ANNUAL REPORT OF

THE MENTAL HEALTH REVIEW TRIBUNAL

1 JULY 2020 to 30 JUNE 2021

Contents

Abbreviations used in this report

Application	Application for Review
CTO	Compulsory Treatment Order
DAMHS	Director of Area Mental Health Services
DHB	District Health Board
DI	District Inspector of Mental Health
Director	Director of Mental Health (for New Zealand)
MOH	Ministry of Health
RC	Responsible Clinician
The Act	Mental Health (Compulsory Assessment and Treatment) Act 1992
Tribunal	Mental Health Review Tribunal

Introduction

Tēnā koutou,

The Mental Health Review Tribunal is pleased to present its annual report for the year from 1 July 2020 to 30 June 2021.

The Tribunal helps to support and protect the rights and interests of patients subject to compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992. *"Patient"* is the word used in the Act. We recognise that characterising a person as a patient reflects only one aspect of their life.

The Tribunal's principal function is to hear applications for a review of the condition of a patient and express its view regarding whether a patient ought to remain under the Act, as an ordinary, special or restricted patient. In the case of ordinary patients, its opinion is determinative. In other cases its opinion is generally advisory.

It also approves clinicians to provide second opinions for the purpose of sections 59 and 60 of the Act and investigates complaints when there is dissatisfaction with the outcome of a complaint investigation of a District Inspector.

The Tribunal reviews only a small proportion of patients receiving compulsory treatment. In the period from 1 July 2020 to 30 June 2021, the Tribunal received 157 applications and determined 82 applications. It discharged nine patients who were subject to ordinary compulsory treatment orders and recommended the discharge of three special patients from special patient status.

The timeliness of hearing reviews and the importance of good reports and supporting evidence from health professionals continue to be a major focus. This reporting period the hearing of one review commenced outside of the statutory timeframe. The quality of reports from health professionals was generally excellent, but deficiencies occurred with several applications.

Covid-19 and the associated Alert Levels necessarily impacted on how we undertook our role. In person hearings remain our strong preference, but increased use of audio-visual link (AVL) occurred when appropriate.

Patients, health professionals and lawyers were very accommodating of the disruption to Tribunal hearings resulting from COVID-19 restrictions. We acknowledge the pressure and uncertainty COVID-19 places on all of those involved with the mental health system.

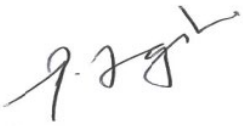
The Tribunal is in the special position of being able to observe how care is provided to particular patients by District Health Boards, hospitals and community-based facilities, throughout New Zealand. We continue to see the need for:

- in some cases, greater emphasis on ensuring that a patient's ties with family and whānau are properly valued and supported;
- in some cases, greater understanding of the gender, cultural and ethnic identity of patients and the implications of those for the provision of health care and treatment; and
- more, and more diverse, community-based facilities and supports.

We record our thanks to all of those who have helped ensure the Tribunal can function effectively, including patients, family and whānau, health professionals, lawyers, the Ministry of Health and the Secretariat.

Ngā mihi nui,

James Wilding QC
(Convener)



Phyllis Tangitu
(Community member)

Dr Nick Judson
(Psychiatrist member)

About the Tribunal

The Tribunal was established by the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Act enables the compulsory psychiatric assessment and treatment of people who have a mental disorder. It is intended to define and better protect patient rights than the preceding legislation.

The members of the Tribunal reflect the diverse nature of our society. We convene in Tribunals of three, comprising a lawyer, a psychiatrist and a community member, to hear cases throughout New Zealand, in the locality where the patient lives.

Some people welcome support under the Act. Others consider it to be a significant and unwanted intrusion into their lives. We endeavour to consider all of the views put forward in reviews, by patients, their family and whānau and health professionals, and to strike the balance required by the Act.

This remains a challenging task. We recognise that our functions and decisions directly affect the rights and interests of patients treated under the Act, and often impact on their friends, family and whānau and the community.

The Tribunal endeavours to discharge its statutory role in a manner which takes account of the principles of Te Tiriti o Waitangi.

It places significant weight on the importance of the cultural and ethnic identity, the language and the religious or ethical beliefs, of patients who appear before it, and of their ties to family and whānau. These matters are affirmed by s5 of the Act.

The functions of the Tribunal

The functions of the Tribunal are to:

- on application or of its own motion, review the condition of patients who are subject to ordinary compulsory treatment orders, special patient orders and restricted patient orders, pursuant to ss79 to 81 of the Act. Reviews are for the purposes of assessing whether, in the Tribunal's opinion, a patient ought to be released from compulsory treatment or from special patient or restricted patient status;[1]

[1] Decisions regarding the release of special and restricted patients are generally for the Minister of Health or Attorney-General, depending on the circumstances.

- to investigate complaints of breaches of specific patient rights. This occurs when a patient or complainant is not satisfied with the outcome of the investigation of a complaint by a District Inspector of Mental Health[2] or an Official Visitor[3] pursuant to s75 of the Act;
- report to the Director pursuant to s102 of the Act on any matter relating to the exercise or performance of its powers and functions; and
- appoint psychiatrists who assess:
    - whether treatment is in the interests of a patient who does not consent to that treatment, pursuant to s59 of the Act;
    - whether electro-convulsive treatment is in the interests of a patient who does not consent to that treatment, pursuant to s60 of the Act; and
    - whether brain surgery is appropriate, if the Tribunal is first satisfied that the patient has given free and informed consent to surgery, pursuant to s61 of the Act. The Tribunal is not aware of this provision having been used.

Many patients accept compulsory treatment or the outcome of a District Inspector's complaint investigation and neither they, nor others in their interests, make an application for review to the Tribunal. Consequently, the Tribunal reviews only a small proportion of patients receiving compulsory treatment. The issues on review are summarised below.

Ordinary Patients

For ordinary patients who are subject to compulsory treatment orders the issue for the Tribunal is whether the patient is fit to be released from compulsory status. That requires that the patient no longer be *"mentally disordered"*.[4] To be *"mentally disordered"* a patient must have a continuous or intermittent abnormal state of mind of such a degree that it poses a serious danger to the health or safety of the patient or others or seriously diminishes the capacity of the patient to self-care. If the Tribunal considers the patient is no longer mentally disordered, he or she is released from compulsory treatment. Otherwise, the patient remains subject to compulsion.

Special Patients

Some special patients receive compulsory treatment because they were found unfit to stand trial on criminal charges. The Tribunal must express an opinion as to whether the patient remains unfit to stand trial and whether he or she should continue to be detained as a special patient. Depending on the outcome and whether the Attorney-General is the applicant, the opinion may be provided to the Attorney-General to enable a decision to be made for the purpose of s31 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

[2] District Inspectors are lawyers who are appointed under the Act to help safeguard the rights of patients.
[3] There are no Official Visitors in New Zealand.
[4] *Waitemata Health v the Attorney-General* [2001] NZFLR 1122.

Other special patients receive compulsory treatment because they were acquitted on account of insanity. The Tribunal must express an opinion as to whether the patient's condition still requires that he or she should be detained as a special patient. Depending on the outcome and whether the Minister of Health is the applicant, the opinion may be provided to the Minister of Health to enable a decision to be made for the purpose of s33 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

Restricted Patients

Restricted patients have been declared so because they present special difficulties due to the danger they pose to others. The Tribunal must express an opinion as to whether the patient is mentally disordered. If not, then the patient is released from compulsory treatment upon the direction of the Director of Mental Health. If the Tribunal considers the patient is mentally disordered but no longer needs to be a restricted patient, the matter is referred to the Minister of Health, who after consultation with the Attorney-General, will decide whether restricted patient status should continue.

Right of Appeal

Section 83 of the Act provides a right of appeal where the Tribunal considers that a patient is not fit to be released from compulsory status. It is mainly to be exercised by the patient or certain classes of people acting in their interests.

The psychiatrist responsible for the patient's care does not have a right of appeal. In practice, they can make a fresh assessment for the purpose of compulsory treatment if a patient who has been discharged later becomes sufficiently unwell.

Investigations

Under section 75 of the Act, the Tribunal can investigate complaints made to a District Inspector (or official visitor) if the complainant is not satisfied with the outcome. Within this period, the Tribunal investigated one complaint under section 75. It commenced investigating another.

The powers of the Tribunal

The Act confers on the Tribunal a range of powers in order to enable it to discharge its functions.

Pursuant to s104(3) of the Act these include the same powers and authority to summons witnesses and to receive evidence conferred upon Commissions of Inquiry by the Commissions of Inquiry Act 1908. The provisions of that Act apply (except for sections 11 and 12 which relate to costs).

The Tribunal prefers to operate in a cooperative manner, without resorting to formal use of such powers.

Membership of the Tribunal

Every review is heard by a Tribunal comprising three members, a lawyer, a psychiatrist and a community member, although additional members may be co-opted by the Tribunal for a particular hearing.

The members are appointed by the Minister of Health. The membership is reviewed every three years. The appointment end date for current members is 26 September 2021, but their appointments continue until a successor is appointed.[5] At the time of writing this report we await confirmation of any renewals or new appointments.

The Tribunal seeks to ensure ethnic and gender diversity in the Tribunal hearing an application for review, to ensure a fair allocation of work and to ensure all members undertake sufficient work to retain their expertise.

The members who held office during the report year are listed below. More full information about members is contained in Appendix 1.

Tribunal members

Mr A J F Wilding QC (Convener)

Dr N R Judson, psychiatrist

Ms P Tangitu, community member

Deputy community members

Mrs F Diver

Ms A Lucas

Mrs K Rose

Deputy psychiatrist members

Dr B Beaglehole

Dr J Cavney

Dr C Dudek-Hodge

Dr H Elder

Dr S Schmidt

Dr M Honeyman

Professor G Mellsop

Dr S Nightingale (Resigned in 2020)

Dr P Renison

Deputy lawyer members

Mr N J Dunlop

Mr T Clarke (Appointed April 2021)

Mr R A Newberry

[5] Section 106 of the Act.

Co-opted Members

Section 103 of the Act enables, and in some cases requires, if requested by the patient, the Tribunal to co-opt:

- any person whose specialised knowledge or expertise would be of assistance to the Tribunal in dealing with the case;
- any person whose ethnic identity is the same as the patient's where no member of the Tribunal has that ethnic identity; or
- any person of the same gender as the patient, where no member of the Tribunal is of that gender.

This power was exercised in several review hearings during the reporting year. The Tribunal is grateful to the co-opted members who made themselves available.

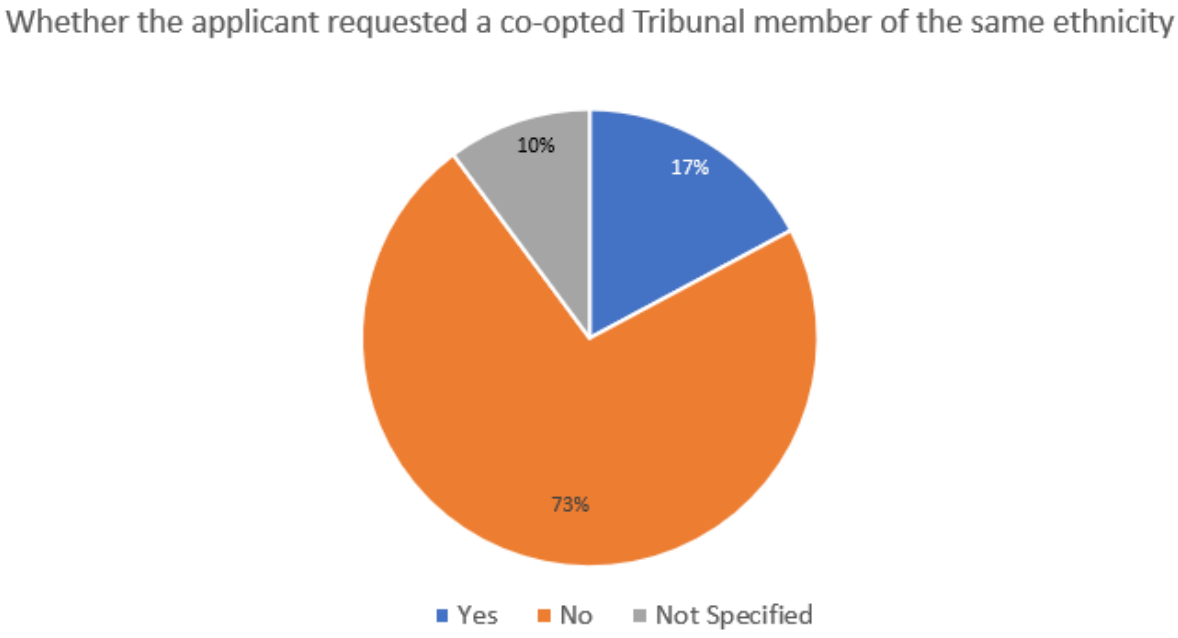


Figure 1: Request for co-opted Tribunal member 1 July 2020 – 30 June 2021

Interpreters

Section 6 of the Act enables, and in some cases requires, if requested by the patient, the Tribunal to provide the services of an interpreter, if:

- the first or preferred language of the person is a language other than English, including Māori and New Zealand Sign Language; or
- the person is unable, because of physical disability, to understand English; and
- it is practicable to provide the services of an interpreter.

The Tribunal must ensure, as far as reasonably practicable, that the interpreter provided is competent.

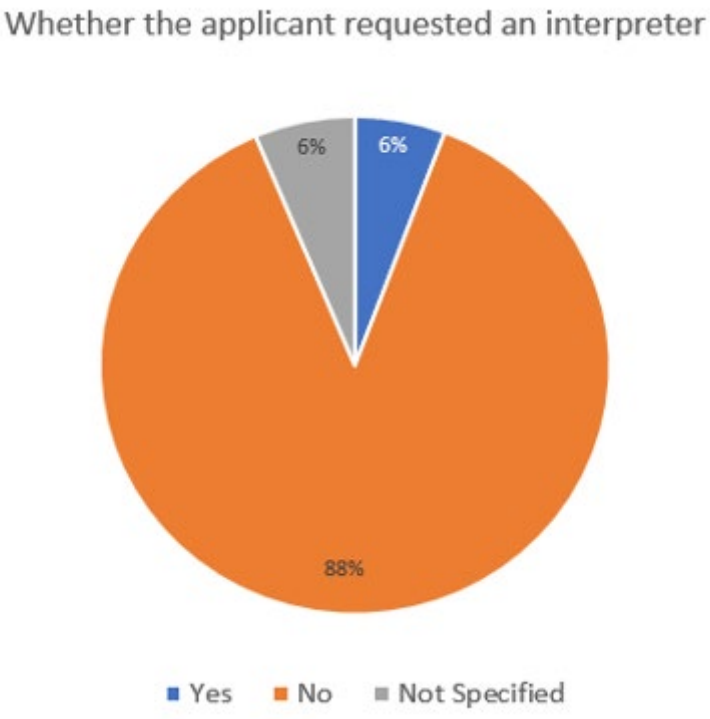


Figure 2: Request for an Interpreter 1 July 2020 – 30 June 2021

Appointments to give opinions pursuant to ss 59 and 60 of the Act

The Tribunal is required to consider applications for the appointment of psychiatrists who assess:

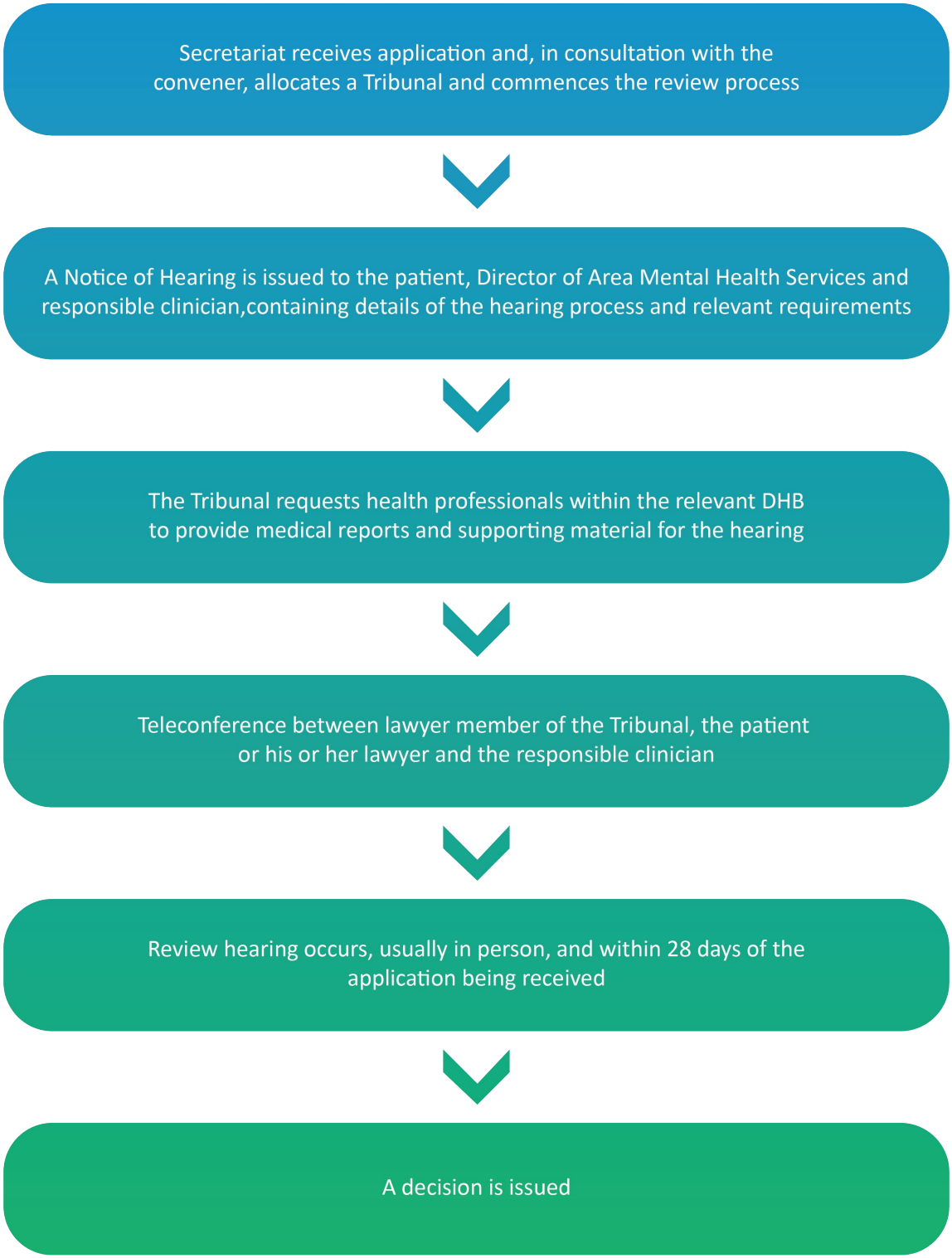
- whether treatment is in the interests of a patient who does not consent to that treatment, pursuant to s59 of the Act;
- whether electro-convulsive treatment is in the interests of a patient who does not consent to that treatment, pursuant to s60 of the Act; and
- whether brain surgery is appropriate, if the Tribunal is first satisfied that the patient has given free and informed consent to surgery, pursuant to s61 of the Act.*

In this reporting period 14 psychiatrists were appointed by the Tribunal to give opinions regarding whether the proposed treatment of patients without consent (including electro-convulsive treatment) is in their interests.

* The Tribunal is not aware of this provision having been used before. No applications were received to give opinions regarding whether brain surgery is appropriate.

The review process

The review process is determined by the Tribunal hearing each particular case. The usual sequence is:



The approach taken by the Tribunal

The Tribunal tends to conduct hearings without undue formality. But because the process is quasi-judicial and the determination affects important rights and interests, a degree of formality is necessary.

Formality is also inherent in the process outlined in Schedule 1 of the Act, which contains provisions regarding the conduct of reviews.

The process is partly inquisitorial. The Tribunal tends to lead much of the questioning. It prefers to do so in a way which helps rather than undermines the therapeutic relationship between the patient and health professional, but not at the risk of relevant aspects not being addressed.

Parties to hearings have the ability to cross-examine. It is common for the patient or his or her lawyer to do so, often in a manner which avoids or limits damage to therapeutic relationships.

Tension is sometimes apparent, reflective of the context. Health practitioners are contending that a patient ought to be subject to compulsory treatment, when the patient objects to current and future compulsory treatment.

The Tribunal benefits from patients giving candid accounts of, at times, intensely personal matters, involving their background, family and whānau, health, current circumstances, and aspirations.

The Tribunal sometimes makes broader observations, reflecting concerns about the patient's care. It sometimes does so with supporting evidence from health practitioners, who work within a constrained system. Health practitioners are to be commended for their frankness.

An effort is made to provide applicants with constructive and positive comments.

The Tribunal sometimes makes recommendations or observations, focused on the care and treatment of the patient and also on procedural and evidential issues.

Who attends the hearings?

The hearings are not public.

Those attending are usually:

- the applicant, who may be excused if need be;
- the applicant's lawyer;
- the responsible clinician, who is usually a psychiatrist; and
- the keyworker, who is usually a psychiatric nurse who is familiar with the patient.

Others who might attend include:

- a support person or advocate for the patient;
- family and whānau of the applicant;
- a social worker;
- a psychologist;
- an occupational therapist;
- a cultural advisor;
- other medical and nursing staff; and
- a district inspector.

How hearings are conducted

The hearing format tends to be similar regardless of whether the patient is an ordinary patient subject to a compulsory treatment order, a special patient, or a restricted patient.

In advance, the Tribunal receives written reports from health professionals and sometimes written material from the applicant or his or her lawyer or advocate.

Prior to the hearing, the patient meets with a member of the Tribunal, usually the psychiatrist member, for the purpose of a preliminary examination. The purpose is to ascertain whether the patient is able to participate in the hearing and to identify any issues, for example a difficulty in communication, which may need to be accommodated.

The hearing commences with the Tribunal introducing itself. It clarifies who is present and, where appropriate, whether there is any objection by the patient to any particular person being present.

An opening submission or statement is called for from the applicant or their lawyer. Following that, evidence is heard.

Usually, the first witness is the patient, followed by the responsible clinician, being the clinician responsible for the care and treatment of the patient, and then a second health professional. Family and whānau are then usually invited to speak.

Evidence can be required on oath, but this would be unusual.

Each witness is usually questioned by the Tribunal. The applicant or lawyer for the applicant is then invited to ask questions of that witness. It is rare, but not unknown, for a responsible clinician to question other witnesses.

At the conclusion of the evidence, closing submissions are invited.

Those present are then asked to leave the room to enable the Tribunal to deliberate. If possible, a decision is given shortly after, on the same day.

Sometimes written submissions are sought or an adjournment is necessary, for example to enable further medical evidence to be obtained. Where further evidence is received, an opportunity to be heard is given, reflecting the rules of natural justice.

Following the hearing the Tribunal issues a written decision, or written reasons for a decision if the decision was announced orally.

The attendance of family and whānau

Section 5 of the Act requires the Tribunal to exercise its powers with proper recognition of the importance and significance of the patient's ties with family and whānau.

Often, patients will seek to have one or a few members of their family and whānau present. This and the understanding which results from that is welcomed by the Tribunal. It is often of assistance to the patient, the Tribunal and health professionals.

Ethnic and cultural identity and language

Section 5 of the Act requires the Tribunal to exercise its powers with proper respect for the patient's cultural and ethnic identity, language, and religious or ethical beliefs.

When applying for reviews applicants are asked whether they wish to have the Tribunal include a person of the same ethnic identity as the patient. If so, that is arranged, including by co-opting a member where necessary.

The Tribunal recognises the issues which can arise where English is not the language or first language of the patient. If an interpreter is sought or necessary, then it helps to facilitate that.

The Tribunal composition reflects a mix of genders where possible.

Hearings may be opened or closed by a karakia, blessing or waiata if a patient seeks that.

Where do hearings take place?

If the applicant is being treated in hospital the hearing usually takes place at the hospital. If the applicant lives in the community, the hearing usually takes place at the outpatient clinic which the applicant attends.

Some hearings take place by video conference. Where that occurs, the format described above is followed as much as possible. Whether video conferencing is used is a matter of judgment, exercised consistently with natural justice and the Act.

Applications by category of patient

157 applications were received during the reporting year. Of those:

- 106 were in respect of patients under a community treatment order;
- 34 were in respect of patients under an inpatient treatment order;

- 16 were in respect of special patients; and
- 1 was in respect of a restricted patient.

Proceeded applications by category of patient

82 applications proceeded during the reporting year. Of those:

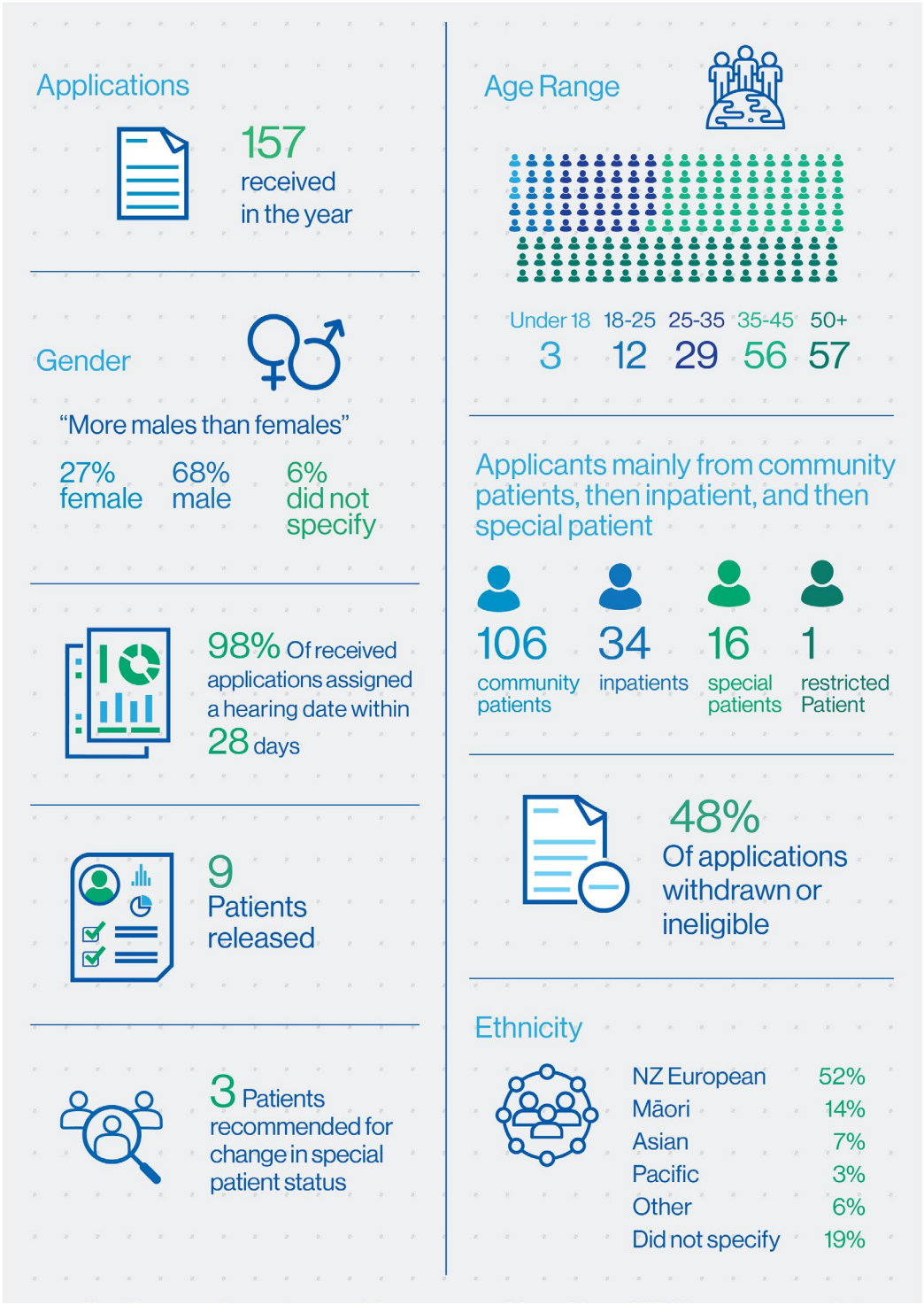
- 50 were in respect of patients under a community treatment order;
- 20 were in respect of patients under an inpatient treatment order;
- 11 were in respect of special patients; and
- 1 was in respect of a restricted patient.

Withdrawal of applications

Many applications are withdrawn or found to be ineligible in advance of a hearing. There are a range of reasons. They include the patient and health professionals having discussion and reaching an accommodation in the context of a review, for example regarding the type and nature of treatment and whether it ought to be compulsory. In the case of ineligible applications, this is often due to the treatment order commencing within the three months prior to the application being made.

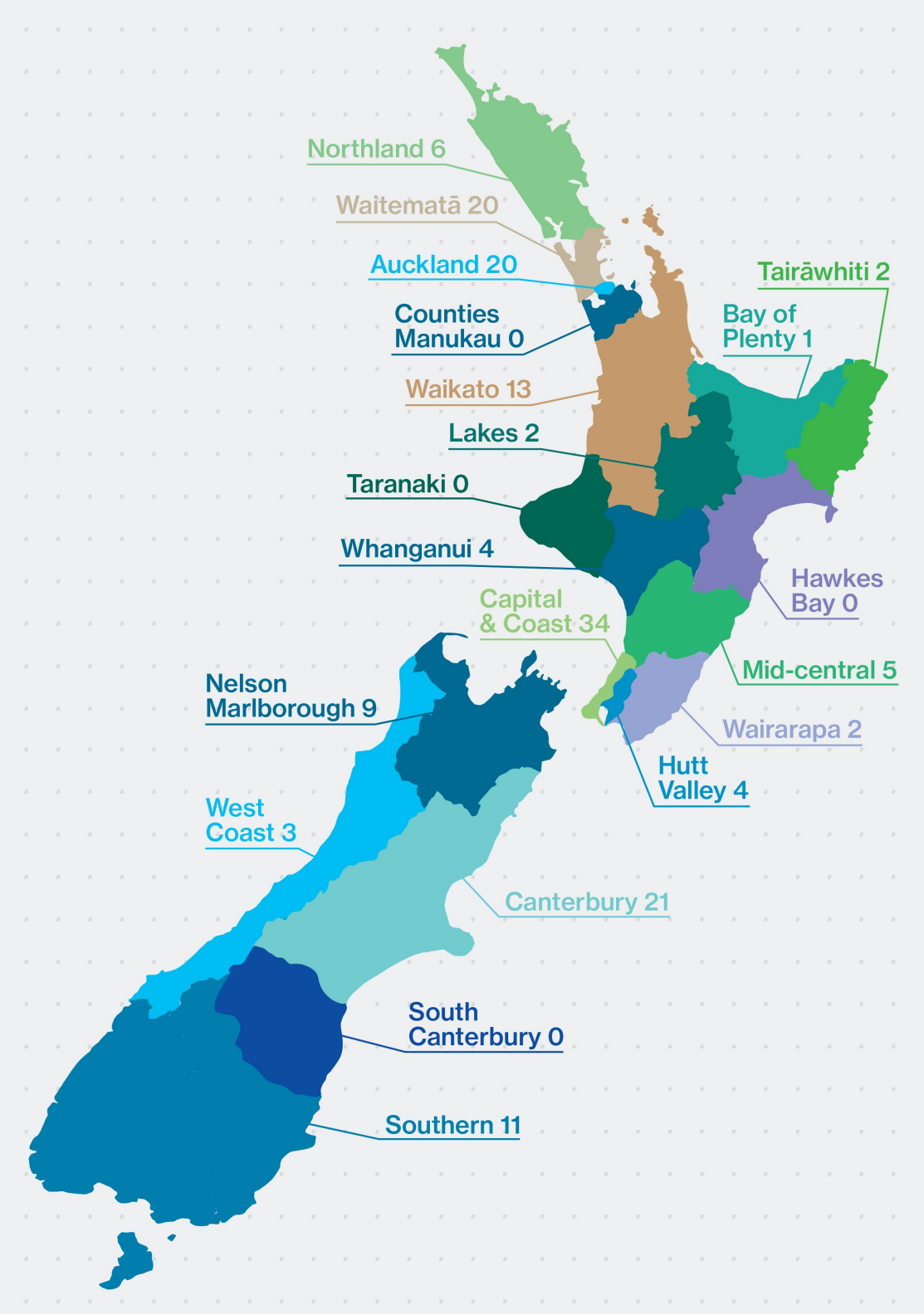
During this reporting year 75 applications were withdrawn or ineligible. This equates to 48%. Across the past six years the average has been 51%. The 2019/2020 reporting period saw a peak of 60%.

An overview of applications at a glance



Further detail illustrating the breakdown of applications is contained in **Appendix 2.**

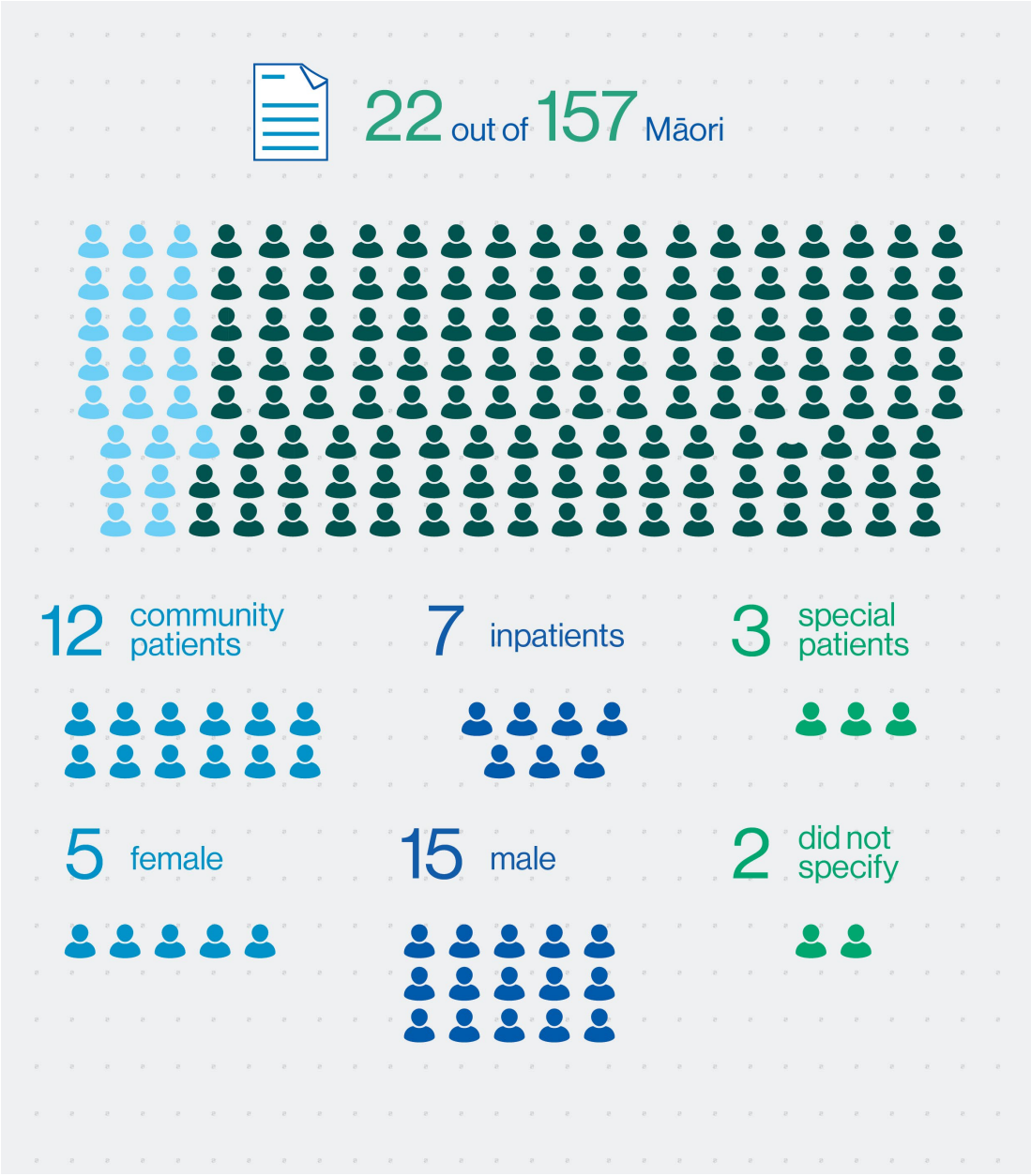
Applications received by DHB



Further detail illustrating the breakdown of applications is contained in **Appendix 2.**

An overview of applications involving Māori patients

Māori make up 16.5% of New Zealand population. In 2018 and 2019 Māori were more likely to be subject to community and inpatient treatment orders than non-Māori.[6]



Further detail illustrating the breakdown is contained in **Appendix 2.**

[6] Office of the Director of Mental Health and Addiction Services – Annual Report 2018 and 2019

Timeliness

An ongoing focus for the Tribunal is the timely hearing of applications for review. We continue to see improvement.

By 2016 the hearing of fewer than 30% of applications commenced within 28 days, being the statutory timeframe (inclusive of a seven-day extension). Last year (2019/2020), four reviews commenced outside of the statutory timeframe, less than 5% of the total number of applications. This year, one review commenced outside of the statutory timeframe, 1% of the total number of applications proceeding to review.

This has been possible with the commitment of the Secretariat and the generally excellent support and cooperation received from patients, lawyers and health professionals.

We continue to see the benefits of the revised guidelines issued in 2018 for responsible clinicians when writing reports and the Tribunal issuing notices regarding the hearing process and who has to do what, following applications being received.

We have also been assisted by 2020 Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, promulgated by the Ministry, which better explain our functions, processes and powers than the earlier guidelines.

There will continue to be circumstances in which the hearing of cases commences outside of the statutory timeframe, and where an application may be withdrawn and refiled rather than proceeding within the timeframe. Reasons include:

- patients sometimes seeking deferral in order to have a lawyer of their choice or to obtain a second opinion or a grant of legal aid. In some cases, applications are withdrawn until all information is to hand;
- responsible clinicians or lawyers being unavailable, for example in another hearing, or family and whānau are not available, and the Tribunal and patient or his or her lawyer agree it is preferable that a hearing be delayed;
- scheduling difficulties. Difficulty is inherent in trying to coordinate dates suitable to patients, their lawyers, health professionals and the Tribunal;
- travel factors, being the availability of flights and cancellations due to COVID-19 or poor weather conditions. Hearings tend to involve at least two if not three members travelling from different locations; and
- the interests of time giving way to the interest in having sufficient good quality information to enable the Tribunal to make a properly informed decision.

Regrettably at times there are difficulties in scheduling telephone conferences and hearings. The Tribunal seeks to accommodate parties to a review but will impose timeframes and use formal powers where necessary, in order to avoid the patient's right to a timely and informed hearing being undermined.

It is intended to draw to the attention of the Director certain cases in which there is inappropriate delay, either by way of direction in particular cases or by way of report pursuant to s102(2) of the Act.

Publication of Decisions

Clause 7 of Schedule 1 of the Act provides that Tribunal proceedings are not open to the public. Clause 8 allows for the publication of reports of proceedings with the leave of the Tribunal and in publications of a bona fide professional or technical nature.

Decisions of the Tribunal are rarely made public. This reflects the right of the patient, and often others, for example victims and family, to privacy. Decisions are highly fact specific and anonymisation may not prevent identification.

Those receiving compulsory treatment under the Act likely assume that the usual privacy and confidentiality requirements attaching to medical matters will apply. They are vulnerable and may not be well placed to address issues of publication.

Patients, their families and clinicians who provide private information during the course of Tribunal hearings may be alarmed if decisions find their way onto the internet. Publishers of professional and technical journals now publish journals online.

Weighing against those is the public interest in being informed of the workings of the Tribunal.

In April 2010 the Tribunal and the Ministry agreed on guidelines intended to ensure that the relevant interests in privacy and making information public are balanced and that appropriate cases are identified for publication. The protection provided by these guidelines is essentially three-fold:

- only a selection of cases identified by the Tribunal is sent to publishers, by the Ministry;
- those cases will be anonymised, by the Tribunal and then the Ministry; and
- they will be sent only to three established professional and responsible publishers, namely Brookers (Thomson Reuters), LexisNexis and the New Zealand Legal Information Institute.

In August 2021 the Tribunal provided a further suite of decisions for publication, which following review by the Ministry to ensure patient anonymity, are due to be published.

As at the date of this report 52 cases can be found online on the New Zealand Legal Information Institute website: http://www.nzlii.org/nz/cases/NZMHRT/.

Relationship with the Director of Mental Health and the Ministry of Health

The Tribunal is an independent statutory body, supported by its own Secretariat. Decisions reflect its independent view.

The Tribunal enjoys a constructive relationship with the Director of Mental Health, Dr Crawshaw. That relationship involves support for the work of the Tribunal outside of the context of specific cases and consideration of issues which can adversely impact on the functioning of the Tribunal.

Rarely, the Tribunal will invite the Director to be heard on an issue arising in a particular case. This is done formally.

The Ministry of Health administers the Act. The Tribunal enjoys a constructive relationship with it, in respect of training, administrative, personnel and funding issues.

The Tribunal extends its thanks to Dr Crawshaw and the team at the Ministry for their support during the year.

Secretariat

Public policy firm *Allen + Clarke* is contracted by the Ministry to be the Tribunal's Secretariat. It commenced that role in November 2018.

It supports the work of the Tribunal, which includes managing the flow of information between parties and the Tribunal, organising Tribunal pre-hearings and hearings, supporting the Tribunal to give effect to its statutory requirements under the Act, and undertaking quarterly and six-monthly reporting to the Ministry on Tribunal activities.

The Tribunal is grateful for the hard work of *Allen + Clarke* and the team of Ms Powell, Ms Brown, and Ms Reeve.

Professional Development

The lawyer and psychiatrist members of the Tribunal are qualified in their respective professions. The community members possess a diverse range of skills and experiences. All members have considerable experience in their respective areas of expertise prior to appointment.

Members maintain their own professional development. The Tribunal usually holds a plenary once, and sometimes twice, a year.

Website

The Tribunal has a website, within the Ministry's website: http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/mental-health-review-tribunal.

The website contains relevant information, including Policy and Practice notes and Guidelines.

What's next for 2021-2022

The Tribunal will continue its focus on providing patients with meaningful and effective reviews within the statutory timeframe.

It will also:

- as part of its reviews and where appropriate, encourage reconsideration of the way in which a patient is being cared for and treated and the way in which a patient might engage with care and treatment;
- continue to address circumstances where there is avoidable delay which is not supported by the patient; and
- continue to focus on receiving high quality information to inform its decisions.

As a result of a current appointment round, it anticipates that it will benefit from new members.

Conclusion

The work of the Tribunal involves intensely personal issues for patients, their families and whānau and those involved in their care and support.

The competing arguments for why the significant step of compulsory treatment is or is not required are challenging.

The Tribunal hopes that its work has helped to support:

- the rights of those who are mentally disordered to be treated under the Act;
- the rights of those who are not mentally disordered to be discharged from the Act; and
- the interests that arise in the case of special and restricted patients.

Thank you.

Appendix 1 – Tribunal members

Mr A J F Wilding QC
(Tribunal Convener)
James is a barrister based in Christchurch. His work includes family law and medico-legal issues. He was a District Inspector of Mental Health from 1999 until to 2011.

Dr N R Judson
Nick is a psychiatrist based for the last 25 years in Wellington. In the past he worked in Dunedin and then as Deputy Director of Mental Health. His interests are in forensic psychiatry and intellectual disability.

Ms P Tangitu
Phyllis hails from the Iwi of Ngati Pikiao, Ngati Ranginui and Ngati Awa. She has a background in education and health and has worked in the Mental Health and Addictions and Māori Health sector for 32 years. Phyllis has whānau members who have experienced mental ill-health and continues to advocate for recognition of Māori world views. She is employed by Lakes DHB as Pou Manukura Relationships and Engagement in Māori Health, where she has worked for 21 years.

Deputy Members

The Minister of Health also appoints deputy members of the Tribunal. During the report year, the deputy members of the Tribunal were:

Deputy lawyer members:

Mr N J Dunlop
Nigel is a Wellington based barrister and mediator. He has been a member of the Tribunal since 1992 and for many years was the convener. Additionally, Nigel conducts investigations, mediates, and sits on statutory review and complaint bodies in the areas of censorship, retirement villages, physiotherapy, medicine, and dentistry.

Mr R A Newberry
Robb is a barrister based in Wellington. Prior to becoming a deputy lawyer member of the Tribunal, he was a District Inspector of Mental Health from 1993 until 2008. He also practices in other jurisdictions, such as the Protection of Personal and Property Rights Act 1988 and Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Mr T Clarke
Tim is a lawyer, mediator and facilitator for Collaborative Solutions, based in Hamilton. He has 40 years of experience with mental health, legal and conflict issues. Tim values combining his legal and social experience with mediation and facilitation skills, to assist the rights of those who experience mental illness.

Deputy psychiatrist members:

Dr B Beaglehole
Ben is a Christchurch based psychiatrist. He is the clinical head of the Anxiety Disorders Service based at Hillmorton Hospital. Ben is also a Senior Lecturer for the University of Otago. He teaches medical students and researches mood disorders and mental health outcomes following disasters.

Dr J Cavney
James is a forensic psychiatrist based in Auckland. He is a lead clinician, Kaupapa Māori and Pacific Services, Mason Clinic.

Dr C Dudek-Hodge
Christine Dudek trained as doctor in Germany and The Netherlands. She gained her PhD in Germany and went on to complete her vocational training as a psychiatrist at the Academic Medical Centre in Amsterdam, The Netherlands. Christine relocated with her family to Christchurch in 2012 and has since worked as a general adult psychiatrist for the Canterbury DHB.

Dr H Elder, MNZM
Ngāti Kurī, Te Aupouri, Te Rarawa, Ngāpuhi. Hinemoa is a psychiatrist, who works in a range of settings including the Child and Family Unit (CFU) Starship Hospital, and as a court report writer for the Family and District Courts and Kōti Rangtahi, and under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. She specialises in the neuropsychiatry of traumatic brain injury and is a researcher in that field and in the field of dementia. She is the Māori strategic leader at Brain Research NZ.

Dr M Honeyman, QSO
Margaret is a psychiatrist based in Auckland and who is semi-retired but still undertakes clinical work. She works mainly in adult psychiatry. A large part of her career has been in leadership and management roles, including as Clinical Director and DAMHS in DHB settings and as Chief Psychiatrist in South Australia. She has thus been involved in the application of mental health legislation from a number of different perspectives.

Professor G Mellsop, CNZM
Graham is a psychiatrist who has spent most of his working life contributing to adult mental health services, medical education, and research. He held Professorial positions for 37 years (1982-2019), sequentially at the Universities of Otago, Queensland, Melbourne and Auckland. Currently he works part time for the Waikato DHB, provides expert opinions to various New Zealand courts and is an Emeritus Professor at the University of Auckland.

Dr S Nightingale
Sue, who retired from the Tribunal this reporting period, is a psychiatrist who worked in Christchurch for many years. She had been the Chief Medical Officer for the Canterbury District Health Board and was the Chief of Psychiatry and DAMHS from 2010 to 2016. She has a strong interest in health law, completing a Masters in Bioethics and Health Law in addition to her medical qualifications.

Dr P Renison
Peri is a psychiatrist who works clinically in adult general psychiatry, currently in the area of adults with Intellectual Disability and Mental Illness. She was previously Chief of Psychiatry for the Canterbury DHB and Director of Area Mental Health Services for Canterbury. She has worked in both inpatient and community mental health services.

Dr S Schmidt
Sigi lives in Christchurch and is employed by the Canterbury DHB as Chief of Psychiatry and DAMHS for Canterbury. He is of German descent and grew up in South Africa. He moved to New Zealand in 1999 after completing his psychiatric training at the University of Cape Town. He has worked in a range

of mental health services at the Canterbury DHB since that time, which include Adult General Psychiatric Services (both inpatient and outpatient settings), Rehabilitation, Early Intervention in Psychosis and Rural Psychiatry and he has previously also been a Clinical Director with the organisation. His current role has afforded him the opportunity to engage with communities across the region and work collaboratively with stakeholders in the health sector both at regional and national levels.

Deputy community members:

Mrs F Diver, QSM

Francis is a community member based in Central Otago. She is Ngai Tahu, Waitaha, KatiMamoe and works closely with the Māori community. She founded the Te Ao Huri whānau group and has held leadership roles with charities and local government initiatives. She has a close focus on mental health.

Ms A Lucas

Albany is a PhD Candidate at the University of Otago, based at the Centre for Pacific Health. She has a law degree and a Master's in Bioethics and Health Law. Albany is of Kiribati and Dutch descent.

Mrs K Rose

Kay has a background in nursing and has owned and operated a Nursing Bureau and a Recruitment Placement business. She was a Justice of the Peace from 1980 until 2012 having exercised jurisdiction in the District Courts in Auckland. She has an extensive background in commerce and voluntary services.

Appendix 2 - A breakdown of applications

This section provides information on applications received from 1 July 2020–30 June 2021.

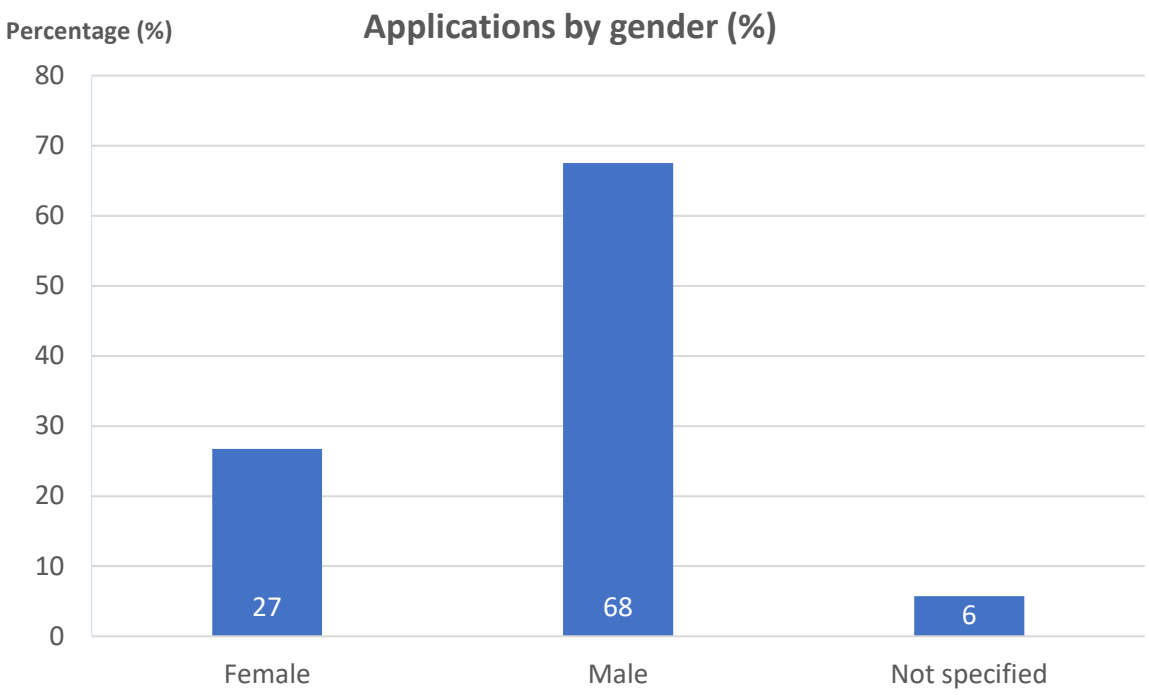


Figure 3: Applications received 1 July 2020 – 30 June 2021 by gender

Patients may identify their gender on their application. The number of applications received from male patients was 106 and the number from female patients was 42. The number of applications which did not specify a gender was nine (6% as reported in the graph above). The Tribunal is working with the Ministry to provide patients with greater options on the application form, to better reflect gender diversity.

(Total may not sum to 100% due to rounding)

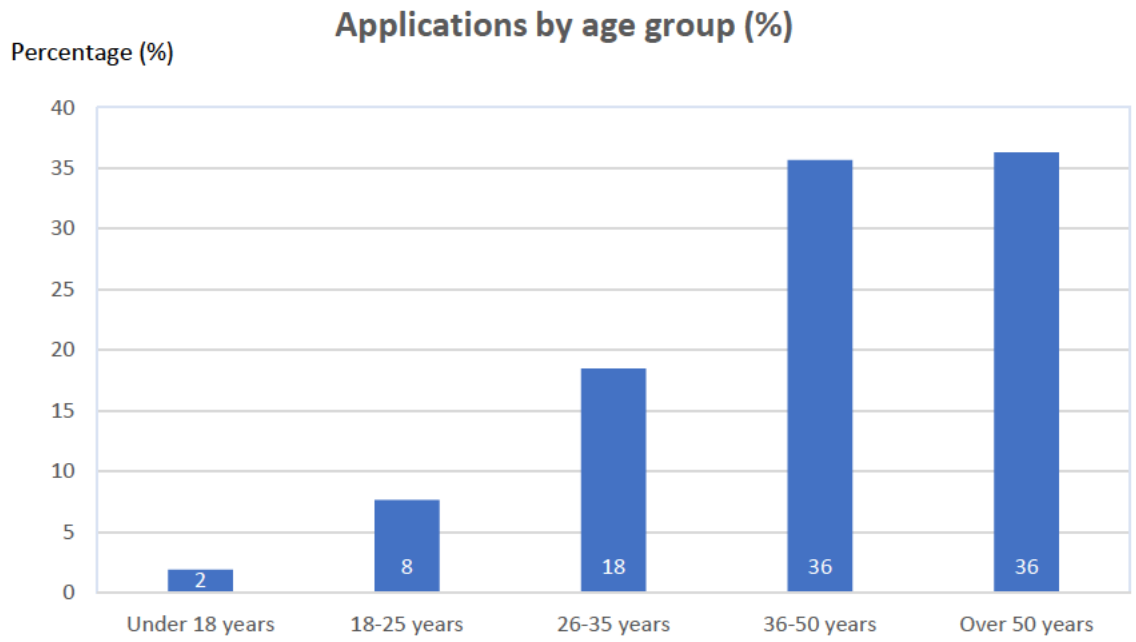


Figure 4: Applications received 1 July 2020 – 30 June 2021 by age range

The majority of the applications received were from people over the age of 36 years (76% total). Only one more application was received in the over 50 age group (57), than the 36-50 age group (56). This year we saw three (2%) applications from those under 18 years.

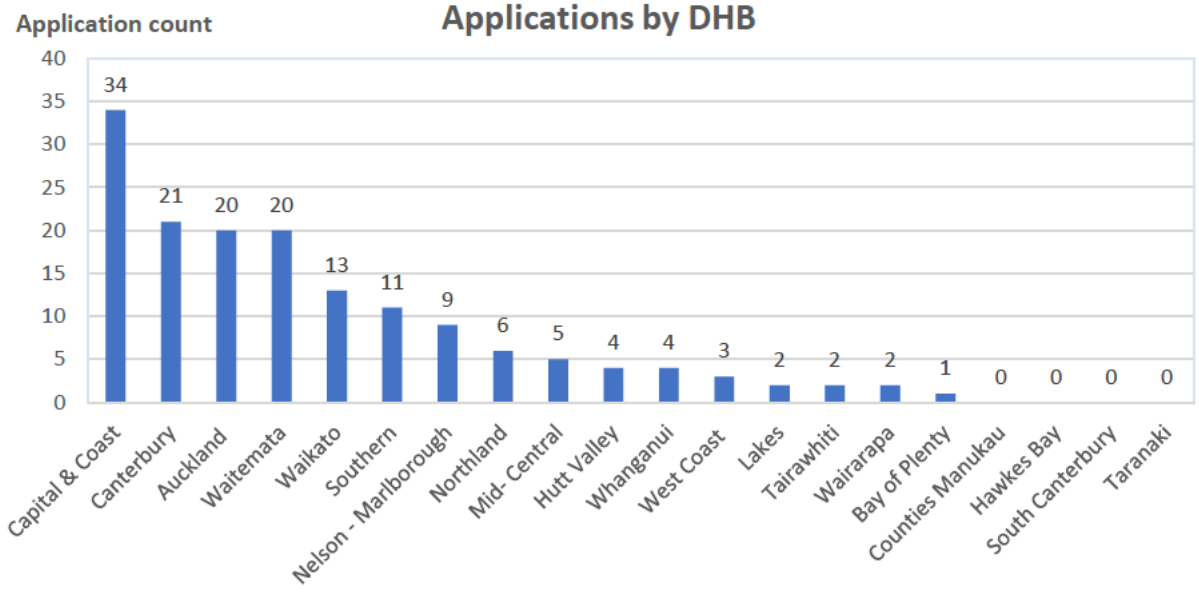


Figure 5: Applications received 1 July 2020 – 30 June 2021 by DHB location

Most applications were received from the main city centres across New Zealand. There were a high number of applications from Capital & Coast DHB, compared to other DHBs. Thirteen more applications were received from this DHB compared to the next highest, Canterbury DHB. The Auckland region (across Auckland and Waitemata DHBs) received the highest number of applications. These results are consistent with the 2019/2020 report.

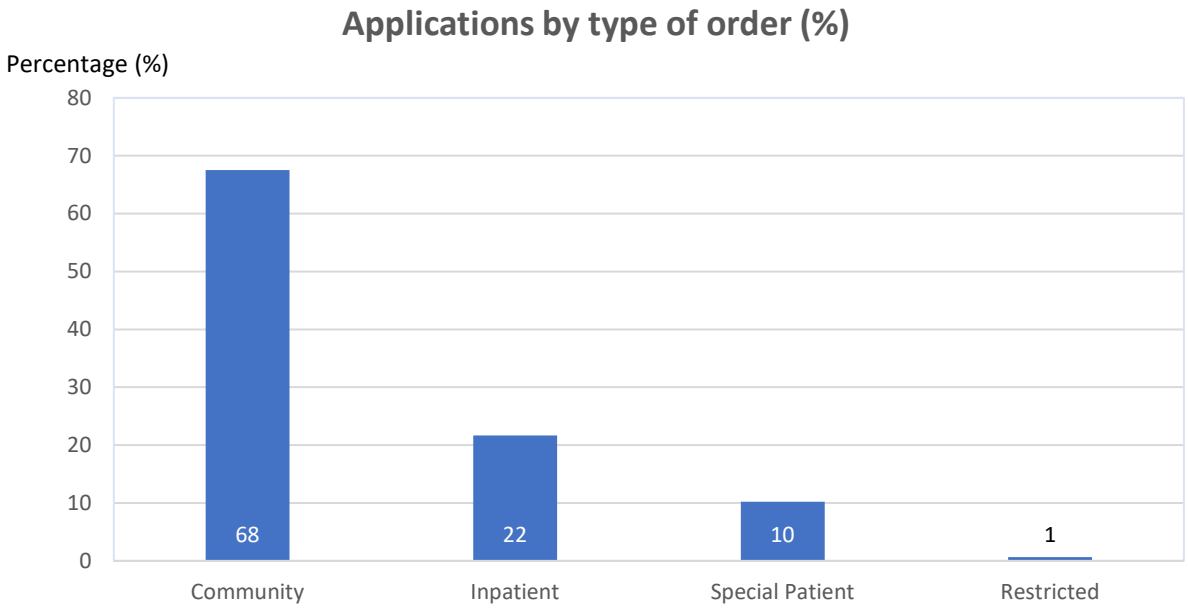


Figure 6: Applications received 1 July 2020 – 30 June 2021 by type of order

The largest number of applications received was from patients on community treatment orders. Of 157 applications, 106 (68%) were from patients on community treatment orders. One application was received from a restricted patient.

(Total may not sum to 100% due to rounding)

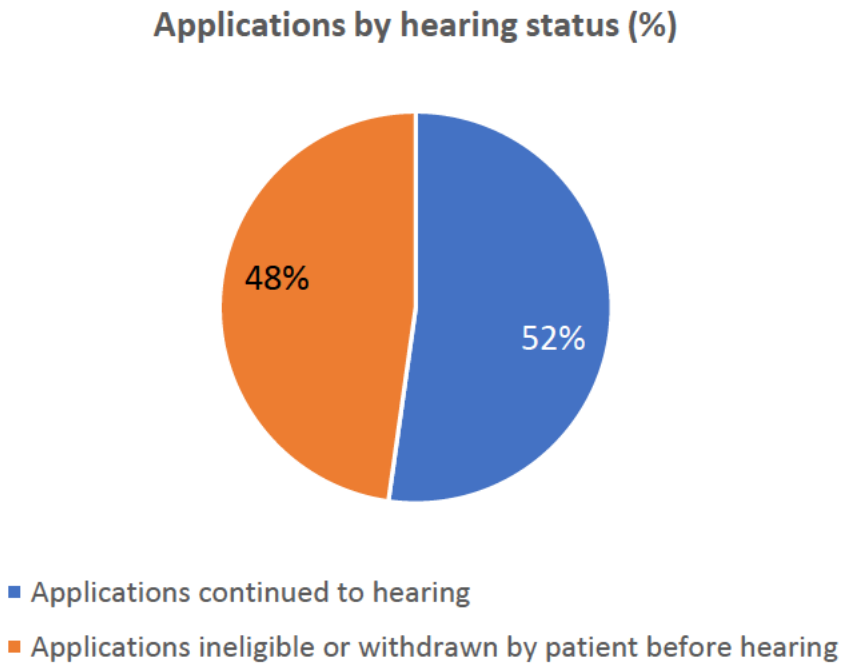


Figure 7: Applications received 1 July 2020 – 30 June 2021 by hearing status

Just under half of all applications received were withdrawn, or ineligible. This is a decrease from last year's figure, when 60% of all applications were withdrawn or eligible. A patient can withdraw an application at any stage. Eleven patients withdrew their application because they were released from the Act.

Table 1: Applications received 1 July 2020 -30 June 2021 percentage withdrawn

Year	Applications	Applications ineligible or withdrawn by patient	Percentage
1 July 2020 – 30 June 2021	157	75	48%

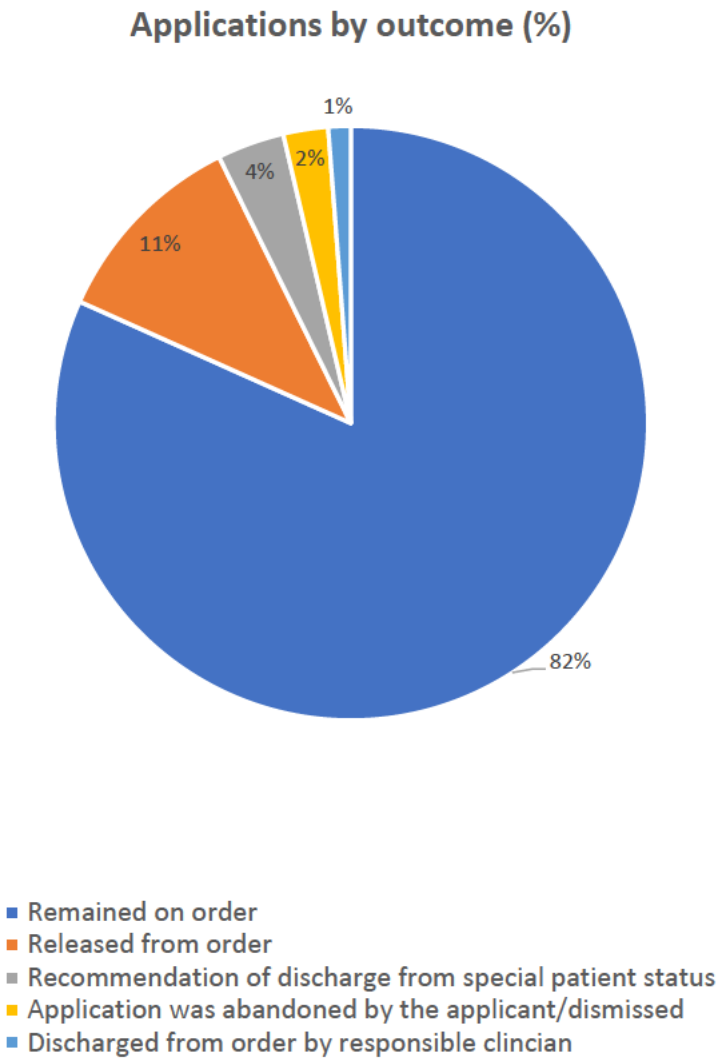


Figure 8: Applications received 1 July 2020 – 30 June 2021 by decision outcome

In most cases, the Tribunal decided that patients should remain on their orders. Nine patients were released from the Act during the year. The Tribunal recommended that three special patients be released from that status. Two applications resulted in dismissal or abandonment at the hearing. One application involved the patient being discharged from the order by their responsible clinician, after the hearing proceeded.

Table 2: Applications received 1 July 2020 – 30 June 2021 decision outcome by percentage

Number of cases determined: 82									
Remained on order	%	Released from order	%	Recommendation for a change in special patient status	%	Application was abandoned by the applicant/dismissed	%	Discharged from order by responsible clinician	%
67	82	9	11	3	4	2	2	1	1

Table 3: Applications received 1 July 2020 – 30 June 2021 and percentage of applications heard within 28 days

Quarterly	Number of applications	Withdrawn	Number proceeding	Heard within 28 days	%
1 July 2020 – 30 September 2020	41	16	25	25	100%
1 October 2020 – 31 December 2020	33	26	7	7	100%
1 January 2021 – 30 March 2021	43	18	25	24	96%
1 April 2021 – 30 June 2021	40	15	25	25	100%

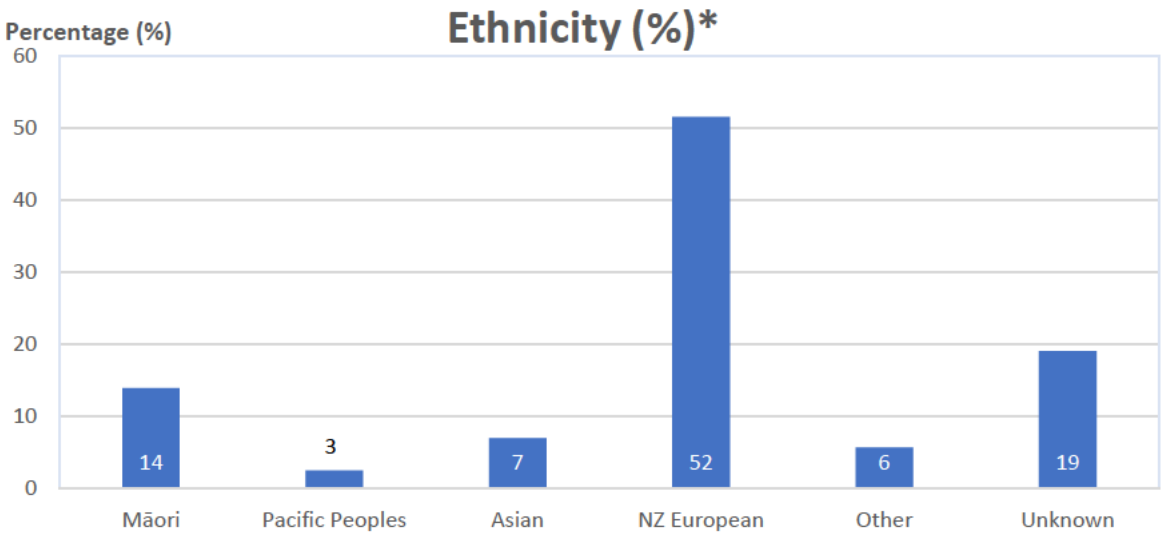


Figure 9: Applications received 1 July 2020 – 30 June 2021 by ethnicity

The largest ethnic group to apply to the Tribunal was New Zealand European. The graph does not fully reflect the ethnicity of all applicants because patients are not required to identify their ethnicity, and some did not do so.

(Total may not sum to 100% due to rounding)

*Prioritised ethnicity has been used to report on the data. Prioritised ethnicity involves each respondent being identified by a single ethnic group, in the prioritised order of Māori, Pacific, Asian, European, or Other. For example, if someone identified as being both Chinese and Māori, their prioritised ethnicity is Māori for the purpose of analysis. The prioritised ethnicity group European and Other effectively refers to non-Māori, non-Pacific, and non-Asian people.

Table 4: Applications received 1 July 2020 – 30 June 2021 by ethnicity

Ethnicity	Count	Percentage
Māori	22	14
Pacific Peoples	4	3
Asian	11	7
NZ European	81	52
Other	9	6
Unknown	30	19
Total	**157**	**100**

(Total may not sum to 100% due to rounding)

Appendix 3 – A comparison over time (previous five Annual Reports)

This section provides a comparison from the past five annual reports, together with data from this reporting period.

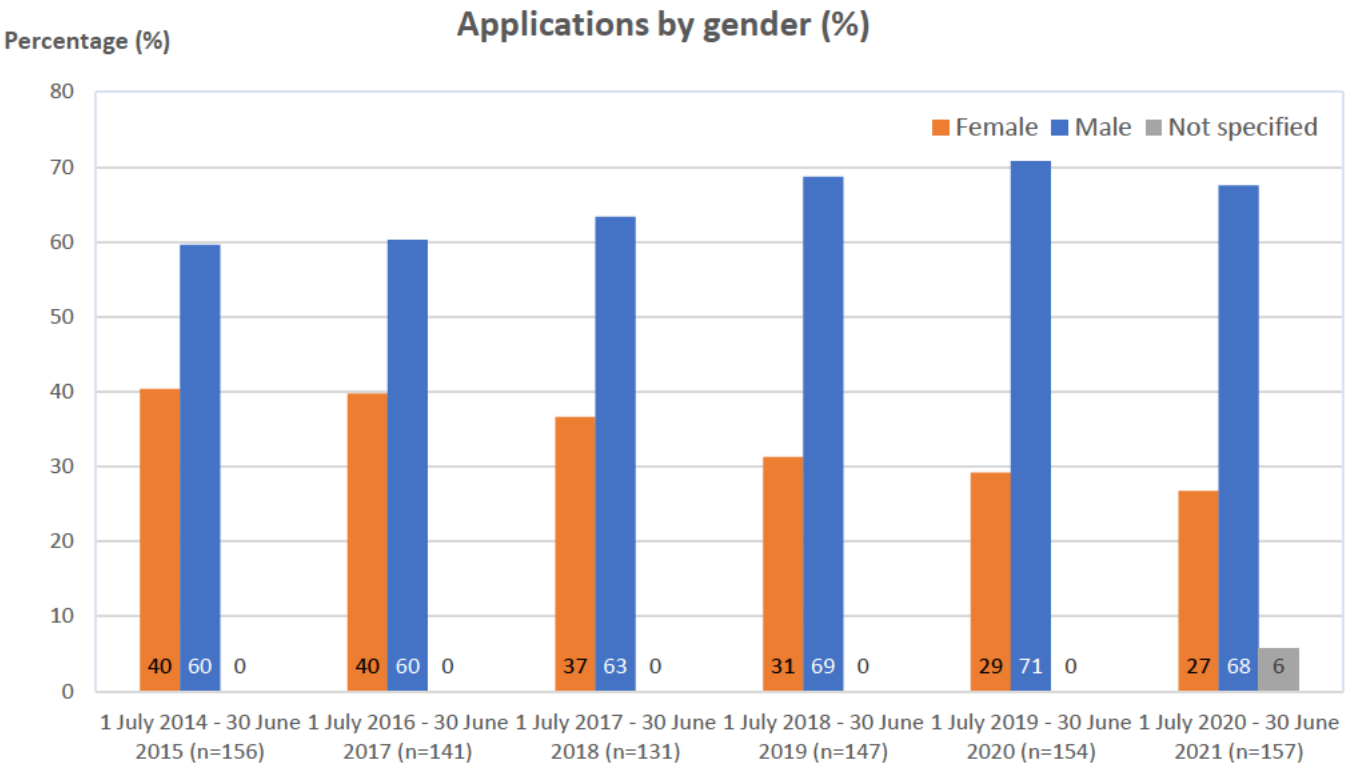


Figure 10: Applications received by gender compared to the last five annual reports

The number of applications of all descriptions stated as being from male patients was 106 and the number from female patients was 42. Since 2014, over 65% of the applications have been from males. There has been a decrease in the number of female applications since 2014. Some applications did not identify gender.

(Total may not sum to 100% due to rounding)

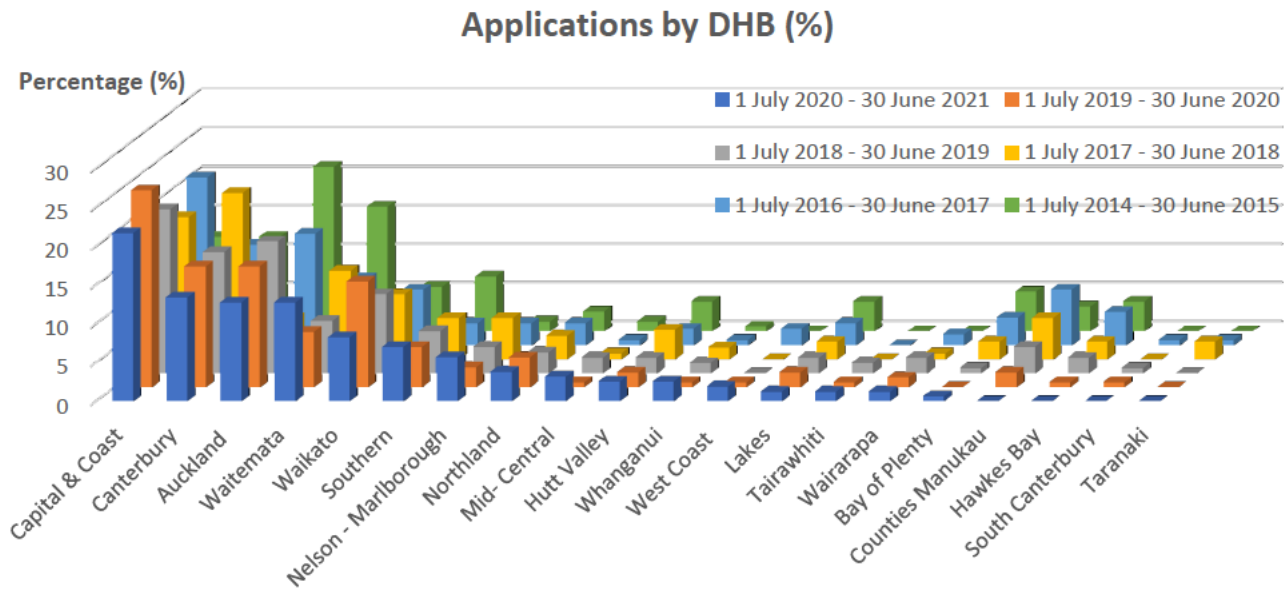


Figure 11: Applications received by DHB compared to the last five annual reports

The major cities continue to be the locations from where a large proportion of applications are received. The combined Auckland region (including Auckland, Waitemata and Counties Manukau DHBs) continues to be the highest.

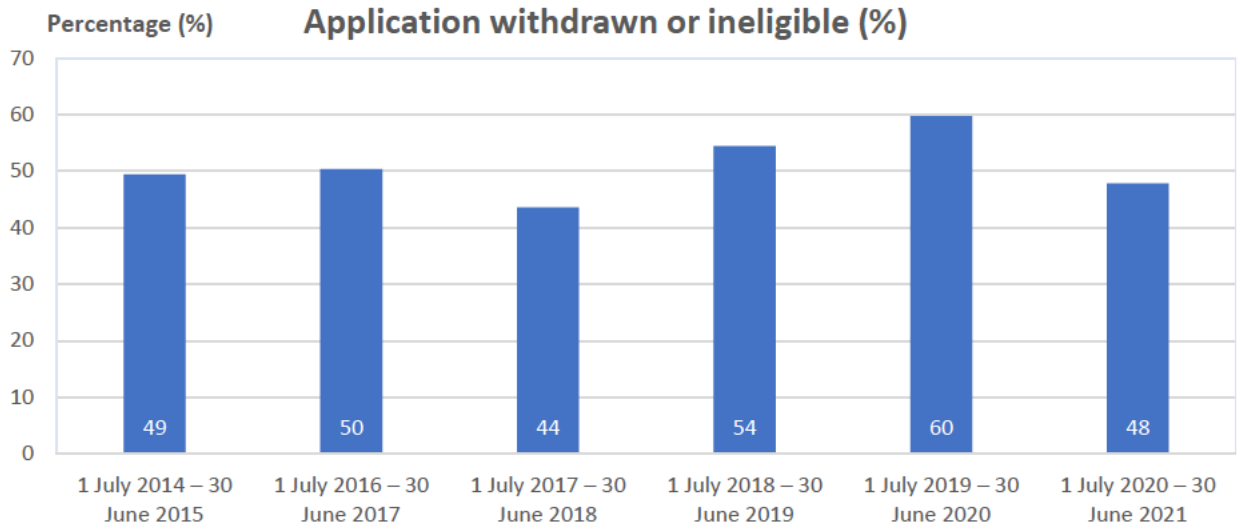


Figure 12: Application status compared to the last five annual reports

Table 5: Comparison of applications withdrawn or ineligible compared to the last five annual reports

Year	Number of applications	Withdrawn or Ineligible	Percentage
1 July 2014 – 30 June 2015	156	77	49%
1 July 2016 – 30 June 2017	139	70	50%
1 July 2017 – 30 June 2018	131	57	43%
1 July 2018 – 30 June 2019	147	80	54%
1 July 2019 – 30 June 2020	154	92	60%
1 July 2020 – 30 June 2021	157	75	48%

During the year there was a decrease in the number of withdrawn or ineligible applications compared to the two previous years.

In some cases, withdrawal has occurred because, following making the application, there has been substantive discussion between the patient and responsible clinician resulting in the resolution of the issues of concern to the patient, and then the withdrawal of the application or the discharge of the patient by the responsible clinician.

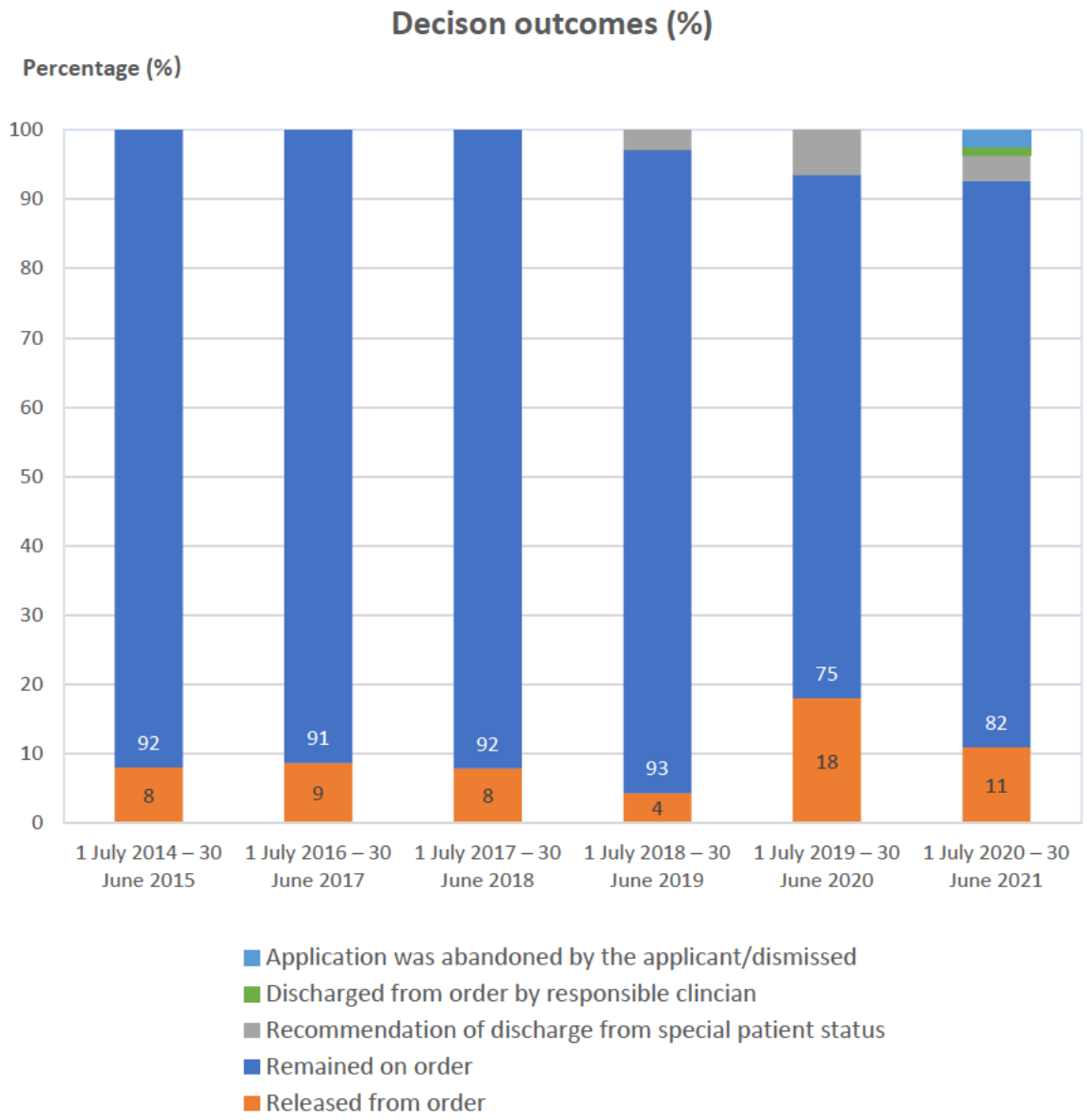


Figure 13: Comparison of decision outcome compared to the last five annual reports

Table 6: Decision outcomes over the last five annual reports

Year	# of cases determined	Remained on order	Released from order	Recommendation of discharge from special patient status	Application was abandoned by the applicant/dismissed	Discharged from order by responsible clinician
1 July 2014 – 30 June 2015	62	57	5	-	-	-
1 July 2016 – 30 June 2017	69	63	5	-	-	-
1 July 2017 – 30 June 2018	63	58	5	-	-	-
1 July 2018 – 30 June 2019	67	62	3	2	-	-
1 July 2019 – 30 June 2020	62	47	11	4	-	-
1 July 2020 – 30 June 2021	82	67	9	3	2	1

This year saw a slight decrease in the number of patients who the Tribunal discharged from compulsory status. That does not take into consideration 11 patients who were discharged by their responsible clinicians following an application being made, and in discussion with the patient.

There were 11 special patient hearings this year. Three resulted in recommendations that the patient be discharged from special patient status.

Two applications were abandoned by the applicant/dismissed at the hearing, and a further application saw the patient discharged from the order by their responsible clinician after the hearing had proceeded.

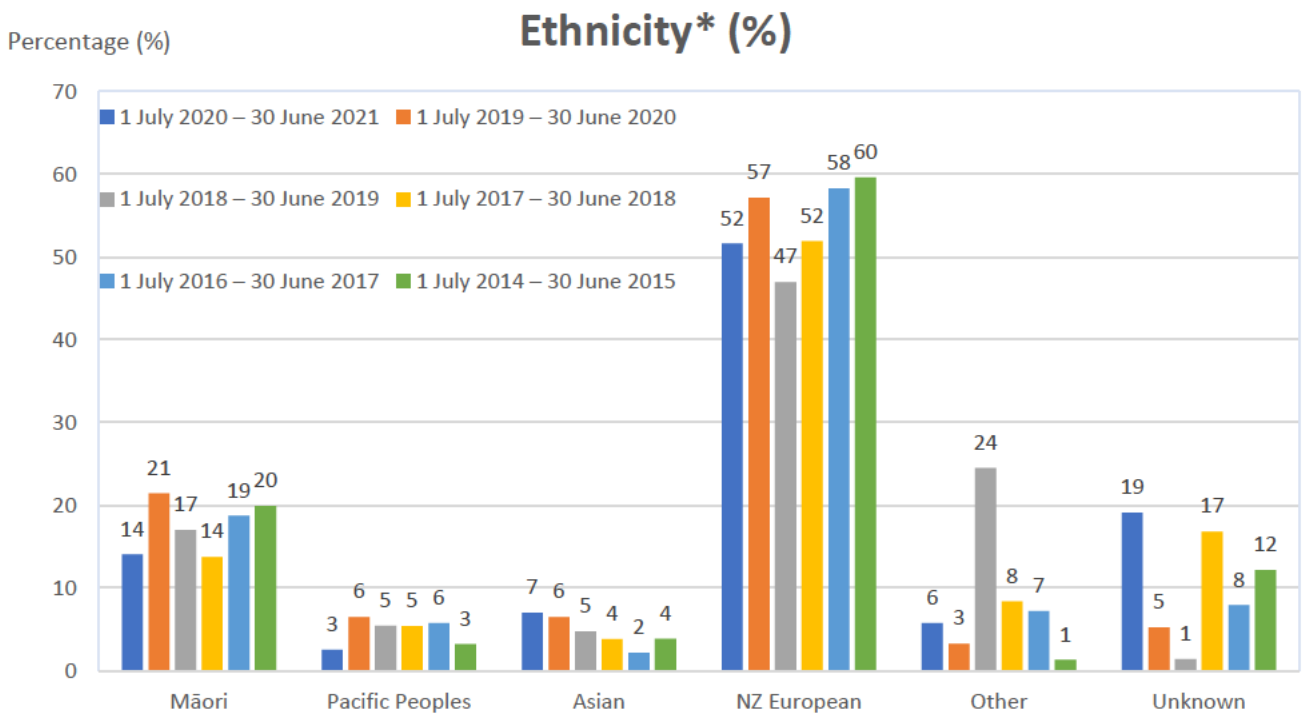


Figure 14: Applications by ethnicity compared to the last five annual reports

*Prioritised ethnicity has been used to report on the data. Prioritised ethnicity involves each respondent being identified by a single ethnic group, in the prioritised order of Māori, Pacific, Asian, European, or Other. For example, if someone identified as being both Chinese and Māori, their prioritised ethnicity is Māori for the purpose of analysis. The prioritised ethnicity group European and Other effectively refers to non-Māori, non-Pacific, and non-Asian people.

Table 7: Number of applications received by ethnicity compared to the last six annual reports

Ethnicity	1 July 2020 – 30 June 2021	1 July 2019 – 30 June 2020	1 July 2018 – 30 June 2019	1 July 2017 – 30 June 2018	1 July 2016 – 30 June 2017	1 July 2014 – 30 June 2015
Māori	22	33	25	18	26	31
Pacific Peoples	4	10	8	7	8	5
Asian	11	10	7	5	3	6
NZ European	81	88	69	68	81	93
Other	9	5	36	11	10	2
Unknown	30	8	2	22	11	19
Total	**157**	**154**	**147**	**131**	**139**	**156**

New Zealand Europeans continue to be the largest ethnic group applying to the Tribunal. This has been consistent over the last six annual reports. This year saw a decrease in applications from Māori, and an increase in the number of applications where an ethnicity was not specified.