

# INSTRUCTIONS FOR PREPARING THE "REPORT ON INVOLUNTARY STATUS FOR THE MENTAL HEALTH REVIEW BOARD"

Version 2.0 Dec 2004

## Purpose of the Report

This Report is the principal written medical report provided by or on behalf of the Authorised Psychiatrist of the mental health service concerning the medical history and current condition of an involuntary patient about whom a review or appeal has been scheduled for hearing. It should provide in detail all relevant information gained from personal observations and knowledge, from careful perusal of the patient's clinical file(s), and from collaboration with other members of the patient's treating team, especially the patient's case manager.

Subject to the transitional provision in the amending Act allowing six months to prepare treatment plans for continuing involuntary patients, the latest copy of the patient's treatment plan, prepared in accordance with s19A, must be attached to, or incorporated in, the Report, as the Board is required to conduct a review of the treatment plan under s35A. The standard questions in the Report have been updated to address the issues that the Board must determine at the hearing.

## Preparing the Report

The Report must be completed (no later than by the close of the business day **two days** before the hearing) and five copies made (3 for the Board, 1 for the patient, and 1 for any representative). These are in addition to the treating doctor's copy.

Given the new requirement to prepare, review or revise (as the case may be) the patient's treatment plan, service staff should discuss with the Consultant Psychiatrist the appropriate protocol and timeframe that the service has adopted to complete the patient examination, consultation about the preparation, review or revision of the treatment plan, and the drafting and sign off of the Report and (prepared/revised) treatment plan.

On the hearing day, the Report, treatment plan and the patient's clinical file must be made available to the Board members at least 30 minutes before the first scheduled hearing, or at such other time/s as the Board may specify in special circumstances).

## Patient's access to report and clinical file

The patient (and their representative) must be given a copy of the Report and latest copy of the treatment plan, the opportunity to read it (or have it read to them or discussed with them by an appropriate staff member), and access to the patient's clinical file, **at least 24 hours before the hearing**. This is required by section 26(7) of the *Mental Health Act 1986* (the Act), and does **not** require a Freedom of Information request.

Where there is any doubt about the patient's capacity to read and/or understand the Report, an attempt should be made to read and explain it to them in language they can understand. When such doubt exists, as a consequence of the patient's lack of understanding of English, an interpreter of the patient's language should be provided and used.

If the patient is subject to a community treatment order and it is inadvisable for medical reasons that the Report and treatment plan are read by the patient alone, arrangements should be made to read it to the patient in advance of the hearing.

If the patient is not capable of understanding the contents of the Report, the treatment plan and/or the clinical file, this fact should be reported to the Board at the commencement of the hearing.

## Presenting the Report and treatment plan at the Hearing

In some instances, the service may wish to withhold some information in the clinical file from the patient. The procedure to be followed in such cases (that is, making an application for non-disclosure under s26(8) of the Act) is set out in appendix 1 (page 39) of the Chief Psychiatrist's CTO Guidelines booklet issued in November 2001.

The representative/s of the mental health service attending the Board hearing should be clinically acquainted with the patient and should be able to present details directed towards the criteria for continued involuntary or security status, and the patient's treatment plan, or other matters being considered by the Board (eg. transfer, special leave of absence for security patients etc.). They should also be capable of answering questions about the criteria and treatment plan asked by Board members and the patient.

Even more so than before, as a result of the recent amendments requiring the preparation of a treatment plan and continuing consideration of the appropriate treatment setting, the Board encourages the service to carefully consider which members of the treating team are best placed to provide comprehensive information to the Board in each case. The Board's experience has often been that the patient's case manager is best able to inform Board members about the patient's social circumstances and current treatment and management issues.

Again, because treatment plans are to be prepared collaboratively by the treating team, patient and, where appropriate, family members, patients should also be informed of their right to involve family members or carers in the Board hearing. Where appropriate, service staff should contact family members or carers to inform them about Board hearings and invite their attendance. In the Board's experience, the participation of family members or carers provides Board members with valuable additional information and perspective on the patient's current social circumstances and treatment management issues.

### **Board Powers**

The Board may **adjourn a hearing and/or require the attendance of the patient's consultant psychiatrist** if the service fails to provide the Report and treatment plan to the patient and/or representative in accordance with the requirements of s26(7) of the Act, or an appropriately knowledgeable representative of the Authorised Psychiatrist is not available at a hearing.

### **NOTES ON COMPLETING THE REPORT AND TREATMENT PLAN**

1. The form should be typed. If hand written, print clearly using black ink in BLOCK letters.
2. Details provided should include information obtained from other treating team members, especially case managers (see the new para 6.1 of the Report) or others who have most regular contact with the patient.
3. If you are unsure of the details to include, discuss this with your consultant psychiatrist.
4. Reports prepared more than three weeks before a hearing should be updated. The timing of reviews of treatment plans should be based on sound clinical judgment. Board hearings may provide one (but not the only) trigger for such a review.
5. The Report document is the primary source of written evidence tendered on behalf of the Authorised Psychiatrist of your service. It is important that it is prepared carefully and includes all relevant and detailed information. The patient or the patient's representative may wish to challenge or clarify aspects of the Report during the hearing, and Board members may ask questions about its contents. The Board's decision will be based on all the information and evidence available to it at the hearing.
6. The treatment plan is a clinical document designed to be prepared in collaboration with the patient and, in appropriate cases, the patient's family. It is important that the service comply with the requirements set out in s19A or explain why not. Any issues relating to implementation of the plan should also be thoroughly discussed.

John Lesser  
President

