

Hearings before the Mental Health Review Board of Victoria



Advocates' Guide

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Note on Referencing of Cases:

Decisions published by Mental Health Review Board before 1997 in either Volume 1 or Volume 2 of their decisions books are referenced with initials, the publication date of the decision book, the volume number of the decision book, the initials of the decision book, and a page reference eg: *Review of AB* (1992) 1MHRBD p.40 or the *Review of RJS* (1998) 2MHRBD p.199.

Decisions after that date are referenced with the type of hearing and an identification number whether they were reported or unreported and the date of the hearing eg: *Re the Appeal and Review of 05-009* (unreported, MHRBD (Vic), 22 July 2004 or as the type of hearing, an identification number, and the reference in the third published volume of decisions eg: *Re the Appeal of 03-004* [2002] VMHRB 7

Contact the Mental Health Review Board for copies of these decisions. Ph: 86015270

The Board are currently in the process of uploading decisions to the Australasian Legal Information Institute (AUSTLII) website.

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The Mental Health Legal Centre Inc. encourages readers to seek out legal advice and representation wherever possible.

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1 INTRODUCTION

The Mental Health Review Board is an independent tribunal formed pursuant to the Victorian Mental Health Act 1986 (Vic). Amongst other functions, it conducts hearings to determine whether people should continue to be treated as involuntary patients under the Act.

Typically, three Board members conduct a hearing; a lawyer, a psychiatrist and a community member, and the Board is chaired by the legal member. In some circumstances, one Board member only can conduct a hearing (see page 16).

At a review of or appeal into a person's involuntary status, the Board must be satisfied that all of the following five criteria set out in the Mental Health Act are met:

- a. the person must appear to be mentally ill; and
- b. the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
- c. because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in their physical or mental condition or otherwise) or for the protection of members of the public; and
- d. the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- e. the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action.

What is the approach to advocacy in this jurisdiction?

The most important principle is to promote a person's legal rights by acting according to the client's wishes and not according to what you perceive as their best interests. This does not mean that an advocate must do anything that is instructed but rather that it is the client who sets the goals for the hearing process once they are fully informed about their legal options.

The treating team and the Mental Health Review Board's role is to apply the criteria and principles of the Act in the best interests of the person.

This is quite different from the role and the perspective of the advocate. It is crucial that client's own wishes are fully considered in the process and that the advocate fully understands what a client's expectations and objectives are. One of the most frequent concerns of users of mental health services is that their views are routinely disregarded. Advocates have a duty to ensure that Board hearings are not a continuation of this experience.

The Board operates on an inquisitorial rather than an adversarial model. However, it may be that from a particular client's perspective the fundamental dynamic may be adversarial and you must respect the reality of that experience. If a client experiences a situation as win/lose, that must be appreciated and instructions taken as to what goals the client has in terms of the process beyond win/lose.

One application of this is that you should not present material that is adverse to the client's case, subject to the duty owed to any court or tribunal not to positively mislead.

Be aware that members of the public are sometimes unaware of the mutual roles inherent within the client / solicitor relationship and it may be necessary to explain duties such as acting on instructions.

As with any solicitor/client relationship, a client has the right to instruct an advocate as they see fit. Where the very issue in dispute is essentially one of capacity, you should never assume that someone lacks the capacity to instruct on an issue. If a client has received a diagnosis which may affect capacity then that is not synonymous with an inability to instruct and it is extremely unusual within this jurisdiction for an advocate to not be able to obtain instructions.

When you are receiving instructions, it may be necessary to advise a client of the possible legal ramifications of their instructed course of action but to respect their right to make their own decision about their case once they have been properly informed about and have understood their rights and the consequences of each legal alternative as well as the practical hurdles.

In interviewing a client try to get a real understanding of the client's perspective so that you can work together to get as much out of the hearing for the client as possible, irrespective of outcome in terms of discharge or continuation of status.

2 BEFORE THE HEARING

Is the person an involuntary patient or a security patient?

Most people who have hearings before the Board are involuntary patients who are either in-patients or subject to community treatment orders (CTOs). As a result of amendments to the Mental Health Act, both in-patients and people on CTOs are subject to an involuntary treatment order (ITO).

People who are on hospital orders under s93(1)(d) of the Victorian Sentencing Act (1991) or hospital transfer orders under s16 of the Mental Health Act, or restricted community treatment orders (RCTOs) made under s15A of the Act (for people who have been on s93(1)(d) hospital orders are also involuntary patients. From October 2006 Hospital Orders will be known as Restricted Involuntary Treatment Orders.

Security patients are people who have been placed on hospital security orders by the court after being found guilty of an offence in accordance with s93A of the Sentencing Act or have been transferred to hospital from prison under s16 of the Mental Health Act (under a restricted hospital transfer order).

There is a further category of involuntary patient under s12A of the Mental Health Act, subject to a particular review and appeal regime. To date s12A of the Act has not been used. This section is discussed below in relation to the meaning of a mental illness.

The Board also hears appeals by people being transferred to another mental health service and has to approve the making of RCTOs and interstate transfers.

How is the hearing initiated?

Automatic Review

All involuntary patients and security patients have an automatic review initiated by the Board within eight weeks of becoming involuntary, and then every twelve months while still involuntary.

A person's initial automatic review hearing may not be listed until close to the eight week period. To bring the hearing on sooner you can lodge an appeal. Hearings take place every two weeks, sometimes every month. Even if the hearing date is close, the Board may be able to bring an

appeal hearing on quickly. To facilitate this it may be helpful to confirm with the treating doctor whether the date will be suitable.

Appeals

All involuntary patients and security patients can have an appeal hearing at any time. There is no limit to the number of times a person can appeal.

An appeal form is included in Appendix [1]. It can be lodged with the staff at the hospital or clinic or it can be lodged with the Board by fax, post or by electronic means. Alternatively, a person can appeal by writing to the Board without using the standard form.

Detailed reasons for the appeal need not be stated in the appeal form.

Will an interpreter be required?

If an interpreter is required to take instructions and you cannot obtain one through your own organisation or Victoria Legal Aid, it is possible that the mental health service the person uses might arrange one for you. The Mental Health Review Board will arrange an interpreter to be present at the hearing. The hospital or clinic will usually advise the Board if an interpreter is required, but it is a good idea for you to contact the Board's hearing co-ordinator yourself to confirm that an interpreter has been arranged. Contact details are at the end of the document.

Where do hearings take place?

Hearings will take place at the local psychiatric in-patient service or community mental health service. The Board can advise of the location of hearings in each area.

At what time are the hearings?

The hearing program usually commences at 10am. You can ask the staff member who co-ordinates the hearings at the mental health service to roughly indicate what time a particular client's hearing will start. The Board can tell you which member of staff (usually a medical records officer) is responsible for scheduling the hearing.

It can be very difficult for a client to present at the Board after a lengthy wait. If you give the staff member co-ordinating the hearing enough notice, you can often arrange for a particular hearing to be listed first, or close to first, on the day to reduce delay.

Can hearings be adjourned?

You can have a hearing adjourned, for example to allow the person to be represented, to allow time for written or more complex submissions to be made, to allow time for medical reports or other supporting material to be obtained, or witnesses to be available, or to allow for consideration of material which the service failed to disclose before the hearing and on which they rely.

Even though the Mental Health Act requires that reviews take place within eight weeks and then every twelve months, the Board will agree to adjourn a hearing to outside those times if the client is properly informed and wants the adjournment.

Give the Board as much notice as you can of the request for an adjournment. Phone the hearings co-ordinator at the Board to request an adjournment. If an adjournment cannot be requested until the day of the hearing, put the request to the Board on the day of the hearing either in person, or by faxing a written request via the staff member at the service who co-ordinates the hearings. Appendix [2] contains a precedent letter to request the adjournment. The request should state the reasons and your contact details.

Access to clinical file

A person has the right to see their file for the purposes of a Board hearing under s26(7) of the Mental Health Act. These rights flow to the representative. If there are a number of files, access should be given to all volumes to which the Board will have access.

The Mental Health Act says access must be given at least 24 hours before the hearing. Access to the file can usually be arranged much earlier than that, but the Report on Involuntary Status written by the doctor for the hearing may not be available until 24 hours before the hearing or later (though this is a contravention of s26(7) of the Act).

Appendix [3] 'Report on Involuntary Status for the Mental Health Review Board' is a practice direction which requires that all documents to be presented to the Board must be available to parties at least 24 hours prior to the hearing. It directs that staff make the doctor's report available for clients and legal representatives at the latest by the close of business two days before the hearing to accord with principles of procedural fairness and natural justice. In this regard see also Appendix [4] 'Practice Direction 98/2'.

Access usually takes place at a hospital or clinic and can be arranged through the staff member who organises the hearings at the clinic or hospital (details of those staff can be obtained from the Board) or the person's case manager or doctor.

Written authority for access to the file should be obtained and then attached to the clinical file. A second authority should also be kept with your file notes (see Appendix [5] for examples of authorities).

Appendix [6] is a guideline from the Office of the Chief Psychiatrist about access to files and outlines the right to have access in a quiet and private area. It provides that photocopying should be facilitated. Appendix [6.1] is an older guideline from that office dealing with the right of an advocate to peruse the file confidentially with the client. This guideline should be used if a service seeks to have a member sit in on the interview and file viewing.

Appendix [7] contains 'Instructions for Preparing the 'Report on Involuntary Status for the Mental Health Review Board' issued by the Mental Health Review Board in December 2004. The instructions expressly provide that access to the clinical file to prepare for a hearing pursuant to s26(7) of the Mental Health Act does not require the production of a freedom of information request. It is a completely different, less formal process than under freedom of information legislation. Mental health services are unable, for example, to insist on the 45-day access period enforced by the Freedom of Information Act. The instructions also set out that the doctor's report and treatment plan should be typed or printed in block letters if it is hand written. Reports prepared more than three weeks before a hearing are required to be updated.

Sometimes a mental health service will deny access to earlier volumes of a clinical file on the basis that those volumes are not intended to be given to the Board in connection with the hearing. If issues are raised at the hearing, or are contained in the doctor's report and these are not explicable by reference to the accessed files this should be raised, either with the Office of the Chief Psychiatrist (if issues arise before the hearing) or with the Board on the day. In many cases issues such as diagnosis can only be properly explored if clients have access to early volumes. An adjournment may be sought to allow file evidence on which that adverse material is based to be made available to a party. However, in pursuing this course the client should be advised that additional files may contain additional material which would not otherwise be brought to the Board's attention and could potentially be prejudicial.

Reviewing clinical file

Once access has been granted and a time arranged the client and advocate can review the file together. This is a crucial part of the hearing process as it gives the advocate an opportunity to understand the client's perspective and review the health service's evidence. A file review may also allow advice to be given in relation to issues such as electroconvulsive therapy (ECT), seclusion or non-psychiatric treatment like contraceptive medication.

When reviewing the file it is important that the following are perused and any relevant dates and other issues checked against statutory requirements:

- Admission documents (Request, Recommendation etc).
- Record of Examination following admission (Examination of Involuntary Patient by Authorised Psychiatrist).
- Involuntary Treatment Order/ Community Treatment Order documentation.
- Continuation file notes made by mental health services during periods of admission and community treatment.
- Discharge form and discharge summaries from mental health services.
- Treatment plan.
- Doctor's reports and Board's statements of reasons from previous hearings if applicable.
- Correspondence on file, progress reports etc.

If incidents are noted in the clinical file and relied upon by the treating team and are of questionable relevance it may be useful to refer to the decision 'Re the Appeal and Review of 05-009 (unreported, MHRBD (Vic), 22 July 2004' where the dissenting legal opinion favoured probative value being attached only to incidents where the currency and relevance of the happening had been demonstrated.

What if the service seeks to exempt part of the file from disclosure?

Under s26(8) of the Mental Health Act, the service can apply to the Board to not supply material which might:

- cause serious harm to the person's health or the health and safety of any other person; or
- involve unreasonable disclosure of personal affairs of any person; or
- breach a confidentiality provision imposed by a person.

Only the particular words or lines of entry, which are exempt, can be removed. You may find when you arrive to view the file with your client that the exempted entries have already been removed.

At the beginning of the hearing you should argue for disclosure of the material. The client cannot be present at that argument. The service will, however, usually agree to show the entries in question to the advocate before the day of the hearing so you can argue for disclosure, on the undertaking that you do not disclose information to the client unless and until the Board decides it can be disclosed. If you are going to have access to those entries before the hearing you should always explain this to your client—including the fact that they may never get to see it.

If the Board allows the material to be disclosed, you will be given time to go through the material with the client.

Frequently, the Board will form the view that the excluded material is not relevant to the issues under review and will not be considered by the Board if the doctor is agreeable to the information being withdrawn and not being relied upon. The disadvantage of this approach is that there may be material within the excluded sections which may have assisted your client's case.

Witnesses

Ask the client if there is anyone who can be contacted who may be able to assist giving evidence to the Board e.g. friends and family, clergy, other doctors, therapists or support people.

Only contact people on behalf of the client with the client's authority. Never divulge to them any information unless the client has authorised

you to do so. Those other people can participate in person, in writing or by telephone (or where available, video-conferencing facilities).

Discussion with treating team

With the client's permission, contact their case manager or psychiatrist before the hearing to clarify any matters that might be helpful for the case. Note that following amendments to the Mental Health Act, case managers are required to receive a copy of the notice of the hearing.

Discussions and negotiations with the treating team can sometimes result in a client's discharge prior to the hearing or provide insight into the team's deliberations regarding the continuation of involuntary status.

Even if the hearing proceeds, treatment team discussions can result in changes such as adjustments in medication or a reduction in the intensity of supervision.

Obtaining second opinions

A second opinion from an independent psychiatrist may be of assistance particularly if the client has previously seen the psychiatrist privately.

Before recommending that a second opinion be sought consider whether this is likely to be of assistance or will simply corroborate existing assessments. If a client has already been assessed for several admissions there may be several opinions already contained on the file. Further, the Board does not need to be satisfied of a particular diagnosis but only that on the balance of probabilities the client appears to be mentally ill.

Clients can be referred to the Victorian Mental Illness Awareness Council (ph: 9387 8317) for the names of psychiatrists who bulk bill. However, the advocate should advise the client of costs which may be incurred if the psychiatrist does not bulk bill and that legal aid may be necessary to pay for the cost of a report. Sometimes the costs of preparing a report can be avoided if the psychiatrist is prepared to write a letter or simply a note for the Board following the consultation.

Notification of representation

Phone the hearing co-ordinator at the Board as soon as you can if you are representing someone, and if you can estimate the length of the hearing.

Legal Aid funding

Victoria Legal Aid (VLA) considers funding for lawyers at the Mental Health Review Board a priority. If a client satisfies the means test in that they are judged unable to afford a lawyer, VLA will pay if there are reasonable prospects of obtaining the applicant's release from hospital or some other improvement in his or her condition.

The prospect of improvement in condition is important. The vast majority of people are not discharged at their hearings. However, any potentially beneficial outcome of a hearing, such as early review, changes to the treatment approach, access to information that the service seeks to exempt or even simply having the case put thoroughly by an advocate may well attract funding, particularly if a client has not had representation before.

Treatment Plans

Under s19A of the Mental Health Act, an authorised psychiatrist is required to prepare, review on a regular basis and revise, as required, a treatment plan for each patient. The client must be given a copy of their treatment plan and it must be discussed with them.

In preparing, reviewing and revising a treatment plan the authorised psychiatrist must take into account:

- the wishes of the person as far as they can be ascertained; and
- unless the person objects, the wishes of any guardian, family member or primary carer; and
- whether the treatment to be carried out is only to promote and maintain the person's health and well-being; and
- any beneficial alternative treatments available; and
- the nature and degree of any significant risks associated with the treatment or treatment alternatives.

The treatment plan should give a clear outline of the treatment a client can expect to receive and may contain anything else the authorised psychiatrist thinks appropriate.

A treatment plan for a client under a CTO must also state:

- who is to monitor and supervise treatment; and

- the case manager's name; and
- place at which treatment is to be received; and
- the times when a person is required to attend for treatment; and
- the intervals for the supervising medical practitioner to report in writing to the monitoring psychiatrist.

Advocates should receive the latest copy of the treatment plan when the doctor's report is received (at least 24 hours prior to the hearing). When reviewing the plan be aware of any inconsistencies between the plan and the clinical file notes.

At an appeal or review hearing the Board is required to review the treatment plan pursuant to s35A of the Act to ensure that the authorised psychiatrist has complied with s19A and to determine whether the plan is capable of being implemented by the service. Advocates should review and be familiar with the treatment plan requirements and take instructions from clients accordingly, remembering that treatment plans will only have continuing relevance if a client's involuntary status is upheld.

3 AT THE HEARING

Who is on the Board?

Unless the hearing is an annual review, a review of the extension of a community treatment order or a review of an interstate transfer, the Board consists of three members—a lawyer, a psychiatrist and a community member.

If it is an annual review, a review of the extension of a community treatment order or a review of an interstate transfer, it may consist of one or three members. If it is one member, it can be a lawyer, a psychiatrist or community member.

If a client is uncomfortable with having just one member, a request for an adjournment can be made.

Can you ask for different members from previous hearing?

If a client has been before the Board on a previous occasion, they may wish to ask for a differently constituted Board. Phone the hearing coordinator to make the request, or seek an adjournment on the day if you have been unable to make the request previously.

Alternatively, if a hearing is adjourned part heard, you may wish to ask the Board to ensure that the same members sit when the hearing resumes—this will not automatically occur.

What if the client does not want to attend?

Clients should be made aware that, except in the most unusual cases, failing to participate in the hearing will significantly reduce the chances of discharge.

The Board will sometimes facilitate attendance of a doctor by telephone, and in some cases it may be appropriate to seek to have the client attend via phone.

What if the client doesn't want a person to attend the hearing?

Board hearings are closed to the public. The Board has to give approval for anyone who is not a party to the hearing to be there. If the client objects to anyone other than the treating doctor being there, the Board will usually not let him or her attend. Appendix [8] 'Observers at Board

Hearings’, and Appendix [9] ‘Guidelines for Ensuring Compliance with the Rules of Natural Justice’, both deal with other parties at hearings.

Procedure of the Board

The Board is bound to act according to “equity and good conscience” and “is bound by the rules of natural justice” (s24(1) Mental Health Act). Compliance with the rules of natural justice requires the hearing rule and bias rule to be observed.

The hearing rule basically requires a client to be given a reasonable opportunity to inform the Board of their position prior to the Board’s decision being made. The bias rule states that no decision maker should be involved in the making of a determination if a reasonable person would not see the decision maker as impartial.

The Board will introduce itself and explain the hearing process. The Board is required under s22(2) to have regard primarily to the client’s current mental condition and to consider their medical and psychiatric history and social circumstances. The Board should establish whether access has been granted to the doctor’s report, the treatment plan and the clinical file. The client or their advocate may wish to outline their submission. This may be useful to focus the Board’s attention on the issues central to the case and of most importance to the client. In doing so, the advocate should refrain from putting forward their own views, even when asked and should avoid making personal guarantees. The doctor will address their report. The Board will question the doctor. The client or their representative will get the opportunity to question the doctor. It may be useful at this point to question the doctor with reference to entries in their clinical file.

When formulating questions consider:

- Whether the symptoms/behaviours are evidence of a mental illness or typical of a client’s personality, religion or culture etc?
- Is there current evidence to support the position that the treating team is taking in relation to a client’s presentation and the history and risks identified on the doctor’s report?
- How do these match up with the client’s views and wishes?
- What evaluations have been made of the client’s mental state and how current are those assessments?

- What is the predominant treatment contemplated by the treatment plan and what are its impacts?
- What attempts have been made to provide this treatment in a less restrictive manner?

The client will be given the opportunity to give evidence and will be asked questions by the Board and their representative. The Board may question anyone else who is present. Although the Board is not bound by rules of evidence it may be necessary to consider objecting to questions posed by the Board. For example, if a question has been misunderstood or if it is based on material which is not current or based on unreliable accounts.

The client or their representative will be given the opportunity to present a closing summary. All present will be asked to leave the room while the Board makes its decision. The Board will orally deliver its decision and give a brief explanation of the reasons. The Board will hand a copy of the decision it has made to the client and the doctor.

This procedure is flexible and you can ask to alter it in any way which seems helpful to the case. For example, it may be preferable from a client's perspective to present their evidence first, particularly in the context of an appeal, and in such a case a request to vary the usual procedure should be put to the Board.

In some cases it may be helpful for an advocate to prepare for the Board a short chronology setting out the significant dates from a client's history. This chronology can focus the Board on the file material which is relevant to the advocate's submissions.

What can a client get out of a hearing apart from a discharge from involuntary status?

Inpatients on Involuntary Treatment Orders

If the Board finds that a person satisfies the criteria set out in s8(1), they must confirm that order. However, the Board has the power to order the authorised psychiatrist to revise the treatment plan if they believe it does not meet the requirements under s19A and as set out on page 14, or the plan is not capable of being implemented.

If the order is confirmed the Board also has the power under s36(4) to order the authorised psychiatrist to make a CTO for a person within a reasonable period. Although what constitutes a reasonable period of time

has not been specified in the Act, the explanatory memorandum indicates that the time period is to allow for “accommodation and appropriate community support to be arranged” (http://dms003.dpc.vic.gov.au/archive/Spring_2003/bills/B01701/E05921.pdf).

The authorised psychiatrist can apply to the Board to reconsider this order. The Board can also order the authorised psychiatrist to revise the treatment plan

Security Patients

All the Board can do in relation to security patients is make a decision as to whether a person should continue with that status or not. If a person is discharged from security patient status they will be returned to prison.

Involuntary patients on CTOs

For involuntary patients on community treatment orders, the Board has the power to:

- discharge them from the CTO so they are no longer involuntary, or
- vary the conditions of the CTO, including its duration and any residence condition or
- order the authorised psychiatrist to revise the treatment plan if the Board believes they have not met the requirements of treatment plans under s 19A, set out on page 14, or the plan is not capable of being implemented.

The Board can revoke a CTO if it is satisfied on reasonable grounds that:

- adequate treatment cannot be obtained under the CTO; or
- the client has failed to comply with the CTO or the treatment plan, or
- reasonable steps have been taken to obtain compliance and there is a significant risk of deterioration because of non-compliance (s36C(4)).

If the CTO has expired without being extended, the Board must find that the person is no longer involuntary. Neither the Board nor the authorised

psychiatrist can extend a CTO once it has expired see s14(5) and 14B(4) and *Wilson v Mental Health Review Board and Others* [2000] VSC 404.

Involuntary patients on RCTOs

For people on RCTOs, the Board cannot vary conditions – only the Chief Psychiatrist can do that. The Board can only:

- approve the RCTO; or
- discharge the RCTO; or
- revoke the RCTO and send the person back to hospital if the Board believes they need to be an in-patient.

From October 2006, the Board will also have power to vary RCTO conditions.

Powers in relation to all involuntary patients (Inpatients and CTO patients) and security patients

The Board can order and fund a further psychiatric opinion if an issue about the person's illness or treatment requires clarification. The Board does not exercise this power often. It can order a review sooner than 12 months if the circumstances justify it.

It can award costs under s131 of the Mental Health Act if there are circumstances which are contemptuous or vexatious and justify an order of costs. This power has very rarely been exercised, but we note that the Chief Psychiatrist states that if there is no good reason for a person being denied access to their file before a hearing, the Board may award "costs against" the mental health service Appendix [6].

It can refer a question of law to the Supreme Court for determination under s118 of the Mental Health Act. This power has rarely been used.

For all involuntary and security patients, the Board only has indirect power in relation to treatment, and cannot give any remedies for any breaches of the Mental Health Act. It is important that advocates explain the limitations of the Board's powers to patients.

The Board however does have the power under s35A to order the authorised psychiatrist to revise a person's treatment plan which is not capable of being implemented or has not been made, reviewed or revised in compliance with s19A of the Act. This may arguably give the Board the power to determine the merits of the treatment plan and therefore the

treatment itself (i.e: whether the plan is only being carried out to promote a client's wellbeing, consideration of beneficial alternative treatments etc). It may also give the Board the power to indirectly to have the treatment plan varied.

Although treatment plans are only of continuing relevance if a client's status is confirmed by the Board, they can provide a valuable opportunity for focusing the Board on the s8(1) criteria. Namely, whether treatment can be obtained in a less restrictive manner and whether the balance between the risks and suffering associated with treatment is being adequately weighed against its benefits for the client. The fact that treatment plans are required to take into account the client's wishes can also provide a forum for challenging the assertion that there is an inability to consent to treatment on the basis of those wishes.

In spite of the limitations of the Board's powers in relation to treatment it is important that a client's concerns about treatment are raised with the Board. Their concerns are very often relevant to the criteria for involuntary treatment, and it is important that people's experience with mental health services is recognised. It is also possible that even if the Board is satisfied with the treatment plan that they will make recommendations about treatment, or that raising concerns in the context of a hearing will lead to some change from the treating team.

Inadequacies in treatment plans can, if instructions are received accordingly, allow concerns about a service's approach or procedure to be brought to the Board's attention and possibly result in the Board recommending changes accordingly.

What criteria does the Board apply?

For review and appeal hearings for in-patients as well as people on CTOs, the criteria applied by the Board are the same. References to decisions of the Board interpreting the criteria are included. It must be remembered that previous decisions of the Board do not bind it (and indeed VCAT decisions are not binding, only persuasive). Differently constituted Boards may reach different conclusions on the same fact situation. These cases are included as examples only, but can provide useful guidance. It may also be useful when preparing submissions to make reference to the overarching objects and principles in Part 2 of the Mental Health Act. Most law libraries have two bound volumes of Board decisions, up to 1997. Unbound decisions can be obtained from the Mental Health Review Board website or by contacting the Board's Legal Officer.

A person must be discharged from involuntary status if any one or more of the five criteria set out set out in s8(1) below are not met.

If each of the following 5 criteria are met the person remains an involuntary patient:

1 They appear to be mentally ill.

A mental illness is defined in the Mental Health Act as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

In the Review of AB, (1992) 1 MHRBD p.40 the Board outlined the following three step process in determining the first criteria:

- “1. It should be satisfied that the person has recently exhibited symptoms usually associated with a recognized mental illness.
2. In determining what is a recognized mental illness, the Board should consider both expert evidence and the widely recognised diagnostic manuals.
3. It should be satisfied that the symptoms which the person has recently exhibited are evidence of the fact that the person appears to have some recognized mental illness and are not solely indicative of any of the matters listed in s8(2) by some reason other than the existence of a recognised mental illness.”

Some major categories of mental illness are:

- mood disorders such as depression and bipolar affective disorder;
- schizoaffective disorder;
- psychotic disorders such as schizophrenia and delusional disorders; and
- anxiety disorders such as obsessive-compulsive disorders.

Asperger’s Syndrome is not considered a mental illness see decision ‘Re the Appeal of 03-004 [2002] VMHRB 7’.

An important distinction is between mental illness and mental disorders which are not mental illnesses for the purpose of involuntary detention. The main category you should look out for is personality disorder. If a person has a personality disorder alone, they cannot be involuntarily treated unless s12A is satisfied. As mentioned earlier 12A has not yet been used. This applies to situations where a person has been admitted to hospital with a mental illness and they no longer have a mental illness but have a mental disorder which poses a serious risk to them.

It is worth noting that in the decision ‘Re the Appeal of 03-130 (unreported, MHRBD (Vic), 28 May 2003)’ the Board determined that a woman suffering from borderline personality disorder had a mental illness. The Board were of the view that the woman, who repeatedly harmed herself, was significantly distorted in her thinking when she did not accept the level of risk she was posing to herself. Section 8(2) of the Mental Health Act sets out a range of matters such as religious, political or philosophical beliefs which cannot, of themselves, be the basis for a finding of mental illness (for examples of religious beliefs see decision ‘Re the Appeal of 04-129 (unreported, MHRB (Vic), 6 May 2004)’ and the decision Re the Review of 04-057 [2004] VMHRB 2. However, if the Board believes there is also a mental illness, the first criterion will be met.

Further, s8(2)(k) provides that a person is not to be considered mentally ill by reason only of the person taking drugs or alcohol. However s8(3) provides that “the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol” can still be regarded as an indication that a person is mentally ill. For a discussion of this interplay see the decision ‘Re the Appeal and Review of 03-049 (unreported, MHRBD (Vic), 7 November 2002’.

If the matters considered by the service are more likely to be aspects of a person’s temperament and response to a person’s situation, it may be possible to argue that there is not a mental illness. See for example, the decision ‘Re the Appeal of 01-017 (unreported, MHRBD (Vic), 30 April 2001’ . The Board is also cautious about relying on second hand, un-corroborated and historical accounts as the basis for a diagnosis, see the Review of 05-088 (unreported, MHRBD (Vic), 22 February 2005).

The Board is likely to find there is mental illness where no symptoms have been evident for some time, but that is thought to be because of treatment, or where a person has not been off treatment for a period considered sufficient for a relapse to take place. However, there may be cases where it is possible to dispute the existence of a mental illness due to an absence of symptoms without medication. (See the Review of AB (1992) 1MHRBD p.40; the Review of RJS (1998) 2MHRBD p.199). For example, in the decision *Re the Review of 99-572*, (unreported, MHRBD (Vic), 3 March 1999, a case involving consideration of the difference between drug induced psychosis and schizophrenia, the Board was not satisfied there was a mental illness where a person had been off treatment and had been symptom free for three and a half months.

2 The person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order.

Treatment is defined in the Act as anything done in the course of the exercise of professional skills to remedy the illness or lessen its ill effects. This wide definition includes things such as monitoring, supervision and counselling as well as psychotherapy and medication. Therefore, even if a person is not receiving any medication, involuntary treatment can entail monitoring by the treating team.

It should be noted that interventions which can be categorised as care rather than treatment do not justify involuntary detention. Legislative amendment removed care from this criterion.

A consideration relevant to this criterion is whether the treatment is working. See the decision '*Re the Appeal of 0199-616* (unreported, MHRBD (Vic) 27 April 1999', or the Appeal of PX (1998) 2MHRBD p.334 where the Board pointed out that the pain and suffering caused by treatment must be weighed against the benefits.

It may also be that a person has received nothing in the way of treatment for a sufficiently long period so it cannot be said there is a need for immediate treatment.

3 Because of the person's mental illness, involuntary treatment of the person is necessary for his or her own

health or safety (whether to prevent a deterioration in the person physical or mental condition or otherwise) or for the protection of members of the public.

Clearly, one factor here is whether the risk to the person's health or safety (or to others) is a result of mental illness or some other factor. See for example Appeal of KB (1998) 2MHRB p.445 and the decision 'Re the Review of 02-113 [2002] VMHRB 5'.

The Board identified in the decision Re the Review of 03-057 [2002] VMHRB 11 that the Board's role is not to paternalistically determine what is in the "overall best health and welfare interests of a patient" but to examine whether there are "compelling reasons to intrude upon the liberty interests of a patient".

For the purpose of this criterion, it is also necessary for the Board to weigh up the benefit of treatment as administered for the person's health or safety against the negative impact of that treatment see Appeal and Review of NG (1998) 2MHRBD p.276. Also in the decision 'Re the Review of 04-124 (unreported, MHRBD (Vic), 21 April 2004' the Board stated that:

“...the law recognises that enforcing compulsory treatment does impinge on a person's civil liberties, and sets out criteria which must be satisfied to justify that restriction in liberty. There is a balance to be struck between ensuring a person has the best possible treatment and minimising the intrusion and restriction imposed by the form of treatment provided. Inherent in the system set up by the Act is the likelihood that people will, at times, require compulsory treatment and at other times be able to receive it voluntarily”.

For example, in the decision 'Re the Review of 04-139 (unreported, MHRBD (Vic), 9 June 2004' the Board held by majority that criterion c) was not met when forcing a person to receive medication was counterproductive and not beneficial from a health perspective when the person's mental state had stabilised and was resistant to treatment. There was found to be no evidence that the person was a danger when unwell.

In terms of the level of risk of harm required under the Act, two formulations often referred to by the Board are as follows:

A person should be subject to involuntary treatment if:

1. Such treatment is necessary to prevent a significant deterioration in the person's physical or mental health within the short of medium term; or such treatment is necessary to secure treatment of currently existing mental illness, addressing its significant disturbance of thought, mood, perception or memory, including the need to address social isolation and a wide range of deleterious social and other consequences see Appeal of HL (1998) 2MHRBD p.485.
2. There is a real risk that:

without treatment, the person's physical or mental condition will deteriorate significantly or the ill effects of their illness will worsen significantly; or the behavioural manifestations of the illness will result in the person's isolation from the community in which he or she lives, interacts and is sustained see Appeal and Review of 99-377 (unreported, MHRB (Vic), 28 August 1998).

If the risk is remote, either in terms of being distant in time or unlikely to take place, it is not a real risk see decision Re the Appeal of 99-500 (unreported, MHRBD (Vic), 8 January 1999).

In the decision Re the Review of 02-060 (unreported, MHRBD (Vic), 7 November 2001 it was stated that an element of proportionality is involved in the assessment of risk such that, a gradual deterioration in a person's mental state or a relatively minor act of harm was far less likely to justify involuntary detention than if a rapid relapse was predicted or there was a threat of serious harm to others.

The Board must also consider whether financial harm flowing from the illness can justify involuntary treatment. It has expressed the view that it cannot, unless it is so extreme as to put at risk the person's health or safety see decision Re the Review of 99-655 (unreported, MHRBD (Vic), 28 May 1999).

In terms of the protection of others, the risk of harm must be of a sufficient level to justify intervention and not be relatively minor see decision 'Re the Review of 05-082 (unreported MHRB, (Vic), 3 February 2005'. For example, embarrassment and inconvenience to others may not be enough to justify involuntary intervention (see Appeal and Review of NG (1998) 2 MHRBD p.276.)

4 The person has refused or is unable to consent to necessary treatment for the mental illness.

An obvious issue here is whether the treatment in question is necessary. For example the decision 'Re the Review of 04-057 [2004] VMHRB 2' found that treatment was not 'necessary' when it was not having salutary effects but rather counter-therapeutic consequences.

Inability to consent to treatment includes a consideration of whether a person has insight into their illness. Insight is but one factor in determining whether a person is able to consent-see decision 'Re the Review of (01-039 [2000] VHMHRB 1'.

A person need not have a full clinical understanding of the illness to be able to consent see decision 'Re the Review of 03-057 [2002] VMHRB 11'. For example, the Board has found ability to consent where someone did not necessarily accept a diagnosis or fully recognise all the symptoms, but recognised the need for treatment for behavioural problems and had exercised her right to raise issues about side effects see the decision 'Re the Review and Appeal of 00-993 (unreported, MHRBD (Vic), 31 August 1999'.

In another case the Board accepted that a person was able to consent even though she had a difference of opinion with her treaters about her illness when unwell, and disagreed about the type and level of medication required. The Board accepted however that she had a strong desire to stay well, had always been compliant by attending appointments and taking her oral medication in the past, was willing and able to enter into reasonable discussion and negotiation and had reasonable supports in place to ensure any deterioration would be minimal see the decision 'Re the Review of 04-018 (unreported, MHRBD (Vic), 1 August 2003'.

In the decision 'Re the Review of 01-079 [2001] VHMHRB 1' the Board found that a person had an understanding sufficient to realise the connection between not taking her medication and the possibility of becoming unwell and being re-admitted to hospital. The Board determined that this understanding was coupled with a strong wish to avoid returning to hospital and therefore amounted to an ability to consent to necessary treatment.

Further, the decision ‘Re the Review of 03-043 (unreported, MHRB (Vic) 24 October 2002’ refers to a person who did not agree with her diagnosis but was held to have adequate insight. She was found to clearly understand that the medication helped her to remain well and able to function as a single parent in the community and that without the medication her capacity to cope with stress and anxiety would be significantly reduced.

Ability to consent may include factors such a person’s realistic assessment that consenting may be the only way to ensure they stay out of hospital. The Supreme Court has recognised this in the unreported matter of [1998] VSC 1554 under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, referred to in the previously mentioned Review of 01-039 [2000] VHMRB 1. The Board in their decision ‘Re the Review and Appeal of 03-053 (unreported, MHRBD (Vic), 13 November, 2002’ referred to the Supreme Court decision as a useful matter to be considered in conjunction with the other elements of insight.

5 The person cannot receive adequate treatment in a matter less restrictive of their freedom of decision and action.

Even if a person is considered unable to consent because they lack insight, it might be that they can still receive adequate treatment off the order because they will still comply, be that to avoid hospitalisation or the stigma and restriction of being on an order, or for some other reason.

The Board considers support mechanisms a person has in the community and the likelihood that others will monitor their health relevant to this criterion. For example in their decision ‘Re the Review of 03-017 (unreported, MHRBD (Vic) 19 August 2002’ they held that the existence of a CTO had made little difference to a person’s past admissions. The Board found that the CTO was not the least restrictive way she could be treated when she was able to be monitored by the Mobile Support and Treatment Service (MSTS) and had sufficient community supports to monitor her mental condition and facilitate treatment see decision ‘Re the Review of 03-029 (unreported, MHRBD Vic, 23 September 2002) and the decision Re the Review of 04-105 (unreported, MHRBD (Vic), 26 February 2004).

What if there is invalidity in the person's involuntary status?

It is important to ensure that the requirements of the Mental Health Act have been complied with in relation to the person's involuntary status.

However, there are many matters which will not mean the Board considers the person no longer involuntary. For example, it has been found that failure to review a person within eight weeks, or contravention of the provision in the Mental Health Act which disallows the same doctor making a request and recommendation, or including incorrect dates on documentation, do not deprive the Board of jurisdiction see decision 'Re the Review of 98-191 [1998] VMHRB 3' and XY (1998) 2 MHRBD p.501. This is a complicated area, as on some matters different Board may have different views, and it involves interpretation of decisions of the Supreme Court.

On a recent issue of interpretation of the Mental Health Act, different Boards took different views on whether a person is no longer involuntary if their CTO expires without extension. The Supreme Court decided that such a person is no longer involuntary and articulated the following principle of interpretation:

“Because the Act regulates the apprehension, admission and detention of person in an approved mental health service against their wishes or understanding, and restricts their freedom in the community, the Act must be interpreted in favour of a person affected by the provision of the Act. The Court shall be constrained to interpret the Act in such a way which least infringes upon the civil rights of a person because of the stigma surrounding mental illness.”(*Wilson v Mental Health Review Board* [2000] VSC 404).

Different Boards have expressed different views as to the relevance of this principle to Board decisions. In the decision 'Re the Appeal and Review of 01-112 [2001] VMHRB 3', the Board determined that the decision applies to interpretation of ambiguous or unclear provisions relating to the involuntary detention of patients, but not the way in which the Board goes about its exercise of applying s8(1) of the Act. It is the Mental Health Legal Centre's view that this is still very much an open question.

4 AFTER THE HEARING

Advise the client of appeal rights

The client can apply to the Victorian Civil and Administrative Tribunal (VCAT) for a review of a decision of the Board. Such applications must be filed within twenty eight days of the Board hearing or, if a statement of reasons is requested, within twenty eight days of when that statement is received.

It is usually preferable to Appeal to the Board than VCAT unless it is a matter such as interpretation of the Act or a very clear error. Different Board members can be requested for the new hearing.

Appendix [10] includes some sample letters to use after a hearing.

Advise the patient they can request a detailed statement of reasons for the decision

A statement of reasons can be requested by writing to the Board within twenty eight days of the date of the hearing.

Requests should always be made in time but the Board sometimes exercises its discretion to extend the timeframe if requested.

Useful Contact Details

Mental Health Legal Centre

Level 4/520 Collins Street
Melbourne VIC 3000
Tel: (03) 9629 4422
1800 555 887 (Country Callers)
Fax: (03) 9614 0488
Email: mental_health_vic@fcl.fl.asn.au
www.communitylaw.org.au/mentalhealth

Office of the Chief Psychiatrist

Level 2, 555 Collins St
Melbourne VIC 3001
Ph: (03) 9616 7571
Fax: (03) 9616 7697
Website:
www.health.vic.goc.au/mentalhealth

Mental Health Review Board of Victoria

Level 30/570 Bourke Street
Melbourne VIC 3000
Ph: (03) 8601 5270
Hearing Co-ordinator
Ph: (03) 8601 5260
Board's Legal Officer
Ph: (03) 86015267
Fax: (03) 8601 5299
Email: mhrb@mhrb.vic.gov.au
Website: www.mhrb.vic.gov.au

VCAT (General List)

Level 7/55 King Street
Melbourne 3000
Ph: (03) 9628 9755
Fax: (03) 9628 9788
Website: www.vcat.vic.gov.au

Australasian Legal Information Institute (Austlii)

website www.austlii.edu.au

Appendices

1.	MHRB Appeal Form
2.	Request for Adjournment
3.	MHRB Practice Direction 2004/1
4.	MHRB Practice Direction 98/2
5.	Authority for Release of Information and Authority to Act and Release of Information
6.	Patient Access to Files for MHRB Hearings Guideline from November 2001
6.1	Access to Files 1993
7.	Instructions for Preparing the Report on Involuntary Status for the Mental Health Review Board, Version 2.0 Dec 2004
8.	MHRB Practice Direction 98/3 Observers at Board Hearings
9.	Guidelines for Ensuring Compliance with the Rules of Natural Justice
10.	MHRB Closing Letters