Mental Health Tribunal

Access to documents in Mental Health Tribunal hearings: **Overview** and **Frequently Asked Questions**

A note about language

It is acknowledged that there are diverse views on the most desirable or acceptable terms to use when referring to people who access mental health services and who may receive compulsory treatment. These terms include, among others, 'consumers', 'clients,' 'service users', 'people with lived experience', 'persons with mental illness' and 'patients.' In this document the term 'patient' is used. This is because these materials, and the Practice Note on which they are based, have been developed to explain specific provisions in the *Mental Health Act 2014* (the MH Act) which use the term 'patient', which is a defined term.

In this document, the term 'authorised psychiatrist' includes any delegate of the authorised psychiatrist.

Overview

To ensure that a Mental Health Tribunal (Tribunal) hearing is fair, it is important that patients have the opportunity to prepare for their hearing. To do this patients need to know what the treating team says about them in the report and other documents and what the treating team will say at the hearing.

For this reason, the MH Act states that a designated mental health service (service) must give patients access to documents 'in connection with' a proceeding at least 48 hours before the hearing.

What are documents 'in connection with' the hearing?

Patients' right to access documents raises complex issues. A main source of confusion is what is meant by documents 'in connection with the hearing.' On the one hand, the Tribunal recognises that not every document a service holds about a patient will be relevant to the hearing. On the other hand, it should not be entirely up to the service to decide which documents are relevant to the hearing. Therefore, the Tribunal has identified a broad range of documents that, if they exist, will *automatically be relevant to the proceeding* whether or not the service wants to rely on them in the hearing.

These documents are the clinical report that the treating team has to prepare before every hearing, the current Order the patient is on and a range of 'specified documents' from the current volume of the patient's clinical file. (A list of the specified documents is included in this document under the question *'What does 'in connection with the proceeding' mean?'*).

Other documents, known as 'general documents', will only be connected to the hearing if the service intends to rely on them and give them to the Tribunal before the hearing.

The distinction between specified and general documents is important. This is because it affects whether services can redact or remove documents from the clinical file (without applying to the Tribunal to deny access to documents) simply because they don't need to rely on them at the hearing. Services can only do this with general documents but not with the clinical report, the current Order the patient is on and specified documents.

In addition, the Tribunal will no longer allow treating teams to withdraw applications to deny access to specified documents just because they don't need to rely on the document. However, they may do this with general documents. See, further, the answer to the question *'When can the service remove or redact documents from the file?'*

Exception to the general rule that the service must give the patient access to all documents

There is an important exception to the general rule that the service must give the patient access to all documents in connection with the proceeding. The exception is that the authorised psychiatrist may ask the Tribunal to decide that the patient cannot see a particular document or documents because disclosing the document(s) may cause serious harm to the patient or another person. This is known as the *serious harm test* and the authorised psychiatrist's request is known as an *application to deny access to documents*.

Where the Tribunal has received an application to deny access to documents a hearing will be held in the absence of the patient. In applying the *serious harm test*, the Tribunal will consider a number of factors. For example, the Tribunal will consider whether disclosing the document *may* cause serious harm (not whether it *would* or *would be likely to* cause serious harm). Serious harm has to be important, considerable or significant but a combination of less serious harms may amount to serious harm. The Tribunal will consider whether letting the patient see the document could cause serious harm to their prospects of successful treatment or recovery or prejudice to relationships with their family and / or carers. We discuss the factors the Tribunal considers in more detail below.

When and how to make an application to deny access to documents

This document also explains:

- when and how services need to make an application to deny access to documents, and
- the Tribunal procedures when hearing an application to deny access to documents.

Frequently Asked Questions

When does the Mental Health Act allow patients to access documents relating to their mental health treatment?

The right to access documents under the MH Act only applies when there is a *pending hearing*. This means that the Tribunal registry has listed the hearing. A patient's right to access documents under the MH Act is separate from any rights they have under the *Freedom of Information Act 1982* (FOI Act) or the *Health Records Act 2001* (HR Act). This means a patient is not required to apply for access to documents connected with a pending hearing under the FOI or HR Act.

The MH Act says that the service must give the patient access to documents in connection with the proceeding at least 48 hours before the hearing. This means that the service does not have to provide access any earlier than this (although it may do so).

The part of the MH Act on access to documents only gives the patient the right to access documents. It does not say that nominated persons or carers have any right to access documents. However, carers or nominated persons may look at documents in connection with the hearing if the patient is happy for them to do so.

If there is no pending hearing, patients who wish to access their health information must apply to the service under the FOI Act or the HR Act. The Tribunal is not involved in these processes.

What documents need to be provided?

At a minimum the service must give the patient a copy of the clinical report, the Order which the patient is currently on (and the Assessment Order if the patient is on a Temporary Treatment Order) as well as specified documents and any general documents on which it intends to rely. Specified and general documents are described in detail below under *'Documents that are always connected with the proceeding'* and *'Documents which may be connected with the proceeding depending on the circumstances – general documents.'* Rather than identify all these documents separately, a service may choose to simply give the patient (and the Tribunal if the hearing is in-person) access to the current volume of the clinical file. (However, the service will need to identify and copy these documents for the Tribunal in Tribunal hearings held by video-conference).

A document does not just include a written document like a letter or a file note. It also includes graphs, drawings, photographs and labels as well as devices for taping sounds and films or devices containing visual images.

There is one exception to this right of access to documents. The exception is, if the authorised psychiatrist believes that disclosing a certain document or documents may cause the patient or someone else serious harm. If this is the case the service can remove or redact the document(s) and apply to the Tribunal to deny the patient access to the document(s). The Tribunal will then apply the serious harm test to decide whether to deny the patient access to the document(s).

The Tribunal expects the service to give the patient the clinical report and help them to understand what it says. In addition, the Tribunal expects the service to ask the patient whether they would like to access the other documents that it will provide to the Tribunal at or before the hearing.

It is also important to note that a patient does not have to access their clinical file and other documents before their hearing. This means, if the patient says that they do not want to see their clinical report or look at any of the other documents that the service will provide the Tribunal then the service does not have to provide access to them unless the patient changes their mind.

At the beginning of the hearing the Tribunal will generally ask the patient and the service whether, the patient has been able to access documents in accordance with their rights under the MH Act, the procedure set out in the Practice Note and their own wishes.

The Practice Note is intended to guide members and all participants in hearings on the right of patients to access information before a Tribunal hearing. The Practice Note also outlines when and how an application to deny access to documents needs to be made and the procedure the Tribunal will follow in hearing these applications.

What does 'in connection with the proceeding' mean?

In its Practice Note, the Tribunal has clarified what documents 'in connection with the proceeding' means. The Practice Note states that certain documents on the current volume of the patient's clinical file are always connected to the hearing, whether the service intends to rely on them in the hearing or not.

This means that the service **must always provide the clinical report, copies of relevant Orders that establish the Tribunal's jurisdiction and specified documents** to the Tribunal, and therefore must also allow the patient to see the documents, unless the authorised psychiatrist believes that the serious harm test is met. Where this is the case, the authorised psychiatrist must apply to the Tribunal to deny the patient access to the document(s).

If there is an application to deny access to documents, the Tribunal will conduct a hearing to decide whether the serious harm test is met. In the period leading up to the Tribunal hearing, the service can remove or redact the documents from the patient's clinical file.

Documents that are always connected with the proceeding

The documents that are always connected with the proceeding are:

The relevant clinical report: This is the report that the Tribunal requires the service to prepare before the hearing. The Tribunal has practice notes and templates on its website to assist services to prepare these reports.

Copies of relevant Orders that establish the Tribunal's jurisdiction: these are the current Order to which the patient is subject and, if the patient is subject to a Temporary Treatment Order, the Assessment Order.

Specified documents on the current volume of the patient's clinical file *(if these documents exist)*. These are:

- The following progress notes:
  - (i) Community patients – progress notes covering the last three medical reviews with the treating team and
  - (ii) Inpatients who have been detained in hospital for three months or more (e.g. in a Secure Extended Care Unit) – progress notes covering the last two months
  - (iii) All other inpatients – progress notes covering the current admission
- The patient's current advance statement
- The patient's individual service plan/recovery action plan / treatment plan
- The patient's client management interface (CMI) legal status history (the CMI is a state-wide database containing information about patients being treated under the Mental Health Act)
- Allied health, neuropsychiatric, neuropsychological, risk and/or forensic assessments
- Relevant organic screening
- Reports of adverse events – e.g. critical incidents
- Most recent discharge summary
- Crisis and Assessment Treatment Team or equivalent entries
- Correspondence from private / specialist practitioners or general practitioners especially where a shared care arrangement exists or is planned
- Any second psychiatric opinion
- Any ECT referral documents
- Medication chart
- Any documents required to be attached to the clinical report by Tribunal practice notes 2–6. (These practice note concern less common hearing types for which there is no template. They are available on the Tribunal's website.)
- Any other documents not otherwise in this list that support the patient's position, views or preferences (for example, a document that contains information that disputes or questions the applicability of the treatment criteria, or information indicating that a patient has or may have capacity to give informed consent to ECT).

Documents which may be connected with the proceeding depending on the circumstances – 'general documents'

Documents concerning the patient's mental health treatment on the current volume of the patient's clinical file) that are not listed above are called 'general documents.' Whether general documents are connected with the proceeding depends on whether the service intends to rely on them at the hearing – i.e. whether the service needs to rely on the contents of the documents to support the making of a Treatment Order or ECT Order.

Where the service intends to rely on general documents

If the service wants to rely on any general documents in the hearing to support making a Treatment Order or ECT Order, those documents are 'connected to the proceeding'. This means that the service will provide the documents to the Tribunal, and therefore must also give the patient access to these documents unless the authorised psychiatrist believes that the serious harm test is met. If so, the authorised psychiatrist must apply to the Tribunal for access to be denied to the patient. In the period leading up to the Tribunal hearing, the service can remove or redact the documents from the file.

Where the service does not intend to rely on general documents

If the service does not intend to rely on general documents because the contents of the documents is not needed to support the making of a Treatment Order or ECT Order or is covered in other documents, the service can remove or redact these general documents without asking the Tribunal to deny the patient access to documents.

However, the service must inform the Tribunal, the patient and, where applicable, the patient's legal representative, that documents have been removed or redacted. In these circumstances neither the patient nor the Tribunal will have access to these documents. If they wish, the patient can make an application under the FOI Act or the HR Act to see these documents.

The clinical file has a number of documents that are marked as 'FOI exempt' or 'confidential'. Does the service have to make an application to deny access to these documents?

Yes, if the documents are:

- documents that will always be connected with the proceeding – i.e. the clinical report, the copies of relevant Orders that establish the Tribunal's jurisdiction or a specified document, or
- general documents that the service intends to rely on at the hearing and the authorised psychiatrist believes that the serious harm test is met.

A patient's right to access documents under the MH Act is separate from any rights they have under the FOI Act and HR Act. This means that notations in the clinical file that a document is 'FOI exempt' or similar do not mean that the patient cannot access these documents under the MH Act.

When can the service remove or redact documents from the file?

In other parts of these guidelines we have looked at when the service can remove or redact documents or otherwise not provide them to the patient before a pending hearing. This section summarises when this is permitted.

When an application to deny access to documents has been made but not yet heard

Where the service has made an application for the Tribunal to deny access to certain documents, in the period between making the application and the Tribunal hearing the service may remove or redact those documents from the file or otherwise not give the patient access to these documents. The Tribunal will then consider the application and may decide to grant the application or refuse the application to deny access (in which case the patient will be allowed to look at the documents).

When there is no application to deny access to documents

The service can only redact or remove documents without making an application to deny access, where:

- the documents are general documents; and
- the service does not intend to rely on these general documents in the hearing.

If a service does remove or redact documents they must let the Tribunal and the patient's legal representative (if there is one) know they have done this.

For the avoidance of doubt, the authorised psychiatrist may not withdraw an application to deny access to specified documents because they do not intend to rely on them. This is because such documents will always have the relevant connection with the hearing whether or not the authorised psychiatrist intends to rely on them.

What does 'serious harm' mean?

The MH Act requires the Tribunal to be satisfied that disclosing the document to the patient **may cause serious harm**. It does not have to be satisfied that disclosure *would* or *would be likely to* cause serious harm. In considering the *serious harm test*, the Tribunal will take into account the considerations in the list below. This list does not cover all of the things which the Tribunal may consider as this will depend on the circumstances of the case.

- 'Serious harm' may include a hurt, injury or damage that is important, demands consideration, is very considerable, or is significant (not slight, negligible or incidental)
- Potential harms that alone may not be sufficiently serious to demand consideration, might amount to serious harm when combined or taken together
- The Tribunal may also take into account:
  - the psychological and physical health and wellbeing of the patient or another person (however, serious harm is not necessarily limited to physical or psychological injury)
  - prejudice or damage to the patient's prospects of successful treatment or recovery
  - prejudice or damage to relationships with persons who may support the patient's recovery.

How does the authorised psychiatrist make an application to the Tribunal to deny access to documents?

The authorised psychiatrist can apply to the Tribunal to deny a patient access to documents by completing form *MHT 30 Application to deny access to documents*. This form can be downloaded from the Tribunal's website at www.mht.vic.gov.au. The service must return the completed form to the Tribunal's registry via email to registry@mht.vic.gov.au at least two business days before the hearing date unless special circumstances apply (such as where the hearing concerned was listed as an urgent ECT hearing).

What happens if a service fails to give the patient access to documents in accordance with the Mental Health Act and the Tribunal's practice note?

At the beginning of the hearing the Tribunal will generally ask the patient and the service whether the patient has been able to access information in accordance with their rights under the MH Act and the procedure in the practice note. The Tribunal expects the service to give the patient the clinical report and help them to understand what it says. In addition, the Tribunal expects the service to ask the patient whether they would like to access the other documents that it will provide to the Tribunal at or before the hearing.

If the service has not given a patient access to documents in accordance with the MH Act and the Tribunal's practice note, the hearing may not be able to proceed. Whether it does or not will depend on whether the Tribunal considers that there can still be a fair hearing. An important consideration for the Tribunal will be the views of the patient, including whether they wish to read the documents that are connected with the proceeding. The Tribunal will also consider whether it was possible to provide access at least 48 hours before the hearing and, if not, the reasons why it was not possible. Some examples where this may not be possible include when:

- the hearing involves an urgent application for ECT.
- the patient or their lawyer has asked to see the documents to be provided to the Tribunal on the morning of the hearing (or otherwise less than 48 hours before the hearing) where the patient had earlier indicated that they did not wish to access them.

How will the Tribunal deal with an application to deny access on the day of the hearing?

The Tribunal will consider the application to deny access to documents in a preliminary hearing that takes place before the hearing to discuss the main issues.

Preliminary hearing

The patient does not attend this preliminary hearing; however, their lawyer (if they have one) may do so. The Tribunal will also allow the lawyer to see any documents that the Tribunal views so long as the lawyer undertakes not to tell the patient what is in the documents.

At the preliminary hearing the Tribunal will ask the treating team to say why they believe the serious harm test is met.

Tribunal's decision

After considering the issues, the Tribunal will either decide to *grant* the application (if it is satisfied that the serious harm test is met) or refuse the application (if it is not satisfied that the serious harm test is met).

If the Tribunal grants the application, this means that the patient cannot view or have a copy of the document(s).

If the Tribunal refuses the application, the Tribunal may order the service to give the patient access to the document(s). It may also adjourn the hearing and extend the duration of the Order that the patient is currently on for up to five business days. This will give the patient time to access the documents(s) and prepare for the hearing. Alternatively, the Tribunal may decide to have a short break to allow the patient to view the document(s) before starting the hearing.

A previous division of the Tribunal made an order to deny a patient access to a particular document or documents. Can the service rely on that order denying access in future hearings?

No. The service cannot rely on a determination by a previous division of the Tribunal to apply in the future. A Tribunal decision under the MH Act to grant an application to deny the disclosure of particular document(s) only applies to that particular hearing. If another hearing for the same patient is listed and the authorised psychiatrist still believes that the serious harm test is met, they must apply to the Tribunal again.

Can a carer or family member send confidential documents to the Tribunal that they do not wish the patient to see?

No. The Tribunal does not have the power to consider a document without disclosing that document to the patient except when it receives an application to deny access to documents from the patient's psychiatrist. Only the authorised psychiatrist can ask the Tribunal to deny the patient access to a document or documents. This means the Tribunal cannot decide to deny access if it has not received an application from them.

For this reason, the Tribunal's registry will not accept any document marked 'confidential', 'private' or 'for the attention only of the Tribunal' from carers, family members or other persons connected with a patient. The Tribunal's registry will return any such documents to the sender and advise them to contact the patient's treating team to discuss whether and how the documents can be provided to the Tribunal. The Tribunal's registry will not forward such correspondence to the service.

Similarly carers or family members cannot give the Tribunal documents that they wish to remain confidential on the day of the hearing.

What is the status of documents recording confidential discussions between the treating team and a patient's family or carer?

Under the *Mental Health Act 1986* (which was the law in Victoria before Parliament passed the *Mental Health Act 2014*), services could make very broad undertakings in relation to the record of discussions intended to be confidential. This is because the *Mental Health Act 1986* allowed the authorised psychiatrist to apply for non-disclosure of documents solely because the information in a document had been given on condition of confidentiality.

It is important to note that *there is no equivalent provision in the current* MH Act. Instead, the only grounds for deciding that a patient cannot have access to a certain document or documents connected with their hearing is that disclosure of the document(s) may cause serious harm to the patient or another person (i.e. the serious harm test). It may be that the Tribunal concludes that the serious harm test is satisfied in cases where a person provided information confidentially. However, this will not necessarily be the case. The Tribunal's focus is on the serious harm test and not on whether the person providing the information wished it to be kept secret from the patient.

Applications to deny access to documents for Mental Health Tribunal hearings

If the patient has a **pending** Mental Health Tribunal hearing, **section 191 of the Mental Health Act applies.**

TIP: *If the patient does not have a pending hearing and wants to access their clinical file, they must make an application under the Freedom of Information Act or the Health Records Act to gain access to documents.*

The mental health service must give the patient access to any documents in its possession **in connection with the proceeding** at least **48 hours** before the hearing.

What does **in connection with the proceeding** mean? This includes **documents always connected with the proceeding**, including **specified documents** and **general documents** that the service intends to rely on.

General documents

Materials on the current volume of the clinical file that are not listed as specified documents are **general documents.**

If the mental health service **does not intend to rely** on the particular **general documents**, they do not need to be provided to the Tribunal and the documents can be removed or redacted. The redacted or removed documents do not need to be given to the patient before the hearing and should not be given to the Tribunal. The service should inform the Tribunal and patient's legal representative that some documents have been removed or redacted.

Documents that are *always* connected with the hearing

The Clinical Report and copies of relevant Orders that establish the Tribunal's jurisdiction will always be connected with the proceeding.

The below documents (if they exist) are also always connected with the proceeding whether or not the mental health service wants to rely on them. These are specified documents on the current volume of the clinical file:

- progress notes: last three medical reviews for CTO patients; last two months for inpatients who have been detained in hospital for three months or more; progress notes for current admission for all other inpatients
- patient's current advance statement
- patient's individual service plan/ recovery action plan/ treatment plan
- CMI legal status history
- allied health, neuropsychiatric, neuropsychological, risk and/or forensic assessments
- relevant organic screening
- reports of adverse events
- most recent discharge summary
- CATT or equivalent entries
- correspondence from private/ specialist practitioners or general practitioners especially where a shared care arrangement exists or is planned
- any second psychiatric opinion
- any ECT referral documents
- medication chart
- any documents required to be attached to the clinical report by Tribunal practice notes 2–6 (these practice notes concern less common hearing types)
- any other documents not otherwise in this list that support the patient's position, views or preferences.

The Clinical Report must be provided to the patient **at least 48 hours before the hearing**, and, if the patient wishes, they must be provided with access to all other documents connected with the proceeding except those in relation to which an application to deny access has been made.

An application to deny access can only be made if the documents **may cause serious harm to the person or to another person.** An application must be made if those documents are:

- **documents that are always connected with the hearing,** including **specified documents;** or
- **general documents** that the service intends to rely upon to demonstrate the treatment criteria are met.

The application to deny access must be made two business days before the hearing.

TIP: *What is a document? A document can be a book, plan, graph, drawing, photo, label, disc, tape, recording, or clinical records.*

TIP: *Notations such as "confidential" or "FOI exempt" do not apply under the Mental Health Act*

TIP: *Read **Practice Note 8** for more information about access to documents.*

Contact the Tribunal if you have any questions.

Tribunal hearings about applications to deny access to documents