- (e) If an involuntary patient dies, the date and cause of death.



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