

An Advocates' Guide to Hearings before the Mental Health Review Board of Victoria

Produced by the Mental Health Legal Centre Inc.
4 / 520 Collins St
Melbourne VIC 3000
Tel: (03) 9629 4422
1800 555 887 (Country Callers)
Fax: (03) 9614 0488
Email: Mental_Health_VIC@fcl.fl.asn.au
updated by Sophie Delaney, Principle Solicitor

Disclaimer of Liability:

Legal issues around mental health can be complex and will vary from person to person. While care has been taken in the preparation of this material, the writer and publisher disclaim any liability for actions taken or not taken as a result of the contents of this book or for any errors or omissions in the information. The Mental Health Legal Centre Inc encourages readers to seek out legal advice and representation wherever possible.

BEFORE THE HEARING

Is the person an involuntary patient or a security patient?

Most people who have hearings at the Board are involuntary patients who are in-patients subject to section 12 of the Mental Health Act, or people on community treatment orders (CTO's) subject to section 14.

People who are on hospital orders under section 93(1)(d) of the Sentencing Act or section 16 of the Mental Health Act, or Restricted Community Treatment Orders (RCTO's), made under section 15A of the Act (for people who have been on section 93(1)(d) hospital orders, are also involuntary patients.

Security patients are people who have been placed on hospital security orders by the court after being found guilty of an offence (section 93(1)(e) of the Sentencing Act) or are people who have been transferred to hospital from prison under section 16 of the Mental Health Act (under a restricted hospital order).

There is a further category of involuntary patient under section 12A of the Mental Health Act, subject to a particular review and appeal regime. To date section 12A 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 RCTO's and transfer of patients interstate.

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 12 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 staff at the hospital or clinic or by faxing or posting it to the Mental Health Review Board.

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 organization 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 on 8601 5262 yourself to confirm that an interpreter has been arranged.

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?

Hearings usually commence 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 patient'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 patients 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 patient's 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 will 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 patient is properly informed and wants the adjournment.

Give the Board as much notice as you can of the request for an adjournment. Contact the hearings co-ordinator at the Board on 8601 5262 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. 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. 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 hearing, may not be available until 24 hours before the hearing or later (though this is a contravention of the Act).

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 2).

Appendix 3 is the Guideline from the Office of the Chief Psychiatrist about access to files. Also attached 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 with the client.

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

Under section 26 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;
- Involve unreasonable disclosure of personal affairs of any person; or
- Breach of confidentiality provision imposed by a person.

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

At the beginning of the hearing you should argue for disclosure of the material. The patient 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 not disclose information to the patient 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 patient.

Witnesses

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

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

Discussion with Treating Team

With the patient's permission, contact the patient's case manager before the hearing to clarify any matters which might be helpful for the case.

Notification that you are Representing the Patient

Notify the Hearing coordinator at the Board on 8601 5262 as soon as you can if you are representing someone. If you can you should also give an estimate of the length of the hearing.

Legal aid funding

Victoria Legal Aid considers funding for lawyers at the Mental Health Review Board a priority. If a person satisfies the means test in that they are judged unable to afford a lawyer, Legal Aid 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 an improvement in condition is important. The vast majority of people are not discharged at their hearings. However, particularly if a person has not had representation before, 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.

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

Can you ask for Different Members on a Board compared to a Previous Hearing?

If a patient has been before the Board on a previous occasion, they may wish to ask for a differently constituted Board. Contact the hearing co-ordinator on 8601 5262 to make the request, or seek an adjournment on the day if you have been unable to make the request previously.

What if the patient does not want to attend?

Patients 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 patient attend via phone.

What if the Patient 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 patient objects to anyone other than the treating doctor being there, the Board will usually not let them attend.

Procedure of the Board

The usual procedure of the Board is as follows:

The Board will introduce itself and explain the hearing process.

The Board should establish whether the patient has had access to the doctor's report and the clinical file

The patient 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 patient.

The doctor will address their report.

The Board will question the doctor.

The patient 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.

The patient 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.

The patient 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 a brief explanation of the reasons. The Board will hand a copy of the decision it has made to the patient and the doctor.

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

What can a patient get out of a hearing apart from discharge from voluntary status?

Inpatients

For involuntary inpatients and security patients challenging their status, all the Board can do is make a decision as to whether they should continue with that status or not. The Board cannot place someone on a CTO or an RCTO at an inpatient hearing, but it can take into account that the Service might initiate this as a less restrictive alternative.

Involuntary patients on CTO's

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

Discharge them from the CTO so they are no longer involuntary.

Vary the conditions of the CTO, which are its duration, the doctor supervising or providing treatment, and, if there is a residence condition under section 14(2 A) of the Mental Health Act, that condition.

Revoke the CTO, if the Board believes the patient has failed to comply with it, or needs to be in hospital. If the CTO is revoked, the person becomes an involuntary patient absent without leave.

If the patient's CTO has expired before it has purportedly been extended, the Board will find that it does not have jurisdiction because the person is

no longer an involuntary patient (see the unreported decision Wilson v Mental Health Review Board [2000] VSC 404.)

Involuntary patients on RCTO's

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

Approve the RCTO; discharge the RCTO or revoke the RCTO and send the person back to hospital if the Board believes they need to be an inpatient.

Powers in relation to all involuntary and security patients

Though the Board does not exercise the power often, it can order and fund a further psychiatric opinion if an issue about the person's illness or treatment requires clarification.

The Board can order a review sooner than 12 months if the circumstances justify it.

The Board has the power to award costs under section 131 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 Guidelines at Appendix 3 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.

The Board can refer a question of law to the Supreme Court for determination under section 118 of the Mental Health Act. The power has rarely been used.

For all involuntary and security patients, the Board has no power to order that the type of treatment be changed, or 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.

However, it is also important that patient's concerns about their treatment be raised with the Board. Their concerns are very often relevant to the criteria for involuntary treatment. It is also possible that the Board will make recommendations about treatment, or that raising concerns in the context of a hearing will lead to some change from the treating team.

What is the approach to Advocacy in this Jurisdiction?

The most important principle to remember is to act according to the patient's wishes, not according to what you perceive as their best interests (not that these are necessarily distinct).

The treating team and the Mental Health Review Board's role is to make decisions in the best interests of the person. It is crucial for people subject to involuntary treatment that their own wishes are fully considered in the process.

As with any solicitor client relationship, a person 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 capacity to instruct on an issue.

It seems to be generally accepted by the Board that it operates on an inquisitorial rather than an adversarial model. Whilst an extremely adversarial approach to advocacy is unlikely to be constructive, you should never lose sight of the fact that from a patient's perspective the fundamental dynamic may well be adversarial. The Mental Health service is imposing something on them they do not want. You must always respect the reality of the patient's experience in this sense. If the patient experiences a situation as win/lose, that must be acknowledged, whilst endeavoring to get as much out of the process beyond win/lose.

One application of this is that you should not present material which is adverse to the patient's case, subject to the duty owed to any court or tribunal not to positively mislead. The service is in a position to present adverse material. You must also recognise the great importance of a relationship of trust between the patient and advocate.

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.

There is an increasing amount of discussion about 'therapeutic jurisprudence' in the context of Board Hearings. This basically requires a consideration of processes and outcomes, which are therapeutic for the patient. In the Centre's experience, the therapeutic values of one's own wishes and views being fully considered can be very significant, and is often overlooked.

The other primary consideration is getting as much out of the hearing for the person as possible, irrespective of outcome in terms of discharge or continuation of status.

What criteria does the Board apply?

For review and appeal hearings about involuntary inpatients and involuntary patients on CTO's. The criteria applied by the Board are the same. A person must be discharged from involuntary status if any one or more of the following five criteria are not met.

We include some references to decisions of the Board interpreting the criteria. It must be remembered that previous decisions of the Board do not bind it (and indeed VCAT decisions are not binding, but 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.

Most law libraries have two bound volumes of Board decisions, up to 1997. Unbound decisions can be obtained by contacting the Board's Legal Officer on 8601 5267.

A person remains an involuntary patient if each of the following 5 criteria set out in sections 8 (1) and 14 (1A) for inpatients and people on CTO's respectively are met:

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. 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. 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 under section 12A above, which has not yet been used. That section applies to situations where a person has been admitted to hospital with a mental illness, no longer has a mental illness, but has a mental disorder which poses a serious risk to them.

Section 8(2) sets out a range of matters, such as political or philosophical expression which cannot, of themselves be the basis for a finding of mental illness. However, if the Board believes there is also a mental illness, the first criterion will be met.

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 Appeal of SV, 30 April 2001.

The Board is likely to find there is mental illness where no symptoms have been evident for some time, but it is thought to be because of treatment, or where a person has not been off treatment for a period considered required for a relapse to take place. However, there may be cases where it is possible to argue that the absence of symptoms without medication means no mental illness. For example, in the Review of DS, 3 March 1999, the Board was not satisfied there was mental illness where a person had been off treatment and symptom free for three and a half months.

The person's mental illness requires immediate treatment and that treatment can be obtained in hospital (or on a Community Treatment Order).

Treatment is defined in the Act as anything done in the course of exercise of professional skills to remedy the illness or lessen its ill effects or pain and suffering. The Board generally accepts any treatment ranging from monitoring and supervision to counseling, psychotherapy and medication as treatment.

It should be noted that interventions which can be categorized 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 for example the Appeal of AA 27 April 1999, or the Appeal of PX (1996) 2 MHRBD (Vic.) 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 that there cannot be said to be a need for immediate treatment.

Because of the person's mental illness, the person should be an involuntary inpatient (or subject to a CTO) for his or her own health or safety (whether to prevent a deterioration in the persons 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 (1997) 2 MHRBD (Vic) 445.

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 (1995) 2 MHRBD (Vic) 276.)

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

A person should be subject to involuntary treatment if:

Such treatment is necessary to prevent a significant deterioration in the person's physical or mental health within the short or 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 (1997) 2 MHRBD (Vic) 485).

A person should be subject to involuntary treatment if:

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,

there is a real risk that 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.

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 Appeal of DM 8 January 1999).

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 Review of FC, 28 May 1999.)

In terms of the protection of others, the risk of harm must be of a sufficient level to justify intervention. For example, embarrassment and inconvenience to others may not be enough to justify involuntary intervention. See Appeal and Review of NG (1995) 2 MHRBD (Vic) 276.)

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

An obvious issue here is whether the treatment in question is necessary. 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 Review of NI, 27 September 2000.

A person need not have a full clinical understanding of the illness to be able to consent. For example, the Board has found ability to consent where someone did not necessarily accept the 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 Review and Appeal of KS, 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. (Review of PK, 1 August 2003.)

Ability to consent may include factors such as 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 DC under the Crimes (Mental Impairment and Unfitness to be Tried Act 1997, referred to in the Review of NI, above.

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 that the support mechanisms a person has in the community and likelihood that others will monitor their health, is relevant to this criterion.

What if there is an 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 providing the same doctor cannot make a request and recommendation, or including incorrect dates on documentation, do not deprive the Board of jurisdiction. This is a complicated area, as on some matters different Boards 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 persons 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 should be constrained to interpret the Act in such a way which least infringes upon the civil right of a person because of the stigma surrounding mental illness”. (See 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 Appeal of AS, 18 April 2001, the Board determined the decision has application 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 section 14 (1A) of the Act. It is the Legal Centre's view that this is still very much an open question.

AFTER THE HEARING

Advise the Patient of Appeal Rights.

The patient can apply to the VCAT for a review of a decision of the Board. Such applications must be filed within 28 days of the Board hearing.

A further Appeal to the Board at an appropriate time (possibly requesting different members) is often a preferable course to a VCAT application,

unless there is a matter more appropriate for VCAT, such as a matter of interpretation of the Act.

Advise the Patient they can Request a Detailed Statement of Reasons for Decision

A statement of reasons can be requested by writing to the Board within 28 days of the date of the hearing.

Requests should always be made in time but the Board sometimes exercises its discretion to extend time for requests.

USEFUL CONTACT DETAILS

Mental Health Legal Centre: See front cover of Booklet

Mental Health Review Board of Victoria: Level 30 / 570 Bourke Street Melbourne VIC 3000 Ph: 8601 5270 Fax: 8601 5299 mhrb@mhrb.vic.gov.au www.mhrb.vic.gov.au	VCAT (General List) 7 th Floor / 55 King Street Melbourne 3000 Ph: 9628 9755 Fax: 9628 9788
---	---



Mental Health Review Board of Victoria

Mental Health Act 1986
STATEWIDE MENTAL HEALTH

UR No.

Office Use Only

APPEAL TO THE MENTAL HEALTH REVIEW BOARD

TO THE EXECUTIVE OFFICER MENTAL HEALTH REVIEW BOARD

GIVEN NAMES: _____ FAMILY NAME (BLOCK LETTERS) of patient: _____

address of patient if living in the community: _____ Phone Number: _____

I am: an involuntary patient a security patient a forensic patient
(please cross)

of _____
approved mental health service

I wish to appeal against:
(please cross):

my detention in an approved mental health service

my *proposed/transfer to _____
another approved mental health service

the refusal of the Chief Psychiatrist to grant me *leave/special leave

my community treatment order. I want to be discharged off the order

the conditions of my community treatment order. I want the conditions changed

my restricted community order. I want to be discharged off the order

The grounds of my appeal are: _____

signed: _____ date: / /

TO BE COMPLETED IF A PERSON LODGES AN APPEAL ON BEHALF OF A PATIENT

I have a genuine concern for the abovenamed patient and lodge the appeal against *his/her continued detention on *his/her behalf.

GIVEN NAMES: _____ FAMILY NAME (BLOCK LETTERS) of person lodging appeal: _____

of _____
address of person lodging appeal: _____

signed: _____ relationship to patient: _____ date: / /

eg. Community visitor, spouse, friend etc.

Send your appeal to the Executive Officer, Mental Health Review Board, Level 30, Marland House, 579 Bourke Street, Melbourne VIC 3000
Telephone: (03) 8601 5270 Facsimile: (03) 8601 5299 or Toll Free: 1800 242 703

To find out more about the Board, ask your case manager or a member of staff for a brochure, or call the Board on the above number

AUTHORITY FOR ACCESS TO FILE

I,.....

instruct.....

of.....

to appear on my behalf in the matter of my hearing before the Mental Health Review Board. I authorise her / him to read and copy any file or other documentation and obtain any information relating to me from

.....Hospital/Clinic.

Signed.....

Dated...../...../ 20.....

Patient Access to Files for Mental Health Review Board Hearings

Purpose

To provide information about section 26 of the Mental Health Act 1986, which allows patients to have access to documents for Mental Health Review Board (MHRB) hearings.

Background

For many years, it was required by the Mental Health Act that patients be given access to their clinical file and other relevant documents before a MHRB hearing.

This practice led to concerns by some clinical staff about the release of sensitive information contained in the file. In ordinary circumstances, access to clinical files is regulated by the Freedom of Information Act 1982.

The Mental Health Act was amended in 1996 to provide a statutory right of access to information prior to a MHRB hearing. This guideline explains the relevant provisions and addresses some practical issues.

Legislation

Under section 26(7) of the Mental Health Act, a patient or the patient's representative is entitled to inspect any documents to be given to the MHRB in connection with a hearing, at least 24 hours before the hearing.

Section 26(8) provides for the authorised psychiatrist to apply to the MHRB to prevent access by a patient to a document or part of any document if such access is likely to:

- Cause serious harm to the patient's health or the health or safety of another person; or
- Involve the unreasonable disclosure of information relating to the personal affairs of any person; or
- Breach a confidentiality provision imposed by a person who supplied the information contained in the documents.

The MHRB makes the final decision about whether the patient should see the documents. If the MHRB decides the patient should not see any document, it may allow the patient's representative to have access to the document.

Principles

The MHRB is required in all procedural matters to act according to the rules of natural justice or procedural fairness.

Mental health services should ensure that:

- Patients are informed about their right to have access to their file for MHRB hearings.
- Administrative procedures are simple and accessible and do not discourage patients from seeking access.

(0590901) November 2001

2

- Administrative decisions are open and accountable.
- Procedures are in place for resolving disputes.
- The response to all requests is timely.
- Staff are supportive and facilitate all requests.

Local Policy

Each approved mental health service should develop local policy and procedures governing access to documents for MHRB hearings which:

- Conform with the provisions of the Mental Health Act.
- Comply with the rules of natural justice.
- Incorporate the practice standards described in this guideline.

Procedures for Access

The patient is to be given the opportunity to inspect any documents, which are to be given to the MHRB in relation to a hearing.

Prior to authorising and facilitating patient access, the treating consultant psychiatrist (or another doctor under the supervision of the psychiatrist) should review the clinical file and other relevant documents to identify any information, which should not be released to the

patient. This information could be temporarily removed from the file or a photocopy could be given to the patient with the exempted material deleted or covered. The rest of the file should be made available to the patient as soon as practicable. Access to the whole file should not be denied on the basis of one or two sensitive entries.

The patient must be allowed to inspect the relevant documents at least 24 hours before the hearing. Access should be provided in a quiet and private area. If it is considered necessary, a member of staff may sit with the patient to assist and answer any questions. The presence of a staff member should be a positive experience and not intimidating or restrictive in any way.

If any documents have been withheld, pending an application to the MHRB to prevent access to the documents, the patient should be informed and the process explained.

The patient may wish to take notes or photocopy some pages. This should be facilitated. The patient may also want to spend an extended period of time examining the file or may wish further access at a later time. Decisions about these requests should be made in the context of what is fair and reasonable in the circumstances. For example, where there is extensive documentation, it would be reasonable to allow the patient a longer period of time or a follow-up session. Local policy should establish clear guidelines for dealing with these matters and for resolving disputes if they arise.

Patient's Representative

The Mental Health Act also allows a person authorised by the patient to represent them to inspect all relevant documentation. This may be a friend or family member or it could be an advocate or legal representative. The principles regarding access and procedural fairness apply equally to a personal representative.

Application for Non-Disclosure

The authorised psychiatrist or the medical practitioner representing the authorised psychiatrist may make an application to the MHRB to prevent the patient having access to a document or part of a document.

The MHRB should be informed before the hearing that an application will be made. This can be done on the day of the hearing or earlier by contacting the MHRB's Executive Officer or Legal Officer. The MHRB can be contacted on (03) 8601 5270.

The MHRB will hear the non-disclosure application, which can be verbal or written, as a preliminary issue before the commencement of the hearing. The application should be

3

presented in general terms and address the criteria in section 26(8) of the Mental Health Act. Specific details of the relevant documents are usually not required.

The non disclosure application will be heard and determined by the Board in the absence of the patient. If the patient has a representative, the MHRB may allow the representative to be present and to see the document. The MHRB will ask the representative to undertake to keep the information confidential and not pass it on to the patient if the MHRB makes an order for non-disclosure.

If the MHRB decides the patient should not see a document, it may decide that it too will not see the document. This follows from the rules of natural justice, which require that a determination of the MHRB should be based on information which is available to all parties. The MHRB will decide on a case by case basis whether it should see the document, having regard to the relevant circumstances.

Penalties

If a patient or their representative has not been given the opportunity to inspect all relevant documents before the hearing, the MHRB may need to adjourn the hearing to enable this to occur. If there is no good reason for the patient having been denied access, the MHRB may make an order for costs against the party responsible for the delay (section 131 of the Mental Health Act).

Self Assessment Tool

The following indicators are provided to assist services in the internal quality monitoring of practices, and form the basis for the Chief Psychiatrist's Clinical Review of mental health services.

- Each service has local policy and procedures to facilitate timely and appropriate access to documents for MHRB hearings.
- The clinical record contains documentation that the patient has been given the relevant Patient Rights Booklet 'Mental Health Review Board: How It Can Help You' , and

informed of their right to access their file for MHRB hearings.

- All clinicians are fully informed about a patient's right to access their documents for MHRB hearings, and to assist patients in exercising their right.

For further information regarding these guidelines

contact the Office of the Chief Psychiatrist on 9616 8124.

APPENDIX 3 CONTINUED
Memorandum

File reference: 8/190

TO: Distribution List

FROM: Dr C Perera, Chief Psychiatrist

DATE: 30 July 1993

SUBJECT: Access to Clinical Files by the Mental Health Legal Centre

4 AUG 1993

HEALTHY
HEALTHY
COMMUNITY
SERVICES

The Mental Health Legal Centre provides an advocacy service for people appearing before the Mental Health Review Board. In taking instructions for representation, the Mental Health Legal Centre staff require access to the clinical file in the presence of the patient. This is a principle of natural justice.

The Mental Health Review Board also operates within the rules of natural justice. It has determined that, save in exceptional circumstances, a patient should have the opportunity to read all documents which will be presented to the Board. This principle applies equally to the patient's legal representative.

I understand that some hospitals and clinics have expressed reluctance to permit the solicitors from the Mental Health Legal Centre to have access to clinical files for the purpose of Mental Health Review Board hearings. The reasons for this appear to relate mainly to concerns that the patient may read information in the files which could be detrimental to their treatment or the therapeutic relationship with treating staff. There are also concerns that the file might be lost or damaged in some way. I further understand that some services have directed that staff sit-in on interviews.

As a general rule, clinic/hospital staff should not sit-in on interviews between lawyers and patients. The presence of a staff member can be seen as intimidating to the patient and contrary to the principles of natural justice.

Under no circumstances should the clinic/hospital attempt to invoice the Mental Health Legal Centre for staff time if someone does sit-in on the interview or charge for photocopying relevant parts of the file if this is necessary.

Psychiatric Services takes the view that Mental Health Legal Centre staff are professionals and will act in a responsible manner with respect to the integrity of the clinical file and outcomes for patient treatment and care.

Where there are concerns that disclosure of information on clinical files may have a detrimental effect on the patient's health, this should be discussed with the lawyer. The