Civil Hearing Kit: Review of Voluntary Patients

Mental Health Review Tribunal

Review of voluntary patients

Information to help you apply and prepare for a Tribunal hearing

Background Information

Note: Sections in brackets refer to the *Mental Health Act 2007.*

Review of voluntary patients

A voluntary patient is a person who voluntarily remains in a mental health facility for treatment, care or observation, or a person who is admitted under section 7 as a voluntary patient by his or her guardian. Voluntary patients are generally in hospital as they can benefit from inpatient care.

When does the Tribunal review voluntary patients?

The Tribunal must review a voluntary patient who remains in a mental health facility (in an involuntary or voluntary capacity) for a continuous period of more than 12 months, at least once every 12 months (s9 (1)). The Medical Superintendent of the mental health facility must notify the Tribunal of the name of any voluntary patient of the hospital whose case the Tribunal is required to review (s9 (5)).

What issues will the Tribunal consider at a voluntary patient review?

The Tribunal is required to consider whether:

- the patient consents to continue as a voluntary patient; and
- whether the patient is likely to benefit from further care or treatment as a voluntary patient (s9 (2)).

In keeping with the objects and purposes of the Act, the Tribunal considers the care and treatment given to the patient, and the patient's access to such care in the least restrictive environment.

The Tribunal may also enquire about the patient's understanding of his or her rights as a voluntary patient under the Mental Health Act. **Voluntary patients must be given an oral and written statement and explanation of their rights by an Authorised Medical Officer (AMO) of the mental health facility as soon as practicable after becoming a voluntary patient. If the AMO is of the opinion that the person was not capable of understanding the statement or explanation when it was first given, it must be given again if the person becomes capable of understanding same (74A).**

What can the Tribunal decide?

The Tribunal may order that:

- the patient be discharged; or
- the patient be discharged, but defer the order for discharge for up to 14 days.

If the Tribunal makes no order for discharge (or deferred discharge) the patient continues to be cared for as a voluntary patient.

How to apply to the Tribunal

As soon as you are aware that a review of a voluntary patient is pending, you should start making the necessary arrangements.

Some of the larger mental health facilities have a Tribunal Clerk, or someone who is responsible for organising reviews by the Tribunal. If this is the case you should contact them directly and they will notify the Tribunal on your behalf.

If there is no Tribunal clerk at your site, you will need to contact the Tribunal directly. To book a hearing for an individual patient you will need to fax an application form to the Tribunal (fax number 9817 4543). Application forms are available on the MHRT website (www.mhrt.nsw.gov.au) or by phoning 9816 5955.

The Tribunal has a roster of when panels visit mental health facilities in the Sydney, Illawarra, Central Coast and Newcastle regions. For example, the Tribunal might send a panel to your venue on the second and fourth Tuesday of every month. If you need to have a hearing before the next panel is due to visit, please contact the Tribunal so that alternative arrangements can be made.

Applications should be faxed to the Tribunal **at least five working days** before the requested date for the hearing. This allows Tribunal staff to ensure that the preferred time is available and to organise legal representation where appropriate.

If your application is urgent you should phone the Tribunal after faxing the application form and ask to speak to a Senior Registry Officer to confirm receipt of the fax.

What to do before the hearing

Preparation for the hearing

The appropriate clinician involved with the patient should:

- Organise and prepare reports and necessary documentation.

- Explain the hearing process to the person and inform him or her of the hearing date and time.
- Inform the patient's designated carer(s) and principal care provider, relatives and other key people of the hearing and encourage them to attend (unless the patient objects).
- If the patient's designated carer(s), principal care provider, relatives or friends are unable to attend, facilitate alternative means for them to participate in the hearing, e.g. by telephone.
- Organise an interpreter for the person or family members where necessary.
- Ensure that an appropriate level of security is arranged, if necessary.
- Ensure that legal representation has been arranged, if necessary, and make the hospital file available to the legal representative.

Reports and documents required

The Tribunal needs to see the following reports and documents before the hearing:

- A completed application form
- A copy of the current order.
- A signed voluntary form by the patient (or their guardian if appropriate).
- Report from treating psychiatrist or Registrar.
- Reports from other involved professionals, for example nursing report, social worker report, occupational therapist report, psychological report.
- Copy of recent progress notes from person's hospital file.
- Reports that give a longitudinal view of the patient's condition and response to treatment, and previous assessments.
- Reports should address the need for ongoing care and treatment in a mental health facility.

The reports should also give information about the person's continuing condition, including any likely deterioration.

If the hearing is not being held in person at the mental health facility, all reports should be faxed to the Tribunal at least three working days before the hearing date.

The Tribunal will refer to the reports during the hearing. For this reason, the authors of reports should be available to come to the hearing to answer any questions arising from the reports. Sometimes the Tribunal arranges for the authors of reports to talk with Tribunal members by telephone or over a video link.

The Tribunal may make reports available to the patient and his or her legal representative. See note below.

Medical records

The law allows patients and their representatives to inspect or have access to the patient's medical records (s156). However, it is possible to ask the Tribunal to order that medical records not be disclosed for some good cause. This might happen, for example, if the treating medical practitioner believes that disclosure of the information may be harmful.

If you consider that there is a need for a preliminary hearing to discuss the disclosure of medical records, you should phone the Tribunal to arrange this well before the scheduled hearing.

Report style

Reports should:

- Be written in plain and simple English and avoid where possible the use of medical or technical jargon.
- Provide, as appropriate, a full and frank description of the patient's circumstances (see note above).
- Avoid comments that could be interpreted as judgmental.
- Address the specific issues that the Mental Health Act 2007 requires the Tribunal to consider.
- Identify clearly the sources of the author's information. These sources may be direct personal observations of the author of the report or may be information obtained from file notes or other professionals involved in the person's care.

What should the reports contain?

The reports should address the following issues:

Treating Psychiatrist Report

- Brief background of the patient's history and events leading to current hospitalisation, including co-morbid conditions, for example substance abuse, intellectual disability or other relevant medical conditions.
- Basis for the opinion that the patient continues to be suffering with a mental illness/ mental disorder, including details of delusions, hallucinations, serious disorder of thought form, severe disturbance of mood, sustained or repeated irrational behaviour.
- Opinion as to whether the patient is likely to benefit from further care and treatment as a voluntary patient.

- Details as to why the patient requires inpatient treatment addressing issues of serious harm to self or others, the patient's continuing condition and how they will benefit from ongoing care and treatment as the least restrictive alternative consistent with safe and effective care.
- Details as to current treatment, medication, response to treatment and support to pursue their recovery.
- Details as to efforts made to obtain the patient's informed consent to their treatment and recovery plans; the ongoing monitoring of their capacity to consent and efforts made to understand their plans if they lack capacity.
- Progress in the mental health facility, including current diagnosis, medication and response to medication.
- Plans for the patient's long term recovery, treatment, management and care.
- Confirmation that contents of the report have been discussed with the patient, including the patient's viewpoint.
- Viewpoint of designated carer(s), principal care provider, relatives and friends concerning ongoing hospitalisation.

Nursing Report

- Brief background of the patient's history and events leading to current hospitalisation, including co-morbid conditions, for example substance abuse, intellectual disability other relevant medical conditions.
- Details of contact with the patient and observations in relation to symptoms of mental illness, patient's demeanour, behaviour, attitude to medication and treatment and understanding of the illness.
- Opinion as to whether patient requires inpatient treatment addressing issues of serious harm to self or others, the patient's continuing condition and how they will benefit from ongoing care and treatment as the least restrictive alternative consistent with safe and effective care.
- Progress in hospital, including details as to current treatment, medication and response to treatment.
- Plans for the patient's long term recovery, treatment, management and care.
- Confirmation that contents of the report have been discussed with the patient, including the patient's views.
- Contact with the designated carer(s), principal care provider, relatives and friends and their viewpoint concerning ongoing hospitalisation.

Other reports

Additional reports can be provided by health care professionals involved in the care of the patient, for example, primary nurses, social worker, and occupational therapist.

These reports should include:

- Brief background of the person's history and health professional's contact with the person.
- Other information relevant to the health professional's involvement with the person.

Who should come to the hearing?

- The person concerned (wearing street clothes if possible).
- The person's designated carer(s), principal care provider, family and friends.
- Everyone who has prepared a written report for the Tribunal.
- The treating psychiatrist/doctor.
- Other involved professionals, for example the primary nurse, social worker.

If the designated carer(s), principal care provider, family or friends are unable to come to the hearing, they may still make their views known by writing to the Tribunal before the hearing. It might also be practicable for the Tribunal to hear their views by telephone or video.

What to do after the hearing

It is helpful if clinical staff are available to answer any questions the patient or family members might have about the Tribunal's decision.

If the person continues to receive care as a voluntary patient, the applicant or some other appropriate health care professional should explain to the patient:

- The nature and effect of the order.
- That the Tribunal's next review will usually take place in 12 months time.
- His or her appeal rights to the Supreme Court.

You might find it helpful to refer the patient to the Mental Health Advocacy Service for further information (phone 9745 4277).