MENTAL HEALTH TRIBUNAL

Annual Report 2017

CONTENTS

Hon. Roger Cook MLA
Deputy Premier of Western Australia
Minister for Health; Mental Health
Member for Kwinana
13th Floor Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Minister

I have pleasure in submitting to you a report from the Mental Health Tribunal for the year ended 30 June 2017. This report provides information about the Tribunal and its activities in the year under review, and for comparative purposes includes data from previous years.

Yours sincerely

Michael Hawkins
President

This page has been left blank intentionally.

PART 1: MENTAL HEALTH TRIBUNAL – ROLES AND FUNCTIONS

The Mental Health Tribunal (the Tribunal) was established on 30 November 2015 under Part 21 of the Mental Health Act 2014 (the Act). It replaced the Mental Health Review Board "the Board") which operated pursuant to the Mental Health Act 1996 between December 1997 and 29 November 2015.

The Tribunal consists of a President and two or more members appointed by the Governor on the recommendation of the Minister for Mental Health, and must include at least one psychiatrist, at least one lawyer, and at least one person who is not a lawyer or medical practitioner or mental health practitioner who is a staff member of a mental health service or private psychiatric hostel.

Details of the membership of the Mental Health Review Board during the period 1 July 2012 to 29 November 2015 and of the Tribunal during the period 30 November 2015 to 30 June 2017 are contained in Part 2 of this Report.

The Tribunal's functions and powers are set out in Part 21 of the Act and include:

- The review of involuntary treatment orders, to decide whether or not the patient is still in need of the order: sections 386 - 396. This is perhaps the most important function of the Tribunal and further information about this function and the Tribunal's performance of it are set out in later parts of this Report.
- Deciding whether or not an involuntary treatment order is or was invalid: sections 397 - 403.
- The review of the admission of long-term voluntary inpatients: sections 404 - 408.
- The approval of electroconvulsive therapy: sections 409 - 415.
- The approval of psychosurgery: sections 416 - 421.
- Whether or not to order that a service provider must comply with a non-clinical requirement of the Act: sections 422 - 426.
- Whether or not a restriction on a patient's freedom of communication should remain in place: sections 427 - 429.
- Whether or not a person who a patient has nominated to assist the patient by ensuring that the patient's rights are observed and that the patient's interests and wishes are taken into account, is an appropriate person to perform that role, and whether or not the nomination is valid: sections 430 - 433.
- The review of a decision which affects a person's rights under the Act: sections 434 - 436
- The keeping of particulars concerning every person who is an involuntary patient under the Act, based on information provided by authorised hospitals and mental health clinics: section 484. The Tribunal maintains a computerised database for this purpose.

PART 2: MEMBERSHIP OF THE TRIBUNAL

The Tribunal came into being on 30 November 2015, and, by reason of section 644 of the Act, every member of the Mental Health Review Board immediately before 30 November 2015 became a member of the Tribunal until the date that their membership of the Mental Health Review Board would have continued but for the new legislation. Thus as at 30 November 2015 the Tribunal had 49 members (including the President) comprising the President, 12 psychiatrists, 20 community members and 16 lawyers. All members other than the President work on a sessional basis.

As at 30 June 2017 the Tribunal had 57 members (including the President) comprising 26 psychiatrists, 18 community members and 13 lawyers. During the 19 months ending 30 June 2017 the following people were members of the Tribunal.

President	Commenced	Expiring
Michael Hawkins	03/05/11	29/12/17
Psychiatrist Members		
Dr Dawn Barker	14/5/15	30/4/18
Dr Ann Bell	14/12/99	30/4/18
Dr Simon Byrne	20/12/16	19/12/21
Dr Adam Brett	03/05/11	01/05/22
Dr Nadine Caunt	1/09/12	30/4/18
Dr Hugh Cook AM	19/11/97	01/05/22
Dr Russell Date	20/12/16	19/12/21
Dr Rowan Davidson	20/12/16	19/12/21
Dr Daniel de Klerk	1/09/12	30/4/18
Dr Kevin Dodd	03/05/11	01/05/22
Dr Aaron Groves	3/05/14	01/05/17
Dr Jaroslaw Hryniewicki	1/01/2013	31/12/15
Dr Aleksandra Jaworska	20/12/16	19/12/21
Dr Fiona Krantz	14/5/15	30/4/18
Dr David Lord	20/12/16	19/12/21
Dr Roland Main	20/12/16	19/12/21
Dr Elizabeth Moore	14/5/15	30/4/18
Dr Catherine Nottage	14/5/15	30/4/18
Dr Victoria Pascu	14/5/15	30/4/18
Dr Steven Patchett	3/05/14	01/05/22
Dr Nada Raich	16/06/98	01/05/22
Dr Gordon Shymko	20/12/16	19/12/21
Dr Helen Slattery	20/12/16	19/12/21
Dr Alexander Tait	20/12/16	19/12/21
Dr Bryan Tanney	22/11/05	01/05/22
Dr Gabor Ungvari	20/12/16	19/12/21
Dr Anthony Zorbas	22/01/99	01/05/22

Legal Members	Commenced	Expiring
Geoffrey Abbott	20/12/16	19/12/21
Ryan Arndt	03/05/11	01/05/22
Kathryn Barker	03/05/11	01/05/22
Harriette Benz	03/05/11	01/05/22
Peter Curry	03/05/11	01/05/22
Jeanette de Klerk	3/05/14	01/05/22
Magdeline Fadjjar	22/11/05	27/8/15
Mr Tony Fowke AM	10/03/98	11/11/15
Andrea McCallum	3/05/14	01/05/22
Hannah McGlade	3/05/14	01/05/22
Michael Nicholls QC	03/05/11	01/05/22
Anne Seghezzi	16/06/98	01/05/22
Daniel Stepniak	22/11/05	01/05/17
Merranie Strauss	03/05/11	01/05/22
Jennifer Wall	03/05/11	01/05/22
Rachel Yates	03/05/11	01/05/22

Community Members	Commenced	Expiring
Alan Alford	03/05/11	01/05/22
Kerri Boase-Jelinek	16/12/97	01/05/17
Jennifer Bridge-Wright	3/05/14	01/05/22
Rev Rodger Bull	22/11/05	01/05/22
Donna Dean	03/05/11	01/05/22
Stuart Flynn	03/05/11	01/05/22
John Gardiner	03/05/11	01/05/22
Susan Grace	3/05/14	01/05/22
Emeritus Prof David Hawks AM	16/06/98	01/05/22
John James	26/10/05	01/05/22
Manjit Kaur	03/05/11	01/05/22
Lorrae Loud	03/05/11	19/12/21
Lynne McGuigan	19/11/97	01/05/22
David Rowell	22/11/05	01/05/22
Maxinne Sclanders	22/11/05	01/05/22
Leone Shiels	03/05/11	01/05/22
Josephine Stanton	18/01/05	01/05/17
Anthony Warner AM LVO	18/01/05	01/05/22
Ann White	03/05/11	01/05/22
Hon Keith Wilson AM	3/05/14	01/05/22

The term of appointment of long serving members Rt Reverend Michael Challen AM, Mrs Barbara Holland, Mrs Josephine Stanton, Dr John Penman, Dr Aaron Groves, Mrs Magdeline Fadjiar, Mr Tony Fowke AM, Ms Hannah Leslie, and Dr Daniel Stepniak came to an end on various dates since 30 June 2012. The Board and the Tribunal respectively benefited greatly from their work and dedication.

PART 3: THE REVIEW OF INVOLUNTARY PATIENTS

As noted in Part 1 of this Report, the Tribunal's primary role under the Act is to review the status of people who are ordered to be involuntary patients under the Act.

Who is an Involuntary Patient?

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

- that the person be admitted to, and detained in, an authorised hospital or a general hospital for treatment of the mental illness; or
- that the person be the subject of a community treatment order, that is, an order that requires the patient to comply with a treatment plan specified in the order but which enables the patient to live in the community rather than stay in an authorised hospital or a general hospital. Community treatment orders are commonly known as CTOs.

Before a person can be made an involuntary patient (of either type) the psychiatrist must be satisfied that all the requirements set out in section 25 of the Act, have been met. In summary, the section requires that:

- the person has a mental illness which is in need of treatment;
- because of the illness there is a significant risk to the health or safety of the person or to the safety of another person, or a significant risk of serious harm to the person or to another person, or (in the case of a CTO) there is a significant risk of the person suffering serious physical or mental deterioration;
- the person lacks the capacity to decide whether or not to agree to treatment;
- treatment cannot be adequately provided to the person in a way that would involve less restriction on the person's freedom of choice and movement than making an involuntary treatment order.

Before a psychiatrist can make an order that a person be detained in an authorised hospital as an involuntary patient the psychiatrist must first consider whether the objectives of the Act would be better achieved by the making of a CTO in respect of the person: subsection 24(4). A CTO is not to be made unless the psychiatrist is satisfied of the matters summarised above, and also including whether treatment in the community can reasonably be provided to the person and that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order.

The Types of Reviews

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

(a) Periodic Reviews

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

- As soon as practicable, and in any event not later than 35 days for an adult or ten days for a person who is less than 18 years old, after the person's involuntary patient status commenced: section 386. Such a review is known as an initial period review.
- If an adult patient's involuntary status continues beyond the initial period, the Tribunal is required to conduct further reviews not later than three months after

the initial period review and every three months thereafter: section 387. If the patient is less than 18 years old, the reviews must be conducted at intervals no greater than 28 days. Such reviews are known as periodic reviews.

- If the patient has been on a community treatment order for a continuous period of 12 months when reviewed by the Tribunal, the next and subsequent periodic review periods are extended to six months: section 387 (1).

For the purposes of determining when a person commences a period as an involuntary patient and the determining the date by which reviews are to be held, the Act (section 388) provides that if a person becomes an involuntary patient again within seven days of ceasing to be an involuntary patient, the person is taken to have been continuously an involuntary patient despite that gap.

When conducting an initial or a periodic review, the Tribunal's task is to determine whether or not the patient is still in need of the involuntary treatment order. It does so by having regard to the criteria in section 25.

(b) Requested Reviews.

Any involuntary patient, carer, close family member or personal support person, mental health advocate or any other person who, in the Tribunal's opinion, has a sufficient interest in the matter, may request the Tribunal to conduct a review: section 390. Such a review is known as a requested review. The request may be made at any time except within 28 days (seven days if the patient is less than 18 years old) after the Tribunal has made a determination that involved considering substantially the same issues as would be raised by the requested review: section 390(4).

In a requested review the Tribunal may be asked to review:

- whether a person should continue to be an involuntary patient - either detained in an authorised hospital, general hospital or on a CTO;
- whether or not an involuntary inpatient is still in need of an inpatient treatment order;
- whether or not the terms of a community treatment order are appropriate;
- whether a patient detained in an authorised hospital or a general hospital should be transferred to another authorised hospital or general hospital or should be transferred interstate; or
- whether the responsibility for supervising a CTO or ensuring that a patient receives the treatment specified in a CTO should be transferred to some other person.

The Tribunal may also be asked to decide whether or not a treatment order is or was valid or invalid (section 398), or whether or not a long-term voluntary patient is still in need of the admission to an authorised hospital (section 405).

(c) Own Motion Review

The Tribunal can also on its own initiative, conduct a review of the case of an involuntary patient at any time if the Tribunal considers it appropriate to do so: section 391, and decide whether or not a treatment order was or is valid or invalid: section 398.

The Tribunal's Powers on a Review

As is stated in subsection 455(3), the purpose of a review proceeding "is to produce the correct and preferable decision at the time of the Tribunal's decision on the review proceeding".

At all times the Tribunal must have regard to the objects of the Act set out in section 10 of the Act.

The objects may be relevantly summarised as requiring the Tribunal to do what it can to ensure that the patients are provided with the best possible treatment and care with the least possible restriction of their freedom, the least possible interference with their rights and with respect to their dignity. The Tribunal must also have regard to the best interests of the patient, whilst at the same time ensuring the protection of the patient and ensuring the protection of the community.

Subsection 455(2) of the Act is to the effect that review hearings are conducted de novo. In other words, the Tribunal may take into account new material, whether or not that material was available or existed at the time the involuntary treatment order was made. This means that in its usual practice the Tribunal does not decide whether or not the psychiatrist's decision to make an involuntary treatment order was right or wrong. Instead, when carrying out a review the Tribunal may determine any matter coming before it for consideration and may make such orders in respect of the matter as it thinks appropriate, including:

- that the patient is no longer an involuntary patient;
- that the involuntary inpatient treatment order be revoked and the patient be discharged on a community treatment order to be made in accordance with directions made by the Tribunal regarding the terms of the community treatment order; and
- if the person is already the subject of a community treatment order, varying the terms of the order or giving directions about it.

The Tribunal may also decide whether any restriction on the patient's freedom of lawful communication should remain in place, or, in the case of a long-term voluntary patient, whether there is still a need for the patient's admission.

Electroconvulsive therapy

The Tribunal's approval is required before electroconvulsive therapy ("ECT") treatment can be provided to involuntary patients who are 18 years of age or older. It is also required before ECT can be provided to patients, whether voluntary or involuntary, who are 14 years old but less than 18 years old.

An exception occurs if ECT is required in an emergency situation, in which case treatment can be provided, but only if approved by the Chief Psychiatrist beforehand. The most common course of ECT approved by the Tribunal involves the administration of 12 treatments. The Chief Psychiatrist's usual practice is to approve the administration of ECT only once, and the treating team must seek the Tribunal's approval before it administers the balance of the course of ECT.

Applications for the approval of electroconvulsive therapy are heard as promptly as is possible, as it is not uncommon for the patients to be catatonic, unable to eat or drink, and near death. Although the Tribunal prefers to be in the presence of the patient and the treating team when it hears and determines applications for the approval of ECT, there are occasions when the delay in arranging hearings could have drastic consequences. Thus, on 26 occasions during the period 30 November 2015 to 30 June 2017 the Tribunal used the audio-visual facilities at metropolitan hospitals or clinics to hear an application made in respect of a patient who was located at another hospital in Perth or in one of the regional hospitals. Doing this enabled the Tribunal to see and hear from patients, their families and carers and advocates as well as the treating team in a matter of hours after the application was received by the Tribunal, rather than days or weeks.

Sections 410 and 414 set out a number of things to which the Tribunal must have regard when determining an application. Because is quite common for ECT applications to be made in respect of patients who are extremely depressed, suicidal, catatonic, unable to eat, drink, swallow or breath without assistance and at risk of dying, the Tribunal has implemented procedures which enable it to deal with applications as promptly as possible, including checking the application and the medical report in support as soon as the application is received and if need be sending the medical team examples of de-identified medical reports which are good examples of the type of information and the detail and depth of information that must be provided to the Tribunal before it can approve ECT. As part of the preliminary vetting of an application the Tribunal may point out any gaps in the information provided so that the treating team can obtain the information and provide it to the Tribunal during the hearing.

The Tribunal and the treating profession have adapted well to the Tribunal's new jurisdiction. The first application for the approval of ECT was made on the fourth day after the Act came into general effect. On one occasion the Tribunal was holding reviews in an authorised hospital when it was asked if it could hear an application for ECT for a patient who was not on the Tribunal's list of patients to be reviewed at that hospital. No secretarial support was available to the psychiatrist who made the request, and so he hand wrote the application and the medical report in support of it. The hearing commenced 90 minutes after the psychiatrist had asked if it would be possible for the Tribunal to hear it. The patient took part in the hearing, and was represented by a Mental Health Advocate. After hearing the application and ensuring that it dealt with each of the matters required by sections 410 and 414 of the Act, the Tribunal approved the ECT treatment.

The Tribunal's ECT jurisdiction has significantly increased the Tribunal's work-load.

Between the 30th November 2015 and the 30th June 2016 the Tribunal received 58 applications for the approval of ECT, and approved 51 of them. Four applications were withdrawn, two applications were not proceeded with because the Tribunal revoked the involuntary treatment order and therefore did not have the jurisdiction to hear the application, and one application was withdrawn because the treating team considered that the patient was too manic for treatment to be provided.

Between the 1st July 2016 and the 30th June 2017 the Tribunal received 112 applications for the approval of ECT, and approved 107 of them. Two applications were withdrawn, one application was not proceeded with because the Tribunal revoked the involuntary treatment order and therefore did not have the jurisdiction to hear the application, one application was rescheduled and one application was not approved.

Psychosurgery

Section 208 of the Act permits psychosurgery to be performed on patients who are at least 16 years old, if and only if the patient gives informed consent and the Tribunal approves the psychosurgery.

The Tribunal has not received any applications for the approval of psychosurgery. However, on hearing that psychosurgery was being considered for a patient, the President of the Tribunal requested the appointment of a neurosurgeon to the Tribunal. Neurosurgeon Mr Stephen Honeybul was duly appointed to the Tribunal by the Hon Minister for Mental Health for a period of 12 months commencing 24 July 2017.

Scheduling of Reviews

When a person is made an involuntary patient (whether detained in an authorised hospital, general hospital or on a CTO) or any subsequent orders are made continuing the person's involuntary status (such as an order extending an involuntary inpatient order or a CTO), the Tribunal is provided with a copy of the relevant documentation and from that obtains information which is entered into a database which contains information concerning each patient. The information is used for the purpose of scheduling reviews in accordance with the requirements of the Act. Because the database system is still being adapted from one written for the purposes of the Mental Health Act 1996, the Tribunal's staff have had to develop work arounds pending the completion of a purpose-written database system. Development of the database system is an ongoing process.

Before any review is held, a notice providing details of the date, time, and venue of each review, is sent to:

- the patient;
- the applicant for the review (if the review has been requested by someone other than the patient);
- if the patient is detained in hospital - the treating psychiatrist and the clinical nurse specialist responsible for the patient;
- if the patient is on a CTO - the supervising psychiatrist and the responsible practitioner;
- the patient's representative (if applicable) such as a lawyer or para-legal from the Mental Health Law Centre (also known as "MHLC");
- the Mental Health Advocacy Service (also known as "MHAS"); and
- any close family member, carer, or other personal support person whose name and contact details have been provided to the Tribunal.

If the Tribunal is aware that the patient has a guardian appointed under the Guardianship and Administration Act 1990, the Tribunal will also give the guardian notice of the review hearing. The Tribunal will not always be aware of such an appointment.

The parents or other family members of an involuntary patient sometimes ask the Tribunal if they can be notified of a review hearing date. The Tribunal, as did the Mental Health Review Board, encourages the attendance of family members and friends of a patient at review hearings and hearings of applications for the approval of ECT, but can only invite people to attend hearings if the Tribunal has been given the relevant contact details.

For reasons of confidentiality, the Mental Health Review Board was not able to inform such people of the details of the review. The Act changed that situation and, whilst the Tribunal is obliged to protect the confidential nature of the hearing process and the patient's right to privacy, generally speaking it must give close family members and other personal support people or carers notice of hearings and reviews. As part of that process the Tribunal requests the assistance of the psychiatrist in informing family members of the hearing details. On many occasions family members or other concerned people do attend review hearings, further details of which are set out in Part 5 of this Report.

Venues and Audio-visual conferencing

Involuntary patients may be detained in hospitals or their CTOs may be supervised by staff working out of mental health clinics throughout the State - although the majority are in the metropolitan area.

For patients in authorised hospitals or on CTOs in the metropolitan area the Tribunal usually conducts review hearings at the authorised hospital or the clinic concerned. The Tribunal would prefer to hold all review hearings on a face to face basis, with all participants present in the one room, but that is simply not possible in a State the size of Western Australia. Audio-visual conferencing allows the participants in a review to see and speak to each other despite being great distances apart and is, in the Tribunal's opinion, preferable to holding hearings over the telephone. At times, however, difficulties in making audio-visual conference connections can cause delays and poor picture quality can reduce the ability to see the demeanour of a person.

Between 30 November 2015 and 30 June 2016, the Tribunal conducted 154 review hearings using audio-visual facilities at 22 regional locations from Wyndham to Esperance. Between 1 July 2016 and 30 June 2017, the Tribunal conducted 253 review hearings using audio-visual facilities at 24 regional locations from Wyndham to Esperance.

Most of the time the Tribunal uses the audio-visual facilities that are located in the Tribunal's premises in West Perth, but from time to time (and particularly if the Tribunal is deciding whether or not to approve ECT) the Tribunal will use the facilities that are available in hospitals or clinics where the Tribunal happens to be sitting when the application is received. Between 30 November 2015 and 30 June 2016, the Tribunal conducted 11 review hearings using audio-visual facilities at eight metropolitan locations other than the Tribunal's facilities in West Perth. Between 1 July 2016 and 30 June 2017, the Tribunal conducted 36 review hearings using audio-visual facilities at 17 metropolitan locations other than the Tribunal's facilities.

Interpreters

It is a fundamental principle of procedural fairness that a person about whom a decision may be made is able to understand what is being said in a hearing. Accordingly, if the Tribunal becomes aware that a patient who is to be reviewed, or a person who may give information to the Tribunal at the hearing on behalf of the patient, does not fully understand the English language, the Tribunal will arrange for the attendance of an interpreter at the review hearing. The Tribunal relies, primarily, on hospitals and mental health clinics to advise that an interpreter is or may be required. On one occasion involving a patient who became mentally ill in an immigration detention centre and was hospitalised, an interpreter who spoke the patient's dialect was found and utilised for the purposes of the review, and a second opinion and diagnosis was obtained from a psychiatrist in private practice in Perth who originated from the same country as the patient and was able to converse with the patient in the patient's dialect, thus reducing the risk of cultural misunderstandings.

During the year ending 30 June 2016, 40 reviews were scheduled involving interpreters in 17 languages, namely Auslan (four), Burmese (two), Cantonese (two), Croatian (three), Dari (four), Farsi (six), Hungarian (one), Indonesian (two), Mandarin (two), Polish (two), Romanian (three), Spanish (one), Sudanese Arabic (two), Swahili (two), Tamil (one), Turkish (one), and Vietnamese (two).

During the year ending 30 June 2017, 41 reviews were scheduled involving interpreters in 18 languages, namely Arabic (four), Auslan (two), Bengali (one) Cantonese (three), Croatian (three), Dari (five), Farsi (four), French (two), Greek (one) Indonesian (one), Java East Indonesian (one), Macedonian (one) Mandarin (three), Mauritian (one), Swahili (two), Thai (two), Urdu (one) and Vietnamese (four).

Co-operation from Hospitals and Clinics

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

- At some venues the rooms provided to the Tribunal are not adequate for the holding of a hearing because they are too small to accommodate the Tribunal members, patients and representatives/family, and members of the treating team who attend.
- Some rooms are inadequate in that they do not have a table that is large enough for the Tribunal to set up its recording equipment or for Tribunal members to set out their files and make a proper note of the matters discussed. On these occasions the Tribunal members work with files balanced on their laps.
- In some cases, the rooms are consultation/treatment rooms and may convey the impression to patients that the review hearing is connected with their treatment – and thus convey the impression that the Tribunal is in some way connected with the hospital/clinic and not independent.
- On many occasions the report from the treating psychiatrist or other member of the treating team is not provided to the Tribunal (or the patient) in sufficient time before the hearing and, at times, is not sufficiently comprehensive.
- In some cases, no member of the treating team with up-to-date information about the patient's progress and current situation is available at the hearing to provide information needed by Tribunal members in order to make an informed decision about the patient's involuntary status.

The Tribunal is well aware that some of the above can be attributed to the limited facilities available at hospitals/clinics and to the pressure that clinicians are under because of high caseloads. The Tribunal has made, and will continue to make, its requirements known to the venues so that progress can be made in overcoming these problems.

The Tribunal acknowledges that since 30 November 2015 the Department of Health has taken steps to ensure that safer facilities are provided. For example, new facilities are under construction in Butler to replace unsafe facilities that had been used in Clarkson, and structural alterations have been made to the building which contains the clinic in Mirrabooka so that the hearing room could be fitted with two exits. The size and physical layout of the rooms in which the Tribunal's hearings are held directly affect the physical safety of all who are present at a review. Safe, less cramped conditions help people to relax and enhance the confidence, dignity and comfort of everyone present, including patients, and enhance the process. The Tribunal acknowledges and thanks the Western Australian Police Mental Health Co-Response Unit for its assistance and advice in the assessment of facilities and safety requirements.

PART 4: STATISTICAL INFORMATION ABOUT REVIEWS

Caveat: The Tribunal regularly checks the accuracy of its list of names of patients who are the subject of involuntary treatment orders, by cross checking the list with the hospitals and clinics, thus ensuring that no patient is overlooked as regards the Tribunal's statutory duty to review whether or not the patient should remain subject to an involuntary treatment order. However, due to difficulties experienced with designing and implementing a new database system in place of the system used for many years by the Mental Health Review Board, some of the data referred to in this Section is indicative only.

During the period 1 July 2015 to 29 November 2015, 1681 people commenced periods as involuntary patients as a result of orders being made that they be detained in an authorised hospital (1274 people) or by the making of CTOs (407 people). During the period 1 December 2015 to 30 June 2016, 2346 people commenced periods as involuntary patients as a result of orders being made that they be detained in an authorised hospital (1849 people) or by the making of CTOs (497 people).

Taken as a total, during the year ending 30 June 2016, 4027 people commenced periods as involuntary patients as a result of orders being made that they be detained in an authorised hospital (3123 people) or by the making of CTOs (904 people).

These represent an overall increase of 34.2% over the previous year's corresponding figures, with increases of 36.9% for detained patients and 59.5% for CTO patients. In the same period 668 people who had previously been the subject of a CTO had their CTOs extended for a further period.

During the year ending 30 June 2017, 4032 people commenced periods as involuntary patients as a result of orders being made that they be detained in an authorised hospital (3251 people) or by the making of CTOs (781 people).

These represent an overall increase of 0.12% over the previous year's corresponding figures, with an increase of 3.9% for detained patients and a decrease of 13.6% for CTO patients. In the same period 414 people who had previously been the subject of a CTO had their CTOs extended for a further period.

In other words, the Tribunal has been substantially busier than the Mental Health Review Board was.

The position over the past eight years are shown in Tables 4.1 and 4.1.1

Table 4.1: Orders Commencing/Continuing Periods as Involuntary Patient

	09/10	10/11	11/12	12/13	13/14	14/15	1/7/15 to 9/11/15	30/11/15 to 30/6/16	16/17
Involuntary status commenced by orders:									
• detaining in hospital	2688	2690	2626	2627	2621	2283	1274	1849	3251
• new CTO	339	371	329	362	399	366	407	497	781
Total	3027	3061	2955	2989	3020	2649	1681	2346	4032
Involuntary status continued by orders for:									
• revocation of CTO and readmission to hospital	189	95	122	#	#	#	100*	183	313*
• CTO on discharge from hospital	569	552	516	464	486	437	#	#	#
• extending a CTO	319	280	298	289	343	283	395	273	414
Total	1077	895	936	753	829		–	–	–

* Figure is only number of Revocations of CTO, readmission data not recorded

\# Could not obtain data from the Mental Health Review Board's database or from the Tribunal's database

An order that first makes a person an involuntary patient detained in hospital can only operate for 35 days if the patient is at least 18 years old, or ten days if the patient is less than 18 years old. Before the end of that period the treating psychiatrist must examine the patient and decide whether to discharge the patient outright, make a CTO for the patient, or continue the person's status as an involuntary detained patient (also known as an involuntary inpatient). Many people who are detained in an authorised hospital are discharged from involuntary status within that first 28 day period. Over the last eight years approximately 60% of all people who are detained in hospital are discharged outright (ie they cease to be an involuntary patient) in that time period: see Table 4.2.

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

	09/10	10/11	11/12	12/13	13/14	14/15	1/7/15 to 29/11/15	30/11/15 to 30/6/16	16/17
Number commencing as detained patients	2688	2690	2626	2627	2621	2283	1274	1849	3251
Number discharged outright in 28 days	1552	1590	1579	1579	1469	1412	805	1132	1905
Discharge rate (%)	58	59	60	60	56	62	63	61	59

In addition to those patients who are discharged from involuntary status in the first 28 days, a substantial further number are discharged after the Tribunal has scheduled a review but before the review is actually held. Table 4.3 shows the numbers of reviews held compared to previous yearly periods.

Table 4.3: Numbers and Types of Reviews Held

	09/10	10/11	11/12	12/13	13/14	1/7/15 to 29/11/15	30/11/15 to 30/6/16	16/17
Patients detained in hospital								
Requested Reviews	124	74	145	71	65	36	84	154
Initial Period Review	215	254	294	177	172	92	246	351
6-month Period Review	187	143	140	104	146	39	163	269
Patients on a CTO								
Requested Reviews	104	102	48	93	115	65	68	137
Initial Period Review	402	479	326	373	372	185	281	414
6-month Period Review	99	187	182	161	231	127	393	778
Total reviews completed	1131	1239	1135	979	1101	544	1235	2103

Table 4.4 shows the number of reviews that were scheduled to be held and the number of reviews that were in fact held.

Table 4.4: Numbers of Reviews Scheduled and Number of Reviews Held

	09/10	10/11	11/12	12/13	13/14	14/15	1/7/15 to 29/11/15	30/11/15 to 30/6/16	16/17
Total reviews scheduled	1846*	2085*	1914*	1746*	1962*	1967*	926*	2030*	3320*
Total reviews held	1123	1242	1135	983	1107	1183	544	1235	2103
Percentage held	60.8	59.6	59.3	56	56	56	58.7	60.8	65.3

* *A proportion of these will have been scheduled for sitting within the two weeks after 30 June. For 16/17 this equates to 148 scheduled and 99 of these were held.*

As indicated in Table 4.4, 3320 reviews were scheduled to be held but only 2103 were held during the year ended 30 June 2017. The difference of 1217 is 36.7% of the number of reviews scheduled, and underlines the practical difficulties encountered by the Tribunal in the efficient scheduling and conduct of its statutory function to carry out reviews of all involuntary patients.

The reason for the cancellation in approximately 96% of the cancelled reviews, was that the patient concerned had ceased to be an involuntary patient by the scheduled review date. Often the patient's discharge occurs on the day of, or only one or two days prior to, the review. When reviews are cancelled close to the hearing date, it is impossible for the Tribunal to schedule a replacement review for that day.

The reasons for the cancellation of the reviews after the notices of review have been sent are shown in Table 4.5.

Table 4.5: Reasons for Cancellation of Review Hearing

	9/10	0/11	11/12	2/13	3/14	4/15	15/16	1/7/15 to 9/11/15	30/11/15 to 30/6/16	16/17
Patient no longer involuntary	*	*	526	*	*	*	1073	322	755	1060
Patient discharged from hospital on a CTO	*	*	31	*	*	*	0	0	0	0
Cancelled at psychiatrist's request	*	*	75	*	*	*	0	0	0	0
Patient transferred	*	*	25	*	*	*	27	7	22	29
Withdrawal of request for a review	*	*	11	*	*	*	6	2	4	8
Cancelled at request of patient or representative	*	*	58	*	*	*	0	0	0	0
CTO revoked and patient readmitted to hospital	*	*	14	*	*	*	*	*	*	*
Cancelled at Tribunal's request	*	*	17	*	*	*	0	0	0	0
Other reason for cancellation	*	*	22	*	*	*	43	19	16	11
Total cancelled	*	*	779	*	*	*	1149	346	802	1108

* *Data not retrievable.*

When a patient is discharged from an authorised hospital onto a CTO, the Tribunal will usually continue with the review hearing in the hospital and not cancel it.

It does this for two reasons. The first is that by the date of the review the patient will not have been seen by the person responsible for treating the patient in the community, and so treating team in the hospital is the source of the most up to date source of information regarding the patient. The second reason is that cancellation would postpone the patient's chance to have the involuntary treatment order set aside at the earliest possible date. If the Tribunal upholds the CTO when it is reviewed in the hospital, the Tribunal staff schedule a further review of the CTO to take place as soon as possible after the patient's first appointment with the psychiatrist who has the responsibility of supervising the patient's treatment in the community. However, if a patient is transferred from one authorised hospital to another the review will usually be rescheduled to take place at the hospital to which the patient was transferred, as the treating team there will have more up to date information than would the treating team in the original hospital.

Outcomes of Reviews

In the majority of review hearings, the essential issue for the Tribunal to determine is whether the patient's status as an involuntary patient (whether detained in hospital or on a CTO) should continue. In Australia and elsewhere, the proportion of cases in which a body such as the Tribunal discharges a patient from involuntary status is relatively low. That is also the case in Western Australia. This state of affairs should not necessarily be seen as surprising or as reflecting a failure of the Tribunal (or like entities) to carry

out its duties with rigour. Mental health practitioners are now well experienced in the requirements of the Act and, given the percentages shown above of patients who are discharged from involuntary status in the first 14 or 21 days or immediately prior to the review hearings taking place, those patients who might be regarded as borderline will usually have been discharged by a decision of the treating psychiatrist made in the period between the Tribunal setting a date for the review and the date of the hearing that would have taken place but for the patient's discharge in the meantime.

As shown in Table 4.6, during the period ending 30 June 2017 the Tribunal discharged 52 patients from involuntary status. Eighteen of the 52 were patients detained in hospital and 34 were patients on a CTO. A likely factor in the smaller percentage of reviews in which the patient is discharged by the Tribunal compared with the Mental Health Review Board, is that the Board conducted its initial period review within 56 days of the making of the involuntary treatment order, whereas the Tribunal is required to hold the initial period review within 35 days – in other words, at an earlier stage in the treatment of the mental illness.

Table 4.6: Patients Discharged from Involuntary Status by Mental Health Review Board/Tribunal

	09/10	10/11	11/12	12/13	13/14	14/15	1/7/15 to 29/11/15	30/11/15 to 30/6/16	16/17
Total review completed	1123	1242	1135	983	1107	1183	544	1235	2103
Patients discharged from involuntary status									
• detained in hospital	25	32	20	19	13	20	3	20	18
• on CTO	25	26	27	28	34	28	11	34	34
Total	50	58	47	47	47	48	14	54	52
Percentage discharged by Mental Health Review Board/Tribunal	4.5	7.3	4.1	4.8	4.2	4	2.5	4.4	2.5

Reasons for Decision

In most cases the Tribunal announces its decision at the end of the hearing. Only very occasionally does the Tribunal reserve its decision about a matter - although it has the right to do so.

When it announces its decision at the end of a hearing, the Tribunal will usually orally explain, at least briefly, why it made the decision. This assists the patients and other people present to understand why the patient is still involuntary (if that is the case). However, if any party wants reasons in writing, section 469 of the Act requires the Tribunal to provide a written statement of the reasons for a decision if a party to the review requests that that be done. On occasions the Tribunal will also prepare a statement of the reasons for a decision of its own initiative if the matter is considered to raise significant issues.

The Tribunal must also prepare a statement of reasons if an application to review the Tribunal's decision is lodged with the State Administrative Tribunal and the State Administrative Tribunal requests that reasons in writing be provided to it.

During the period ending 30 June 2017 the Tribunal prepared a written statement of reasons for its decisions in 26 matters.

Table 4.7: Written Statements of Reasons for Decision Prepared by the Mental Health Review Board/Mental Health Tribunal

09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17
26	24	35	27	20	33	32	26

The commencement of the new Act has prompted a significant increase in the number of reviews attended by the treating psychiatrists and registrars. Their attendance enhances the review process.

Table 4.8: Attendance at a review by a treating psychiatrist or registrar

	09/10	10/11	11/12	12/13	13/14	14/15	1/7/15 to 29/11/15	30/11/15 to 30/6/16	16/17
The number of reviews attended by a treating psychiatrist	473	515	539	484	555	*	301	695	1171
The number of reviews attended by a registrar	129	184	128	137	149	*	124	1082	599

* *Data not retrievable*

PART 5: PATIENT ATTENDANCE AND REPRESENTATION AT REVIEWS

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

The Tribunal considers that it is highly desirable that patients attend their review hearings personally and be represented at them - either by an advocate, legal practitioner or some other person. Accordingly, the Tribunal sends to each patient, with the notice of hearing, a brochure containing the contact details of the Mental Health Law Centre and the Mental Health Advocacy Service, both of which may be able to represent patients at review hearings. Every working day the Tribunal also sends the Mental Health Advocacy Service a list of the all the patients which it has scheduled for review, so that Advocates can contact the patients and offer their services for the purposes of the review.

Patient Personal Attendance at Hearings

Table 5.1 details the number and percentages of patients who attended their review hearings. As can be seen, there has been a significant decrease in the attendance rates for inpatients. The commencement of the decline coincides with the commencement of pilot programmes carried out before the Mental Health Act 2014 was passed by Parliament, in which reviews at selected hospitals were held with the frequency that would be required if the Mental Health Bill was passed. Thus, the decline in the rate of participation in inpatient reviews may be due to the increased frequency with which reviews are held, particularly as regards patients who are less than 18 years old. Orders made in respect of children and adolescents are now reviewed within 10 days of the making of the order and thereafter within intervals no greater than 28 days. Subjectively, it appears to the Tribunal that the increased frequency of reviews places the children and adolescents under a great deal of strain.

Table 5.1: Patient Attendance at Review Hearings

	09/10	10/11	11/12	12/13	13/14	14/15	1/7/15 to 29/11/15	30/11/15 to 30/6/16	16/17
Total reviews completed	1123	1242	1135	983	1107	1183	544	1235	2103
Total inpatient reviews	554	654	579	465	524	511	167	484	762
• Patients attended	484	569	477	392	418	407	124	345	517
• Patient attendance rate (%)	87	87	82	84	80	80	74	71	68
Total reviews – CTO patients	569	588	556	518	583	652	377	719	1319
• Patients attended	203	194	228	219	265	289	179	343	638
• Patients attendance rate (%)	35.7	33	41	42	45	44	47	47	48

* *Some totals do not add up as the current database is at times unable to indicate whether a patient is detained or on a CTO when the review was completed.*

During the period ending 30 June 2017, the total number of patients who attended a review was 1155. The overall attendance rate was 55.5%, a slight decrease from previous years.

Representation and Support for Patients at Hearings

In addition to representation by the Mental Health Advocacy Service (which replaced the Council of Official Visitors when the Mental Health Act 2014 came into force) or the Mental Health Law Centre, patients often receive support and assistance at review hearings from other sources. The Mental Health Law Centre does not charge patients a fee

for representing patients, and the Tribunal ensures that brochures publicising the Mental Health Law Centre are sent to every patient who is due to be reviewed by the Tribunal. Despite that publicity, the level of representation by the Mental Health Advocacy Service overall has been significantly higher overall than the level of representation by lawyers from the Mental Health Law Centre.

Table 5.2 sets out details of the extent of representation and assistance received by patients at the various types of review hearings conducted by the Tribunal. When reading the Table, please note that some patients were supported by or represented by a Mental Health Advocacy Service Advocate as well as a Mental Health Law Centre lawyer and/or another person such as a such as a carer, friend, family member or guardian.

Table 5.2 Patients Represented or Supported at Review Hearing

	Detained in hospital			CTO			Total Rep
	Requested Review	Initial Period Review	6-month Period Review	Requested Review	Initial Period Review	6-month Period Review	
09/10							
Mental Health Law Centre	47	6	5	46	8	4	116
Council of Official Visitors	66	31	33	32	19	3	184
Other support	22	24	17	20	39	6	110
Total Reviews Held	124	215	187	104	402	99	1131
Rate of Mental Health Law Centre representation	4.1	2.7	2.7	44.2	2.0	4.0	10
Rate of Council of Official Visitors representation	53	14.4	17.6	30.7	4.7	4.0	16.2
Rate of Other support representation	17.7	11.1	9.0	19.2	9.7	6.0	9.7
10/11							
Mental Health Law Centre	26	5	8	20	11	1	71
Council of Official Visitors	43	57	42	45	36	9	232
Other support	14	39	10	14	44	11	132
Total Reviews Held	74	254	143	102	479	187	1239
Rate of Mental Health Law Centre representation	34	2.0	5.6	19.6	2.3	0.5	5.7
Rate of Council of Official Visitors representation	58	22.4	29.3	44.1	7.5	4.8	18.7
Rate of Other support representation	18.9	15.3	7.0	13.7	9.1	5.8	10.6
11/12							
Mental Health Law Centre	47	19	10	15	9	5	105
Council of Official Visitors	89	91	69	13	5	4	271
Other support	25	36	12	7	23	20	123
Total Reviews Held	145	294	140	48	326	182	1135
Rate of Mental Health Law Centre representation	32.4	6.5	7.1	31.3	2.8	2.7	9.3
Rate of Council of Official Visitors representation	61.4	31	49.3	27.1	1.5	2.2	23.9
Rate of Other support representation	17.2	12.2	8.6	14.6	7.1	11	10.8

Table 5.2 Patients Represented or Supported at Review Hearing continued

	Detained in hospital			CTO			Total Rep
	Requested Review	Initial Period Review	6-month Period Review	Requested Review	Initial Period Review	6-month Period Review	
12/13							
Mental Health Law Centre	29	14	4	54	17	6	124
Council of Official Visitors	32	61	49	24	30	19	215
Other support	4	19	9	7	33	13	85
Total Reviews Held	71	177	104	93	373	161	979
Rate of Mental Health Law Centre representation	40.8	7.9	3.8	58	4.5	3.7	12.6
Rate of Council of Official Visitors representation	45	34.4	47	25.8	8.0	11.8	22
Rate of Other support representation	5.6	10.7	8.6	7.5	8.8	8.0	8.6
13/14							
Mental Health Law Centre	29	11	10	51	24	15	140
Council of Official Visitors	37	61	62	35	35	22	252
Other support	9	11	7	14	40	20	101
Total Reviews Held	65	172	146	115	372	231	1101
Rate of Mental Health Law Centre representation	44.6	6.4	6.8	44.3	6.4	6.4	12.7
Rate of Council of Official Visitors representation	57	35.4	42.4	30.4	9.4	9.5	22.9
Rate of Other support representation	13.8	6.4	4.8	12.	10.7	8.5	9.1
1/7/15 to 29/11/15							
Mental Health Law Centre	20	12	1	30	12	8	83
Council of Official Visitors	20	21	16	12	15	11	95
Other support	5	16	7	15	25	12	80
Total Reviews Held	36	92	39	65	185	127	544
Rate of Mental Health Law Centre representation	55	13	2.5	46	6.4	6.2	15.2
Rate of Council of Official Visitors representation	55	22.8	41	18	8.1	8.6	17.4
Rate of Other support representation	13.8	17.3	18	23	13.5	9.4	14.7
30/11/15 to 30/6/16							
Mental Health Law Centre	14	13	14	19	13	24	97
Mental Health Advocacy Service	41	116	79	26	81	65	408
Other support	25	41	32	18	50	65	231
Total Reviews Held	80	244	160	68	267	384	1203
Rate of Mental Health Law Centre representation	17.5	5.3	8.7	28	4.8	6.2	8
Rate of Mental Health Advocacy Service representation	50.1	47.5	49.3	38.2	30	16.9	33.9
Rate of Other support representation	31.25	16.8	20	26.5	18.7	16.9	19.2
16/17							
Mental Health Law Centre	27	13	16	46	17	47	166
Mental Health Advocacy Service	96	185	123	61	131	142	738
Other support	48	70	39	33	67	133	390
Total Reviews Held	152	341	269	137	410	772	2103
Rate of Mental Health Law Centre representation	17.7	3.8	5.9	33.5	4.1	33	7.9
Rate of Mental Health Advocacy Service representation	63.1	54.25	45.7	44.5	31.9	18.4	35.5
Rate of Other support representation	31.5	20.5	14.5	24	16.3	17.2	18.7

Representation and Support for Children and Adolescents at Hearings

Table 5.2 above includes data in respect of all patients, including children and adolescents.

Table 5.3 below includes data pertaining to review hearings in respect of patients aged under 18.

The Tribunal makes every endeavour to hold the reviews within ten days of the date upon which the child or adolescent is made an involuntary patient.

As can be seen from Table 5.3, during the first seven months after the Mental Health Act 2014 came into force on 30 November 2015, there was a substantial increase in the number of reviews attended by the child's or adolescent's family members. That increase was maintained during the year ending 30 June 2017, in which 81 children or adolescent reviews were held and family members were present at 42 of them. This is a welcome increase over the number of children or adolescents whose family members attended reviews held under the previous Mental Health Act.

The Mental Health Advocacy Service represented 59 child or adolescent patient, and the Mental Health Law Centre represented one.

Table 5.3 Children and Adolescents Represented or Supported at Review Hearing

	1/12	1/7/15 to 29/11/15	30/11/15 to 30/6/16	6/17
Total reviews scheduled	115	19	54	114
Patients discharged before the review was held	44	12	20	33
Total reviews completed	71	7	34	81
Patients represented by the CoOV/Mental Health Advocacy Service	6	2	14	59
Patients represented by the Mental Health Law Centre	2	1	1	1
Number of reviews attended by family members	7	3	22	42

PART 6: APPLICATIONS TO THE STATE ADMINISTRATIVE TRIBUNAL

If a person is dissatisfied with a decision of the Tribunal, the Act confers them with a right of review by the State Administrative Tribunal (SAT). No fees are payable on the filing of an application for a review of the Tribunal's decision and the application can be instituted by the use of a single form.

When SAT reviews the Tribunal's decisions, it must be by a panel consisting of a judicial member or a senior member of SAT or a legally qualified member plus a psychiatrist (or, in some cases, a medical practitioner who is not a psychiatrist), and a third person who is neither a legal practitioner nor a medical practitioner. SAT is presided over by a Supreme Court judge and its members include two District Court judges, but from time to time SAT hearings are presided over by a legal practitioner rather than a legal practitioner.

The Supreme Court recently heard an appeal from a decision made by SAT in an appeal to SAT from a decision of the Mental Health Tribunal. As part of the appeal, the Supreme Court had to consider the object of a review by SAT of a decision made by the Mental Health Tribunal, and the role of SAT in the appeal. The Supreme Court held that the role of SAT was "to make the correct and preferable decisions under sections 386 and 387 of the Mental Health Act as at the time the Mental Health Tribunal made its decisions on the initial and first periodic reviews" of the community treatment order that had been in force when the Mental Health Tribunal made its decision: see AB v Beer [2017] WASC 199 per Corboy J at [76].

The effect of the decision is that any patient whose mental health had improved in the meantime would continue to be detained as an involuntary patient if SAT found that the patient was mentally ill as at the date that the patient was reviewed by the Mental Health Tribunal. It is strongly arguable that the result would not be in the best interest of a patient whose mental health had improved between the date of the Mental Health Tribunal's decision and the date upon which SAT makes its decision, and it is recommended that an amendment to the Mental Health Act be considered so that SAT would be required to consider whether or not the involuntary patient was still in need of the involuntary treatment order as at the date of the hearing by SAT.

Section 495 of the Mental Health Act 2014 gives the Tribunal the power to apply to SAT for a determination of any question of law that arises in a proceeding before the Tribunal. That power has not been exercised to date.

Sections 503 to 506 of the Mental Health Act 2014 create a system by which any person in respect of whom SAT has made a decision or order may appeal to the Supreme Court on the grounds that SAT erred in law or fact (or both), acted without or in excess of its jurisdiction, or for any other sufficient reason. One appeal to the Supreme Court was part-heard as at the 30th June 2017. It was dismissed on the 21st July 2017.

Table 6.1 Appeals to State Administrative Tribunal from Decisions of the Mental Health Review Board/Mental Health Tribunal

	09/10	10/11	11/12	12/13	13/14	14/15	1/7/14 to 29/11/15	30/11/15 to 30/6/16	16/17
Appeals pending in Supreme Court at 30 June			1			0			1
Appeals Lodged	4	6	12	9	6	11	16	8	26
Finalised prior to 30 June									
• Withdrawn/Dismissed without hearing	1	5	12	3	1	9	9	2	10
• Dismissed by SAT	1	1	12	5	3	0	5	2	2
• Patients Discharged from Involuntary Status by SAT	0	0	1	0	0	0	0	0	2
• In progress 1 July	1	0	1	2	1	2	N/A	1	1

PART 7: OTHER MATTERS

The Act creates rights in favour of carers and close family members, such as the entitlement to be provided with information relating to information relating to the mental illness for which a close family member is being provided with treatment or care.

Sections 422 to 436 when read with Part 16 of the Act can be broadly described as giving the Tribunal the power to protect various rights that the Mental Health Act creates in favour of the patient or other people, including the right to be given an explanation of the patient's rights under the Act, the right to information, the right of access medical records and other documents, the right to request an interview by a psychiatrist, and freedom of lawful communication. The Act empowers the Tribunal to issue notices which require compliance with non-clinical matters such as the requirement to give a document or provide information to patient, or to ensure that a treatment, support and discharge plan for a patient is prepared, reviewed or revised: see sections 422 to 426. Applications can be made to the Tribunal for the review of decisions which affect a person's rights under the Act, and on completing the review, the Tribunal may make any orders or give any directions that it considers appropriate: see section 434.

The Tribunal has not issued any compliance notices.

PART 8: TRIBUNAL DECISIONS – CASE STUDIES

The vast majority of decisions made by the Tribunal when conducting reviews of the status of involuntary patients turn on the particular facts of the individual case. As would be expected, the facts and circumstances of each case are unique, and the Tribunal must make findings of the material facts, to which must be applied the relevant principles of law. Sadly, it is quite common for the Tribunal to have to decide whether the patient's behaviour or disturbances of thought was due to the effect of illicit drugs, or whether it was due to a mental illness. Some reviews raise significant questions about the correct interpretation of the Act in matters such as the statutory criteria for being an involuntary patient or the nature and extent of the Tribunal's powers.

The statutory framework

In every case the Tribunal must consider whether or not the requirements set out in the Act relating to when a person can be made an involuntary patient are satisfied. As mentioned in Part 3 of this Report a psychiatrist cannot order that a person should become an involuntary patient unless the psychiatrist is satisfied that all of the requirements set out in Section 25 of the Act are satisfied. Section 25 provides that a person can be an involuntary patient only if:

a) that the person has a mental illness for which the person is in need of treatment;

b) that, because of the mental illness, there is —

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

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

c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;

d) that treatment in the community cannot reasonably be provided to the person;

e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order.

Section 6 of the Act provides that a person has a mental illness (for the purposes of the Act) if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that significantly impairs (temporarily or permanently, the person's judgment or behaviour.

However, s 6 also provides that a person does not have a mental illness by reason only of one or more of the following, namely that the person:

a) the person holds, or refuses or fails to hold, a particular religious, cultural, political or philosophical belief or opinion;

b) the person engages in, or refuses or fails to engage in, a particular religious, cultural or political activity;

c) the person is, or is not, a member of a particular religious, cultural or racial group;

d) the person has, or does not have, a particular political, economic or social status;

e) the person has a particular sexual preference or orientation;

f) the person is sexually promiscuous;

g) the person engages in indecent, immoral or illegal conduct;

h) the person has an intellectual disability;

i) the person uses alcohol or other drugs;

j) the person is involved in, or has been involved in, personal or professional conflict;

k) the person engages in anti-social behaviour;

l) the person has at any time been —

   i. provided with treatment; or

   ii. admitted by or detained at a hospital for the purpose of providing the person with treatment.

When performing its functions under the Act the Tribunal must seek to ensure that the objects of the Act are achieved so far as they are relevant to the performance of the Tribunal's functions. Section 10 sets out that the objects of the Act include:

a) to ensure people who have a mental illness are provided

b) the best possible treatment and care —

   (i) with the least possible restriction of their freedom; and

   (ii) with the least possible interference with their rights; and

   (iii) with respect for their dignity;

c) to recognise the role of carers and families in the treatment, care and support of people who have a mental illness;

d) to recognise and facilitate the involvement of people who have a mental illness, their nominated people and their carers and families in the consideration of the options that are available for their treatment and care;

e) to help minimise the effect of mental illness on family life;

f) to ensure the protection of people who have or may have a mental illness;

g) to ensure the protection of the community.

If a psychiatrist proposes to make an order that a person become, or continue to be, an involuntary patient detained in an authorised hospital, Section 24 requires the psychiatrist to consider whether the objects of the Act would be better achieved by making a community treatment order (CTO). In addition, the psychiatrist must not make a CTO in respect of a person unless satisfied that:

a) that the person has a mental illness for which the person is in need of treatment;

b) that, because of the mental illness, there is —

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

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

   (iii) a significant risk of the person suffering serious physical or mental deterioration;

c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;

d) that treatment in the community can reasonably be provided to the person;

e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order.

The Tribunal approaches its review function with the above statutory framework in mind. In accordance with Section 394 of the Act, the Tribunal must have regard to:

a) if the involuntary patient is a child and the Tribunal is not constituted with a child and adolescent psychiatrist — the views of a medical practitioner or mental health practitioner as defined in Section 394(2);

b) the involuntary patient's psychiatric condition;

c) the involuntary patient's medical and psychiatric history;

d) the involuntary patient's treatment, support and discharge plan;

e) the involuntary patient's wishes, to the extent that it is practicable to ascertain those wishes;

f) the views of any carer, close family member or other personal support person of the involuntary patient;

g) any other things that the Tribunal considers relevant to making the decision.

Below are some examples of decisions made by the Tribunal during the year that were unusual, raised issues of principle, or illustrate the Tribunal's general approach.

Case No 1: Is the decision to refuse treatment – a treatment decision. What is 'treatment'

In this matter the patient was on an inpatient treatment order. The patient was a middle-aged woman with a diagnosis of severe and enduring Anorexia Nervosa. The onset of her illness was in her mid-teen years, and she required extensive treatment in both inpatient and outpatient settings for over three decades of her life. She was first seen by the Tribunal in 2001.

The patient lived in a Nursing Home where she required significant nursing support to facilitate ongoing nutritional support. The medical report described her as having "overwhelming psychological distress in which she is clearly tormented by the eating disorder cognitions which assert that she is "disgusting" and by other non-psychotic phenomena which appear to articulate her own ambivalence that she "doesn't deserve to live." The treating team opined that without force feeding, the patient would die relatively soon.

The patient's advocate argued that the patient had the capacity to make decisions because "it is her choice not to be fed. It is her choice to deal with this in a way that is less distressing to her…. She knows what treatment options there are for her and she disagrees that the feeding tube is a treatment option that she wants to take."

The patient's advocate stated "She knows what the treatment options are. She knows what the risks are of not receiving treatment or refusing the feeding option. She does understand what the effect of it is going to be of that decision and she weighs all of that

up and says – she makes a rational choice". Further, it was argued "all the Act requires is for her to make a treatment decision, not to agree to any treatment decisions. So she does have the capacity to make a decision, which is to refuse".

The patient's treating team agreed that she was aware of the consequences of not refeeding, of the likelihood of death and of what that means. However they argued

> "And so at this point clinically we're, I suppose, prepared to make errors of co-mission rather than omission, that we intervene so that she stays alive rather than withdraw and interfere with her autonomy with the likely serious outcome there.
>
> From the medical team, we actually feel, I suppose, paralysed in some way that we just have to continue to keep her alive by virtue of her having an illness which is driving these symptoms, but we're also aware of the family's preference for proceeding to a palliative role and I believe it's Dr M's belief that we should seek advice from this body or maybe other bodies as indicated to see whether that may be the most suitable long-term plan. So, we have exhausted all routine treatments at this point."

The Tribunal was faced with the fundamental difficulty of deciding whether or not the patient, in accordance with Section 18 of the Act had the capacity to decide whether or not to accept the proposed treatment. That is, whether or not the patient

a) understood the things that are required under section 19 to be communicated to the person about the treatment; and

b) understood the matters involved in making the treatment decision; and

c) understood the effect of the treatment decision; and

d) could and did weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the treatment decision; and

e) communicated the treatment decision in some way.

Further, the Tribunal had to decide whether feeding with a tube was 'treatment' relevantly defined in section 4 of the Act as being "the provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness" but not including "bodily restraint, seclusion or sterilisation."

The Tribunal found that the patient did not have the capacity to make a treatment decision about the provision of treatment at the time of the hearing, and that the least restrictive way of adequately providing the patient with treatment was for the patient to remain on an inpatient treatment order. The Tribunal decided that the patient's malnutrition was a direct consequence of a mental illness, Anorexia Nervosa, and made a further finding that the provision of nutrition via the percutaneous endoscopic gastrostomy ("PEG") tube is treatment pursuant to the Act.

Case No. 2: An example of therapeutic jurisprudence, the benefit of engagement with families encouraged by the Act to attend the review, and cultural sensitivity, again encouraged by the new Act.

The Tribunal was scheduled to conduct an initial period review of a young man of Aboriginal descent, who had been placed on an inpatient order. His mental illness

had been untreated for some period of time, despite experiencing symptoms that had significantly impacted on his daily life. He had no place of residence at the time of being admitted to hospital for treatment. There was no representative scheduled to appear for him and the report referred to his reluctance or difficulty in engaging with the treating team.

Shortly prior to the scheduled hearing time, the Tribunal members were asked if the Tribunal could delay starting for 15 minutes so that the young man's two aunties could attend. Given the emphasis placed in the new Act on taking into account the views of family members, the Tribunal agreed to wait so that they could attend. The hearing commenced with the two aunties present. They explained that the family had been initially suspicious of the efforts of the public health system in engaging the young man with services and had not encourage him to seek help. However, through the work of the hospital treating team and the Aboriginal mental health workers, they had come to realise that their community beliefs around mental illness could work together with the public health system and that they had seen clear benefits for the young man in the treatment provided in hospital.

One of the concerns for the Tribunal was the support available in the community for the young man, particularly in terms of accommodation. Again, the aunties spoke highly of the work done by the social workers at the hospital in engaging them with housing services and they were working on accommodation solutions involving multiple family members offering support. The young man was quietly spoken and of few words, but through the use of the hearing, he was able to hear all of the matters of concern and, at the conclusion, accepted that the inpatient treatment was in his best interests at that time.

Case No. 3: Urgent application for ECT – heart condition – risk of heart event v risk of dying from complications of Bipolar Affective Disease – ECT approved

An elderly lady with a long history of Bipolar Affective Disease was an involuntary patient being treated for severe depression associated with her Bipolar Disease. On a Friday in 2017 the Tribunal received an application from the patient's Consultant Psychiatrist (the Psychiatrist) urgently seeking approval to give up to 12 electroconvulsive therapy treatments (ECTs). The Tribunal sitting at a different hospital on the following Tuesday, heard the application by video link. The risks to the patient of receiving ECT were increased by the serious heart condition that patient had.

The Psychiatrist, a Consultant Psychiatrist, two Consultant Anaesthetists (including the Head of Anaesthetics) and the patient's Mental Health Advocate attended the hearing. The patient's Guardian from the Office of the Public Advocate attended by telephone. The Guardian, who had been appointed about three years earlier, had seen the patient in various states of health, including before and after she had ECT in 2016, so was able to make a valuable contribution.

The Advocate had seen the patient on the morning of the hearing, and advised the Tribunal that the patient was to unwell to give any instructions about the application or come to the hearing.

Due to the severity of her depression, the patient would not swallow tablets, eat or drink. Despite being fed intravenously she was in a catatonic stupor and deteriorating.

The Psychiatrist advised that the patient would eventually die if the depression, catatonia

and lack of nutrition could not be addressed. This had to be weighed up against the risk of the patient suffering a "heart event" such as developing an abnormal heart rhythm or having a heart attack during or as a consequence of ECT. The Psychiatrist advised the Tribunal about a hospital cardiologist's tests and opinion about the risks to the patient's heart.

The Psychiatrist and the Advocate reported on their respective discussions with patient's son who, the Advocate said, was not in favour of the ECT because although it had helped many times in the past, the patient quickly relapsed. The Guardian told the Tribunal it seemed there was little choice other than to try ECT.

The Tribunal weighed up the medical opinions and the views of the Guardian and son. The Tribunal accepted that the treating team would thoroughly review the patient after each treatment, act cautiously, weigh up the risks and benefits of giving another treatment and decide, based on the team members' medical expertise and experience, whether to proceed. The Psychiatrist intended to cease ECT as soon as the patient started eating and drinking.

The Tribunal considered the possibility of giving permission for fewer than 12 treatments. However, if the first few treatments were effective but not to the extent that the patient could be made voluntary, the team would have had to make another application for approval of ECT. Complications can arise if treatment is stopped or paused prematurely. Although the Tribunal had been able to hear the application soon after it was made, it could not guarantee that it would be able hear any further application as quickly. So as to avoid the possible complications the Tribunal approved up to 12 ECT treatments.

The Tribunal contacted the treating team after the course of treatment had begun, and was told that the patient had not suffered any adverse heart events.

Case No. 4: Whether patient in Frankland Centre who no longer required a secure forensic setting was being treated in a way that would involve less restriction of the patient's freedom of choice and movement

The patient was a 23-year-old who was referred to the Frankland Centre via a Hospital Order after being charged with common assault and disorderly behaviour. Because the patient was deemed not fit to stand trial, the charges had not been dealt with by any Court. Because of a shortage of beds, the patient was the only female in an otherwise male occupied ward.

Due to a history of extensive childhood trauma, intellectual impairment, possible foetal alcohol syndrome, illicit alcohol and drug use since the age of 5, and very limited social supports, the patient had complex treatment needs. She was assessed as extremely vulnerable, especially with regards to sexual exploitation. The patient said that she had a fiancée, however he had not contacted her since admission and she did not know his phone number. Prior to admission the patient had been staying with an "uncle" who was not a blood relative.

With regards to mental illness and risk, the patient had presented with mood and psychotic symptoms, as well as showing evidence of serious physical neglect. Following treatment, she was no longer psychotic and her mood had stabilised. She remained vulnerable, however, giving her belongings away to other patients (including patients she did not particularly like), and being willing to offer to have sex with patients and staff if she felt they had been kind to her. The patient accepted she had a mental illness, and had

been compliant with treatment.

The Tribunal found that the patient was no longer in need of treatment in a secure forensic setting. She had been given bail but, due to bed shortages, was on a waiting list for transfer to a mental health unit.

During the hearing, the main point of discussion was around discharge planning, including treatment in a less restrictive environment. The Tribunal accepted the treating team's evidence that the patient needed to be placed in appropriate supported accommodation in order to facilitate community mental health follow up on discharge, as well as to minimise her risk of self-neglect and the risk being taken advantage of physically, sexually and financially by others.

The Tribunal decided that although the patient required treatment for a mental illness, she did not have the capacity required by section 18 to make a treatment decision about the provision of treatment.

It also found that the patient remained chronically vulnerable to assault from others and was at risk of self-neglect. This risk increased when the patient did not receive treatment, as her symptoms when unwell included increased intrusiveness, disinhibition and poor judgement. The Tribunal considered that the patient was too vulnerable to be placed in an open ward. Reluctantly, the Tribunal found that until a bed was available in a locked ward pending the availability of suitable accommodation and support in the community, treatment could not be adequately provided in a way that would involve less restriction than by being a patient in the Frankland Centre.

Case 5: Whether a child should receive treatment at Graylands – review of refusal by psychiatrist to sign transfer order pursuant to section 390(d)

This case illustrated an issue that is repeatedly encountered by the Tribunal – a scarcity of age appropriate beds for children who require compulsory treatment. This case was about a 17-year-old girl with a history of involvement with mental health services and who was under the care of Department of Child Protection. The child's advocate had requested a review, asserting that the treating psychiatrist had refused to sign a transport order for transfer of the patient to a child and adolescent ward.

The report provided described the patient as having a history of complex trauma. She been given a lot of different diagnoses in the past including generalised anxiety disorder, post-traumatic stress disorder, mild intellectual impairment, and emotionally unstable personality and behavioural disturbances. The patient had attended Emergency Departments a number of times following self-harm episodes. Prior to her current admission, she had presented at an Emergency Department after swallowing a piece of glass. Admission to hospital was required but, because there were no beds available at the Fiona Stanley Hospital Youth Unit or Bentley Adolescent Unit, the patient was admitted to an adult ward in the Graylands Hospital.

On the ward, the patient's behaviour was severely disturbed and included banging her head against the floor and walls, biting people, throwing herself against the walls and floors and acting aggressively to staff and other patients. The patient had to be restrained and injected with medications in an attempt to sedate her and try and keep her as well as other patients and staff on the ward safe. The patient had told staff that she was very frustrated with being on a ward full of "old people".

During the hearing, the treating psychiatrist gave an opinion that the patient did have a mental illness requiring treatment, remained a risk to herself and others, and did not have capacity to consent to treatment. The treating psychiatrist agreed that a child and adolescent psychiatrist should assess the patient. Regarding treatment, the patient was being managed with 2 nurses dedicated to her, however medication and seclusion was re-traumatising her. The treating psychiatrist was of the opinion that the patient needed more age appropriate treatment including psychotherapy and a behavioural management programme in the Fiona Stanley Hospital Youth Unit or the Bentley Adolescent Unit. However no beds were available at either place, with the waiting time for a bed in Bentley being about two weeks.

The Tribunal decided that the involuntary inpatient treatment order should continue. The Tribunal then considered the application for an order that the patient be transferred to the Bentley Adolescent Unit, and decided that although it was preferable that the patient be treated in Bentley, the lack of any available bed there meant that the treating psychiatrist's refusal to make the transport order was appropriate in the circumstances.

PART 9: COMMUNITY TREATMENT ORDERS

Section 24 (4) requires a psychiatrist to consider before making an inpatient treatment order, whether the objectives of the Act would be better achieved by making the person the subject of a community treatment order (CTO). Many hundreds of CTOs are made each year – and some patients remain on a CTO for extended periods. An obvious benefit of a CTO is that the person can continue to live in the community rather than be detained in a hospital. However, at the same time, the person will be subject to the coercive aspects of the Act should he or she not comply with the terms of the CTO.

Availability of suitable accommodation

Section 114 of the Act provides that one of the matters about which a psychiatrist must be satisfied before a CTO can be made is that suitable arrangements can be made for the care of the patient in the community. Part of this care includes community support services which should be high quality, personalised, effective and efficient, providing individuals with support to create or rebuild a satisfying, hopeful and contributing life and providing carers, and families with support for their own wellbeing. A significant part of this matrix of care includes the provision and retention of suitable accommodation.

Having a stable form of accommodation is widely recognised as one of the most significant factors in achieving recovery for a person with a mental illness. A stable home helps people keep in touch with family and friends and form new relationships with neighbours and local communities. It provides a basis for other areas of a person's life to fall into place, such as getting back to work, finding a new job, or taking up sport, education and other activities.

Whilst accommodation in the community will not be an issue for patients who live in their own home or with family or friends, for many people who experience mental illness, finding and maintaining life in a stable home can prove difficult. Some people move from house to house or become homeless. People in rented homes can be at risk of losing their home during periods of mental health instability

Studies have found that supported accommodation services are not only highly effective in reducing the number of mental health related outpatient contacts and hospitalisations for people with severe and persistent mental illness, but also, the use of supported accommodation services significantly reduce the cost to the health system by providing better care for these individuals to prevent hospital readmission. Studies have also found if residents of supported accommodation services re-enter hospital, their length of stay and cost per stay is significantly reduced.

Whilst reviewing the involuntary status of people who have been detained in authorised hospitals for considerable periods of time, the Tribunal is frequently told by treating teams that the patient does not need to remain as an inpatient for treatment reasons – but that, rather, the person remains in hospital only because no suitable accommodation can be found for the person in the community. In other words, the patient could be the subject of a CTO but for the fact that suitable arrangements cannot be made for the patient's care in the community because of the absence of supported accommodation.

It is of concern to the Tribunal that the objective of the Act - that people with a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity - may be frustrated by the

prolonged detention in hospital of people who could live in the community if appropriate accommodation were available.

A system-wide multi-agency housing strategy to address the housing needs of individuals with mental illness is essential. The Tribunal notes the Mental Health Commission's Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (the Plan) stated that it aimed by the end of 2017, to develop a housing strategy to address the housing needs of people with mental illness whilst also increasing access to community support services that will assist with daily living tasks and maintaining tenancy. This includes (as a priority) appropriate housing and support for people with a mental illness who are homeless.

The Plan said the "strategy would include the specification of contemporary housing and, where required, support options for people who have historically had difficulties accessing and maintaining housing. People who experience difficulties with accessing and maintaining housing include people with a mental health, alcohol and other drug problem who have come into contact with the criminal justice system, people who have remained in institutional care for a number of years, people who are homeless and people currently living in psychiatric hostels. Consideration should also be given to the ongoing safety and quality of housing, with housing being located close to services and supports."

The Tribunal looks forward to the release and implementation of this strategy.

PART 10: CONTACT AND OTHER INFORMATION

The Tribunal has a website (www.mht.wa.gov.au) which contains information about the Tribunal and its activities, in particular in relation to the conduct of reviews of the status of involuntary patients.

The Tribunal's contact details are:

Postal Address:	PO Box 1623, Hay Street, WEST PERTH WA 6005
Telephone:	(08) 6145 3900
Facsimile:	(08) 9226 2668
Email:	enquiries@mht.wa.gov.au

This page has been left blank intentionally.

MENTAL HEALTH TRIBUNAL

Postal Address:
PO Box 1623, Hay Street, WEST PERTH WA 6005

Telephone: (08) 6145 3900

Facsimile: (08) 9226 2668

Email: enquiries@mht.wa.gov.au