

The Mental Health Review Board: Practice and Process Issues

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*Mental Health
Review Board
of Victoria*

Accepting and Respecting the Review Process and the Board

Place and importance of review process

- positively integrate review process into good clinical practice
- because involuntary orders (ITOs/CTOs) reduce patients' human rights (see *Kracke*), therefore the MHA demands regulated procedures (e.g. admission etc) and regular independent reviews (8 weeks, annual, extension of CTOs) as part of the (involuntary treatment) "deal"
- periodic reviews provide regular triggers for full clinical review of patient/treatment plan and, in particular, justifying the continuing need for involuntary status

Note: clinical discharges (between listing and hearing) - 20-30%; Board discharges at hearing - 3 - 8% (08-09 – 4.8%)

- use opportunity for treating team to engage patient in treatment process; better appreciate broader issues e.g. family, work, rehab, social circumstances etc
- use opportunity to develop good practice and skills in new/junior staff, with senior staff providing leadership, supervision and mentoring

Recurring Service Issues for the Board

1. Access to Documents and Non-Disclosure Applications

General Issues

- Staff training on, and giving accurate advice about, the difference between freedom of information requests by patients and patients' access rights under s26 of the Act (for preparation for Board hearings)
- Establish workable protocols and processes for handling patients' access requests in a **timely** manner (mindful of *Kracke*) – who reviews the file and makes the decisions and at what stage?
- Know and have access to **key documents outlining Board's requirements** – s26(7) – (9), 31 March 2008 Guideline (handout), Guidelines for ensuring compliance with the Rules of Natural Justice (handout)
- **Identify specific documents/parts** – Board will **not** condone unnecessary failure to disclose e.g. applications for whole file

Recurring Service Issues for the Board

1. Access to Documents and Non-Disclosure Applications

Understanding Section 26 (as an imperfect “compromise”)

- Fundamental NJ principle – all parties (in particular, the patient) at a Board hearing are **entitled to access** (no less than 24 hours before the hearing) the same documents and information as the Board will consider to reach its decision, and to **comment on or to challenge** the information in the documents at the hearing
- Section 26(8) – **specific grounds**, to support an application for non-disclosure, that patient inspection or access would:
 - cause serious harm to the patient’s health, or the health or safety of another person
 - involve unreasonable disclosure of information relating to the personal affairs of another person
 - breach a confidentiality provision imposed by the supplier of the information
- **Common issues** – information from families/carers about admission, symptoms/behaviour, compliance with treatment, critical incidents
- **Overlap of grounds** – where strict request for “confidentiality” is missing but risk, relationship or other concerns exist
- **Patient knowledge** of same information in other forms e.g. other documents

Recurring Service Issues for the Board

1. Access to Documents and Non-Disclosure Applications

Good Practice Processes

- Assess relevance of the material, documents or information to current issues to be presented to the Board – consider withdrawal and avoidance of irrelevant information
- Explain in an open and frank manner non-disclosure rules and procedures to patients as part of normal pre-hearing preparation, with general reference to the particular application to be made, or material withdrawn
- Brief and involve patient's legal representative, if any, before the hearing
- Present submissions and evidence in justification for the Board making of a non-disclosure order, based on one or more of the grounds

Recurring Service Issues for the Board

2. Patient Involvement

Pre-Hearing: Assisting patients to prepare and participate

- Explain and discuss prepared Report on Involuntary Status, treatment plan, access to clinical file/applications for non-disclosure of documents
- Explain and discuss relevant issues e.g. legal representation, interpreter, family involvement, other support/advocacy e.g. PDRSS key worker
- Explain and discuss your individual role/s in hearing; what you intend to tell the Board; eliminate/reduce surprises
- Explain and discuss how patient can most effectively participate in the hearing; what they can tell, or bring to the attention of, the Board; eliminate/reduce patient stress or uncertainty about the hearing process
- Explain and discuss Board's decision-making role, powers, procedures - what it can do and its limits
- Conduct a risk assessment in context of Board hearing

Recurring Service Issues for the Board

2. Patient Involvement

Hearings: Pro-therapeutic and Inclusive Presentations

- Attending in what capacity? Clarify dichotomy of roles
- Treat patients with appropriate respect and dignity as an equal party; acknowledge stress and emotion of hearing and be supportive
- Actively demonstrate sensitivity, understanding and empathy
- Address statutory criteria in response to Board's questions comprehensively
- Give information, and discuss issues, in an inclusive manner, using language understandable to patient and avoiding jargon
- Balance fairly positives and negatives
- Act professionally, honestly and without a vested interest in the outcome; respect the authority of independent decision-maker

Recurring Service Issues for the Board

2. Patient Involvement

Post-Hearing Debriefing

- Provide understanding and support to patients feeling residual stress and emotion of hearing
- Explain decision and impact, and generally debrief patient (and family), where appropriate
- Follow up on agreed issues discussed in hearing, and report back to treating team
- Liaise with legal representative or support persons, where appropriate

Recurring Service Issues for the Board

3. CTO Issues

- Clinical examinations and other triggers to regularly assess the s8(1) criteria (and review treatment plans) and discharge if not met
- CTO extensions – timely examination and documentation, and explanation and copy to patient/carers
- Engagement issues – the Charter and the challenge of enhancing autonomy within the CTO environment
- Absconding patients – discharge or wait (and for how long?) - Note change to Board's adjournment policy and discharge under (b) (post-*Kracke*)

Conclusions

Post-Kracke Charter influences on the Board's processes

- Emphasis on hearings being conducted in compliance with statutory timeframes and Charter-consistently (e.g. s24 – fair hearing)
- Changes to Board's previous flexible adjournment and rescheduling policy
- Additional requirements on services to eliminate/reduce causes of delay of hearings e.g. timely clinical review, writing report, reviewing treatment plan, considering non-disclosure issues, preparing/supporting patients
- Requirement for services to make pro-active arrangements to cover staff changes, leave, absences etc e.g. bring hearings forward, involve other treating team staff (consultant psychiatrists/case managers) to cover doctor changeover periods
- Requirement for services to make pro-active arrangements to cover recent inpatient to outpatient transfers e.g. hold CTO hearings at ward