ANNUAL REPORT

OF

MENTAL HEALTH REVIEW TRIBUNAL

1 JULY 2016 TO 30 JUNE 2017

Mental Health Review Tribunal, P O Box 10 407, The Terrace, Wellington
Phone: (04) 499 0431, Fax: (04) 499 0662

http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/mental-health-review-tribunal

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1. Introduction

1.1 The Mental Health (Compulsory Assessment and Treatment) Act 1992[1] came into force on 1 November 1992. Its purpose is to provide for the compulsory psychiatric assessment and treatment of people who have a mental disorder and to define and better protect associated patient rights.[2]

1.2 The Mental Health Review Tribunal is one of the suite of mechanisms that helps to support and protect those rights. This report is directed at how the Tribunal has discharged its statutory function during the reporting year. But that is not to overlook the context.

1.3 The pressing mental health issues facing New Zealand are well known to many. The consequences of mental illness can be devastating, for patients, their families, victims of associated offending and others.

1.4 To us, the face of mental health is often a consumer who is struggling to achieve good mental health, liberty, relations with family and whanau and satisfaction that many in society would regard as usual and modest. Applications for review are often presented to the Tribunal as a means of helping achieve those. Yet their attainment will often depend on the efforts of many.

1.5 As a result of hearing cases across New Zealand and hearing directly from patients, their families, lawyers and health professionals, we gain an overview of some of the challenges within the mental health system and whether and how they are addressed. One issue we wish to explore this year is whether that more general overview might usefully be made available to others.

[1] Herein "the Act".
[2] Mental Health (Compulsory Assessment and Treatment) Act 1992, long title.

2. The functions of the Tribunal

2.1 The functions of the Tribunal are to:

(a) on application or of its own motion in some cases, conduct reviews of 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 purpose of assessing whether in the Tribunal's opinion a patient ought to be released from compulsory treatment, or special patient or restricted patient status;[3]

(b) investigate complaints of breaches of certain patient rights referred to it pursuant to s75 of the Act. That 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[4] or an Official Visitor;[5]

(c) if appropriate appoint psychiatrists who assess:

(i) whether treatment is in the interests of a patient who does not consent to that treatment, pursuant to s59 of the Act;

(ii) whether electro-convulsive treatment is in the interests of a patient who does not consent to that treatment, pursuant to s60 of the Act;

(iii) 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.

2.2 Many patients accept compulsory treatment or the outcome of a District Inspector's complaint investigation and neither they nor others make an application for review to the Tribunal.

[3] Decisions regarding the release of special patients or restricted patients are for relevant Minsters.
[4] District Inspectors are lawyers who are appointed under the Act to help safeguard the rights of patients.
[5] There are no Official Visitors in New Zealand.

2.3 The Tribunal reviews only a small proportion of patients receiving compulsory treatment. The issue when an application is made is summarised below.

2.4 For ordinary patients' 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"*.[6] 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 then he or she is released from compulsory treatment. Otherwise, the patient remains subject to compulsion.

2.5 Some special patients receive compulsory treatment because they were found unfit to stand trial. 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. That opinion is 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.

2.6 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. That opinion is 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.

2.7 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

[6] *Waitemata Health v the Attorney-General* [2001] NZFLR 1122.

to the Minister of Health who, after consultation with the Attorney-General, will decide whether restricted patient status should continue.

2.8 Section 83 provides a right of appeal, for patients and certain others, to the District Court against Tribunal decisions in some cases. The psychiatrist responsible for the patient's care does not have a right of appeal. In practice, he or she can make a fresh assessment for the purpose of compulsory treatment if a patient who has been discharged later becomes sufficiently unwell.

3. Membership

3.1 Section 101(2) of the Act states *"Every Review Tribunal shall comprise 3 persons appointed by the Minister, of whom 1 shall be a barrister or solicitor, and 1 shall be a psychiatrist."* The people appointed to hold office during the report year were:

- Mr A.J.F. Wilding of Christchurch, barrister;[7]
- Dr N.R. Judson of Wellington, psychiatrist;
- Ms P. Tangitu of Rotorua, general manager, health.

3.2 Pursuant to s107 of the Act the three members of the Tribunal have appointed Mr Wilding convenor.

3.3 Section 105 of the Act provides that the Minister shall from time to time appoint deputy members of the Tribunal. During the report year, the deputy members of the Tribunal were:

Deputy lawyer members

- Mr N.J. Dunlop of Nelson, barrister;
- Ms M.J. Duggan of Nelson, solicitor;
- Ms R.F. von Keisenberg of Auckland, barrister;
- Mr R.A. Newberry of Wellington, barrister;

[7] Mr Wilding was appointed to that role with effect from 22 July 2016.

Deputy pychiatrist members

- Dr J. Cavney of Auckland;
- Dr H. Elder of Auckland;
- Dr M. Fisher of Auckland;
- Dr M. Honeyman of Auckland;
- Professor G. Mellsop of Auckland;
- Dr S. Nightingale of Christchurch;
- Dr P. Renison of Christchurch;

Deputy community members

- Mrs F. Diver of Alexandra, Central Otago;
- Mrs K.T. Rose of Auckland;
- Mr A.C. Spelman of Auckland.

3.4 At the end of the report year therefore, the membership of the Tribunal comprised:

Lawyers	5
Psychiatrists	8
Community members	4
Total	17

3.5 The appointment end date for all members and deputy members of the Tribunal is 15 September 2018.

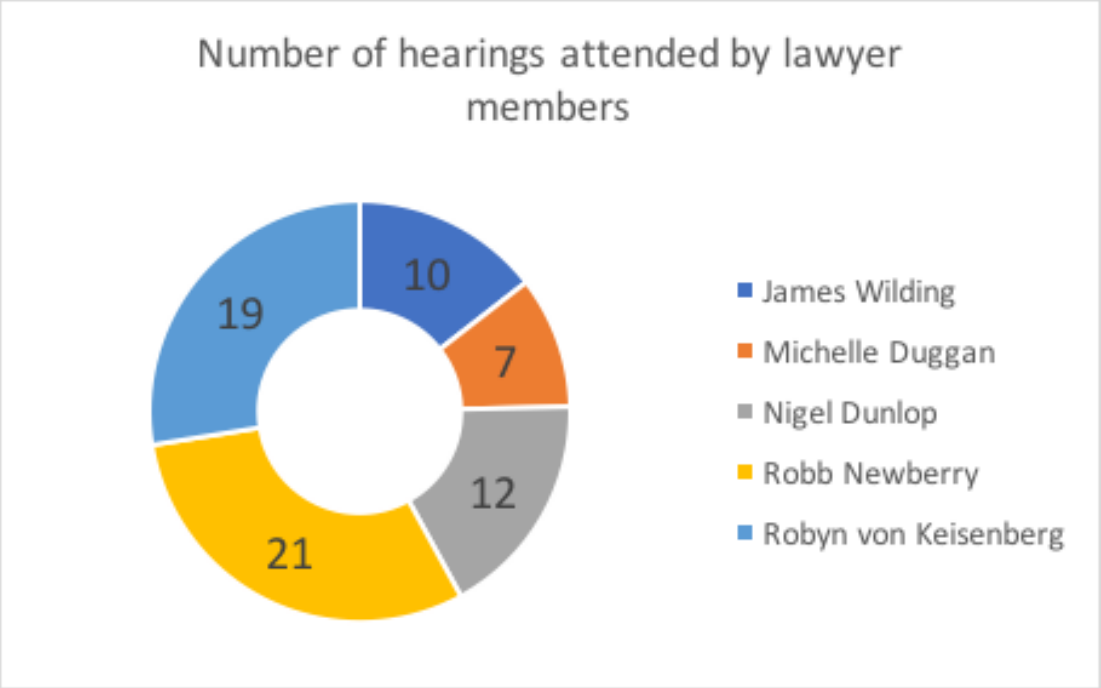
3.6 The number of cases heard by Tribunal members and deputy members over the report year is set out in Figure 1. They reflect a range of factors, including availability, the location of applicants, the dates on which cases can be heard, and the fact that some cases set down for hearing do not proceed.

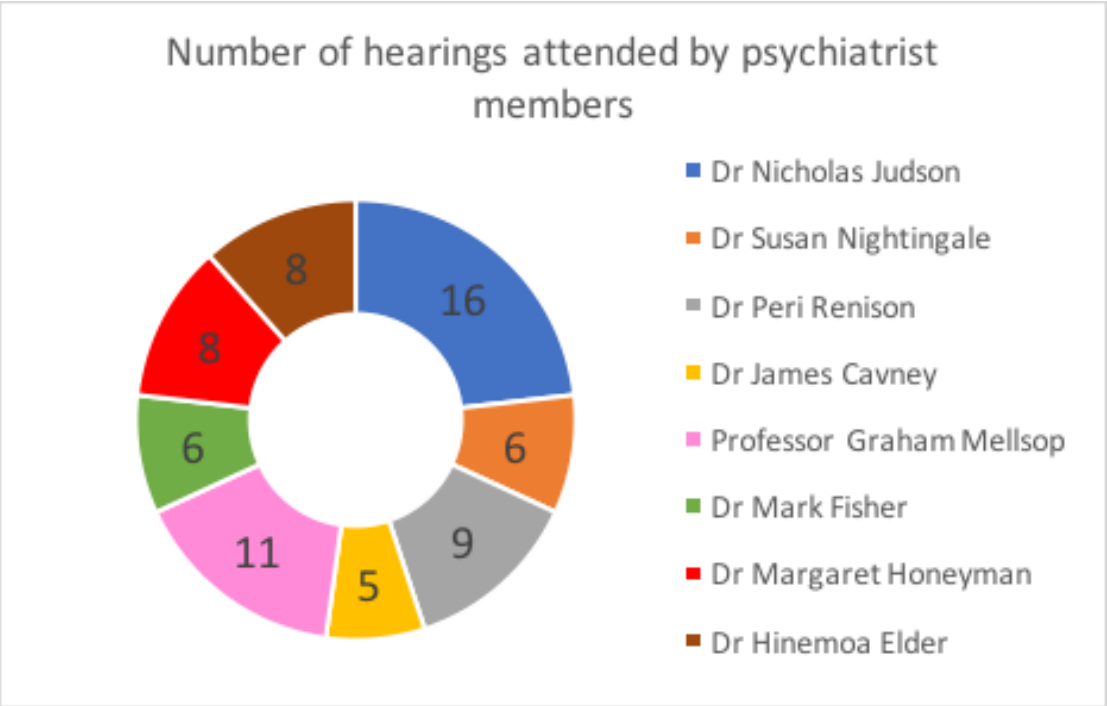
Legal Members	**Hearings**	**%**
James Wilding	10	15
Nigel Dunlop	12	17
Robb Newberry	21	30

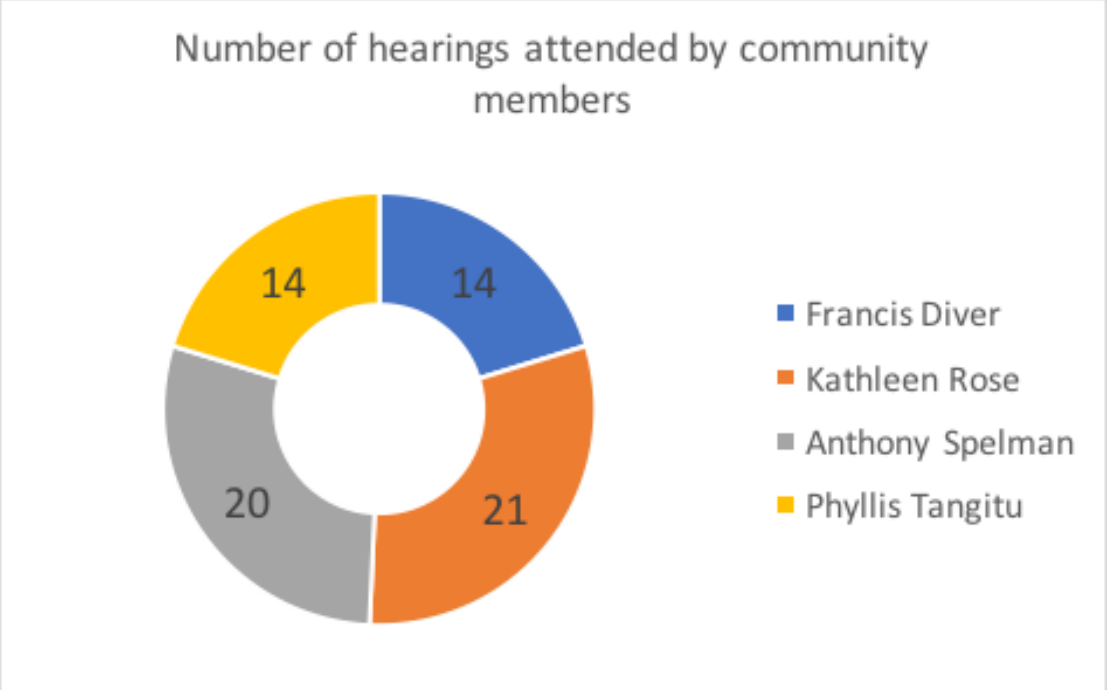
Michelle Duggan	7	10
Robyn Von Keisenberg	19	28
Total	**69**	**100**
Community Members		
Phyllis Tangitu	14	20
Anthony Spelman	20	29
Kathleen Rose	21	31
Francis Diver	14	20
Total	**69**	**100**
Psychiatrist Members		
Dr Nicholas Judson	16	23
Professor Graham Mellsop	11	16
Dr Susan Nightingale	6	9
Dr Mark Fisher	6	9
Dr James Cavney	5	7
Dr Hinemoa Elder	8	11
Dr Margaret Honeyman	8	12
Dr Peri Renison	9	13
Total	**69**	**100**

Figure 1: Hearings per member in reporting year.

These figures are illustrated in the following three graphs:







3.7 From time to time, other people may be co-opted to the Tribunal for the purposes of a particular case. Section 103 of the Act enables (or 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.

3.8 During the report year, the following were co-opted to the Tribunal:

- Mr K Barron-Afeaki S.C;
- Mr F Farah.

4. The typical review hearing

4.1 The review process for ordinary patients is typically as follows:

- an application is made for review, usually by the patient or his or her lawyer;
- the Tribunal (through the Secretariat) requests a medical report in respect of the patient from the psychiatrist responsible for the patient and another health professional;
- prior to the hearing there is a teleconference between the lawyer member of the Tribunal, the patient or his or her lawyer and the responsible psychiatrist. This deals with administrative and procedural steps;
- immediately before the hearing commences, the psychiatrist member of the Tribunal examines the patient pursuant to clause 1 of the First Schedule of the Act, amongst other things to ascertain the willingness and ability of the patient to engage in the hearing;
- an in person hearing then occurs;
- a decision is issued.

4.2 If the applicant is being treated in hospital the hearing 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.

4.3 The hearings are held in private, before the three Tribunal members (the lawyer, as convenor, the psychiatrist and the lay member), together with any co-opted member. Sometimes an interpreter assists.

4.4 Usually those in attendance are:

- the applicant;
- the applicant's lawyer;[8]
- the responsible clinician, who is usually a psychiatrist;
- the keyworker, who is usually a psychiatric nurse.

Others who might be in attendance include:

- a support person for the patient;
- family members or friends of the applicant;
- a social worker;
- a psychologist;
- a cultural advisor;
- other medical and nursing staff;
- a district inspector.

4.5 The hearing commences with the Tribunal introducing itself and establishing the identity of those present. Opening submissions are then heard from the applicant or his or her lawyer. Following that, evidence is heard from those who wish to contribute. Usually, the first witness is the patient or the responsible clinician. Evidence is not given on oath, nor is it recorded except in notes taken by Tribunal members.

4.6 The process is an inquisitorial rather than an adversarial one. Each witness is questioned by the Tribunal. The applicant or lawyer for the applicant is then invited to ask questions of that witness. At the conclusion of the evidence, closing submissions are invited from the applicant's lawyer. Those present are then asked to leave the room to enable the Tribunal to deliberate. Usually a decision is given shortly after, on the same day. Sometimes an adjournment will be necessary, for example to enable further medical evidence to be obtained.

[8] Patients may apply for legal aid for the purpose of a review.

4.7 An effort is made to provide the applicant with constructive and positive comment by way of support and encouragement.

4.8 The Tribunal tends to conduct hearings without undue formality and so as to enhance rather than damage therapeutic relationships. On the other hand, because the process is quasi-judicial and the determination affects important rights and interests, some formality is necessary.

4.9 Following the hearing, the Tribunal issues a written decision, or written reason for a decision if the decision was announced orally. These are posted to the patient, responsible clinician and certain others.

4.10 In some cases, for example for reasons of natural justice or to accommodate the health of a patient, there may be marked departures from the typical hearing described above.

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

4.12 Some hearings take place by video conference. Where that occurs, the format described above is followed as much as possible. Videoconferencing is used to avoid the disproportionate time and expense that may result from Tribunal members travelling from various parts of New Zealand to a hearing or hearings. The Tribunal members hearing the case are gathered together in one venue, and all other participants in another venue. Usually videoconferencing occurs when there are no more than two hearings in one centre on the one day. Whether videoconferencing is used is a matter of judgment, exercised consistently with natural justice.

4.13 On rare occasions, substantive hearings can be conducted by telephone conference.

5. Secretariat

5.1 The Wellington law firm of D'Ath Partners is contracted by the Ministry of Health to be the Tribunal's Secretariat. The Secretariat is kept busy supporting the Tribunal and processing applications, scheduling hearings and distributing decisions.

5.2 Its work involves frequent liaison with Tribunal members, the Ministry of Health, hospitals, responsible clinicians and lawyers, and making travel arrangements for Tribunal members.

5.3 In some regions the Secretariat is involved in helping to arrange legal representation for patients. Whether this is able to be addressed in another way is to be considered.

5.4 The Tribunal's Secretary is Mrs Susan D'Ath. She has been assisted throughout the year by her husband and legal partner Mr Andrew D'Ath. They were ably supported during the report year by a law student, Ms Sarah Christensen.

5.5 The Tribunal is grateful for the efficiency with which the Secretariat attends to the never-ending work. This year has been challenging, with the Tribunal and Secretariat seeking to improve timeliness in the hearing of applications. The Secretariat's work, especially in helping achieve this, is greatly appreciated.

6. Relationship with the Ministry of Health

6.1 The Ministry administers the Act. There is necessarily a close relationship between the Tribunal and the Ministry, particularly in relation to training, administrative, personnel and funding issues.

6.2 The Ministry and Tribunal also liaise in relation to relevant legal and medical issues. The Ministry has the advantage of a high level overview of mental health services and issues across New Zealand. The Tribunal has the advantage of meeting first-hand with clinicians, patients and their families at a wide range of psychiatric institutions throughout the country.

6.3 The Ministry's involvement does not extend to involvement in the Tribunal's substantive decision-making.

6.4 The Tribunal enjoys a constructive relationship with the Ministry. The contact between the two occurs primarily between the Convener and the Director of Mental Health, Dr John Crawshaw.

6.5 The Tribunal extends its thanks to Dr Crawshaw for his support, together with members of his team including Mr Stephen Enright, Ms Imogen Fraser-Baxter and Ms Helen Wong.

7. Professional development

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

7.2 However, ongoing professional development is needed. This occurs both in the context of the members' professional bodies and as a result of specific training organised by the Secretariat and the Ministry of Health. That training includes an induction process for new members and ongoing professional development for all members. Plenary meetings are held at least once, sometimes twice, per year, in Wellington, with presentations and discussion regarding topical issues.

7.3 Tribunal members share relevant information and viewpoints with one another throughout the year. Important Tribunal decisions and relevant articles are circulated to all members. Members and those engaged in hearings are aided by practice notices and other documents that are found on the Tribunal's website.

8. Statistics

8.1 Following are relevant statistics. Many applications are referred to as being withdrawn. Withdrawal occurs at the patient's request, and sometimes follows the responsible psychiatrist and patient being able to resolve issues.

Applications received during the report year

Section 79 applications

Deemed ineligible:	11
Withdrew during report year:	55
Held over to subsequent year:	6
Heard during report year:	60
Total	132

Section 80 applications

Deemed ineligible:	0
Withdrew during report year:	4
Held over to subsequent year:	0
Heard during report year:	3
Total	7

Section 81 applications

Deemed ineligible:	0
Withdrew during report year:	0
Held over to subsequent year:	0
Heard during report year:	0
Total	0

Section 75 applications

Deemed ineligible:	0
Withdrew during report year:	0
Held over to subsequent year:	0
Heard during report year:	0
Total	0
Grand Total	**139**

Summary of applications received

Deemed ineligible:	11
Withdrew during report year:	59
Held over to subsequent year:	6
Heard during report year:	63
Grand Total	**139**

Breakdown of applications deemed ineligible during the report year

Section 79 applications

Applications from previous year:	0
Applications from report year:	11
Total	11

Section 80 applications

Applications from previous year:	0
Applications from report year:	0
Total	0

Section 81 applications

Applications from previous year:	0
Applications from report year:	0
Total	0

Section 75 applications

Applications from previous year:	0
Applications from report year:	0
Total	0
Grand Total	**11**

Summary of ineligibility

Applications from previous year:	0
Applications from report year:	11
Grand Total	**11**

Applications withdrawn during the report year

Section 79 applications

Applications from previous year:	0
Applications from report year:	55
Total	55

Section 80 applications

Applications from previous year:	0
Applications from report year:	4
Total	4

Section 81 applications

Applications from previous year:	0
Applications from report year:	0
Total	0

Section 75 applications

Applications from previous year:	0
Applications from report year:	0
Total	0
Grand Total	**59**

Summary of withdrawals

Applications from previous year:	0
Applications from report year:	59
Grand Total	**59**

8.2 Figure 2 is a comparison of the number of applications of all applications received during the report year and subsequently withdrawn or deemed ineligible during the report year.

Reporting year	Applications	WD or Ineligible	%
8 March 1993 to 30 June 1993	138	27	19.6
1 July 1993 to 30 June 1994	164	44	26.8
1 July 1994 to 30 June 1995	118	40	33.9
1 July 1995 to 30 June 1996	155	36	23.2
1 July 1996 to 30 June 1997	165	51	30.9
1 July 1997 to 30 June 1998	211	89	42.2
1 July 1998 to 30 June 1999	178	61	34.3
1 July 1999 to 30 June 2000	175	76	43.4
1 July 2000 to 30 June 2001	184	85	46.2
1 July 2001 to 30 June 2002	159	72	45.3
1 July 2002 to 30 June 2003	174	68	39.1
1 July 2003 to 30 June 2004	155	62	40
1 July 2004 to 30 June 2005	133	60	45.1
1 July 2005 to 30 June 2006	154	63	40.9
1 July 2006 to 30 June 2007	134	57	42.6
1 July 2007 to 30 June 2008	226	94	41.6
1 July 2008 to 30 June 2009	161	69	42.9
1 July 2009 to 30 June 2010	146	51	34.9
1 July 2010 to 30 June 2011	144	65	45.1
1 July 2011 to 30 June 2012	174	78	44.8
1 July 2012 to 30 June 2013	207	91	44
1 July 2013 to 30 June 2014	157	74	47.1
1 July 2014 to 30 June 2015	156	77	49.4
1 July 2015 to 30 June 2016	134	75	56
1 July 2016 to 30 June 2017	139	70	50.4
TOTALS	**4041**	**1635**	**40.46%**

Figure 2: Applications compared with withdrawals during the reporting year.

The bar graph below illustrates the above table.

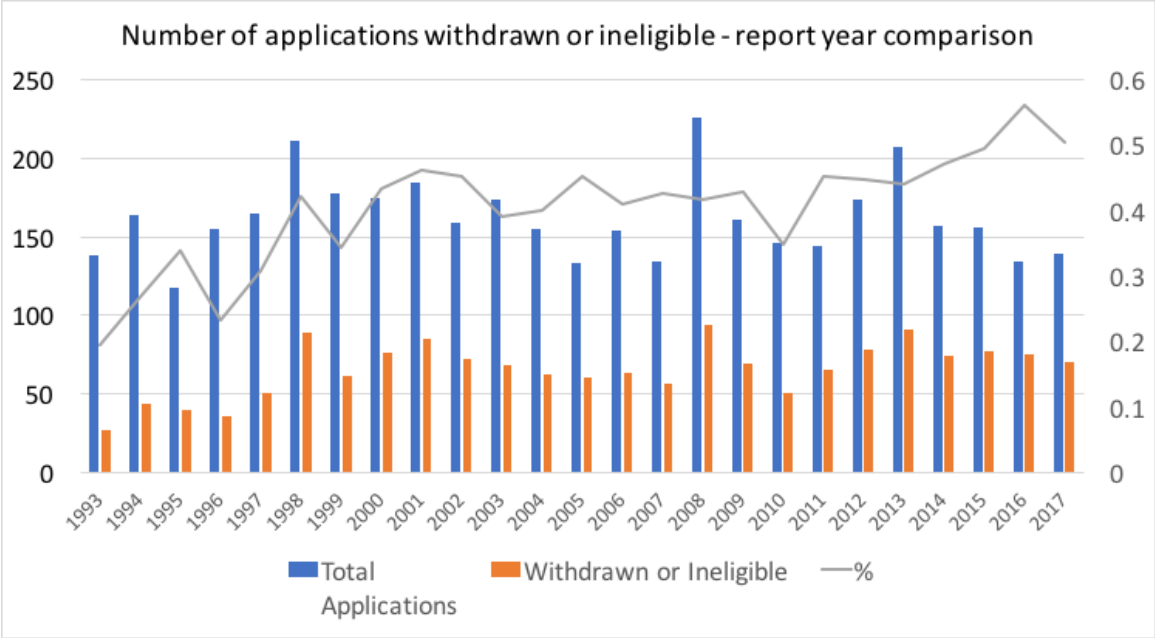


Figure 3: Total applications compared with withdrawn applications during the reporting year (graph).

Breakdown Between Categories

8.3 Figure 4 illustrates the proportion of special patients, inpatients and community treatment patients for all applications received (including s75 complaint decision referrals):

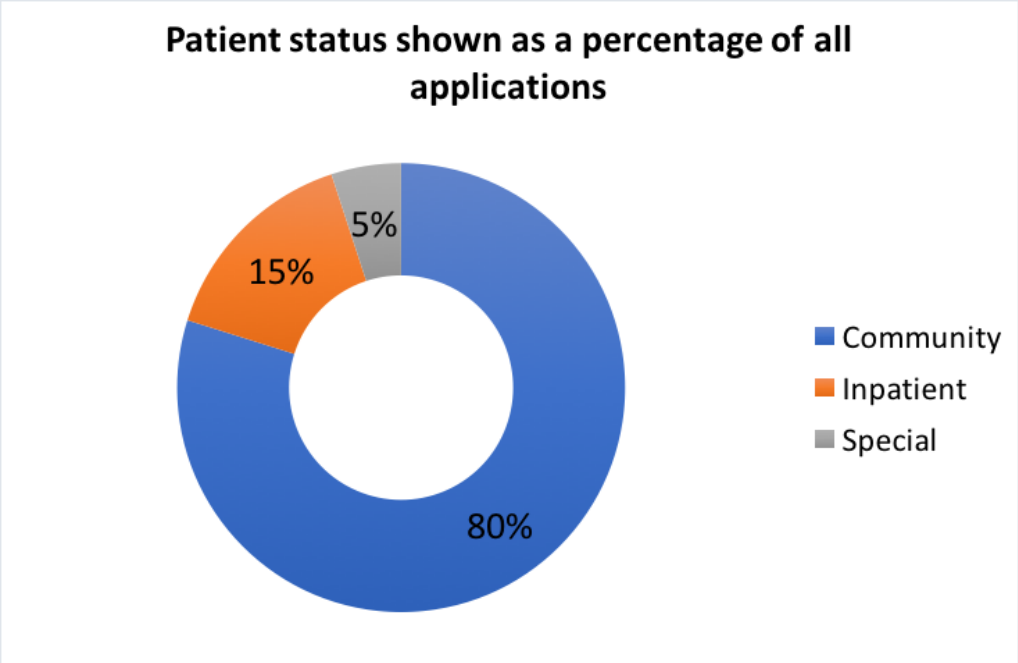


Figure 4: Application type breakdown.

The actual figures were:

Community Patients	111
Inpatients	21
Special Patients	7
Restricted Patients	0
Total	**139**

Gender

8.4 The number of applications of all descriptions received from male patients was 85 and the number from female patients was 56 (see Figure 5) *:

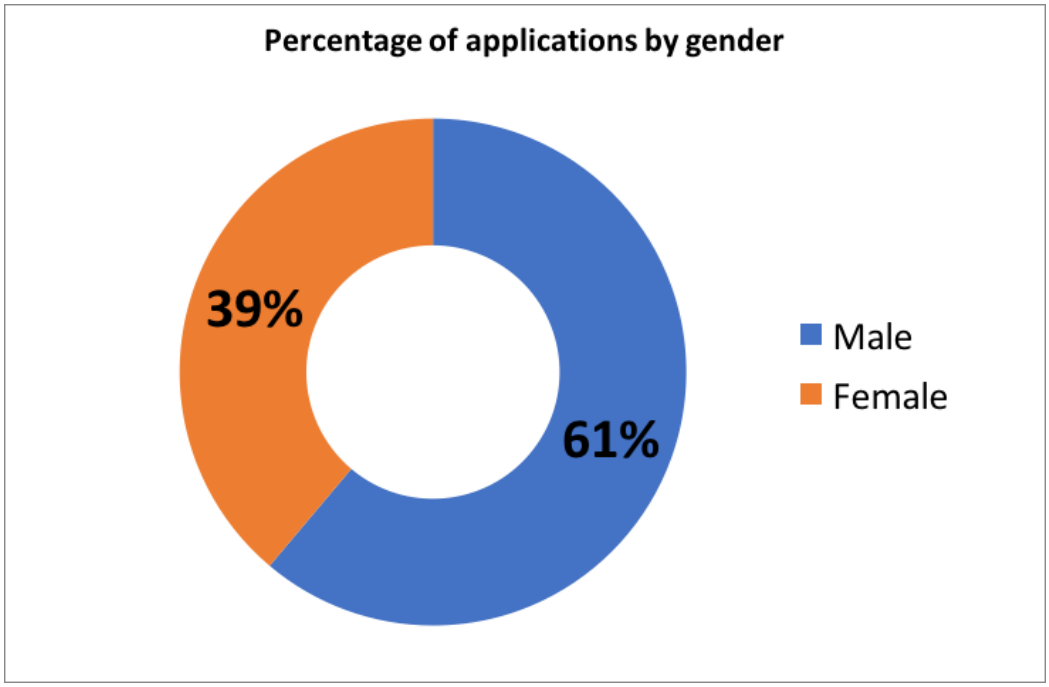


Figure 5: Application gender breakdown.

*NB: Some patients applied more than once.

8.5 By comparison, 2013 census data supplied by Statistics New Zealand indicates that for the age range 20-69 years inclusive (in which nearly all the applicants fall) the total population breakdown was 48.69% males and 51.31% females.

8.6 The gender breakdown of inpatient applicants, community treatment applicants and special patients was as follows:

Applications by patients subject to community treatment orders	
Gender	**Number**
Male	67
Female	44
Applications by patients subject to inpatient treatment orders	
Male	11
Female	10
Applications by patients subject to special treatment orders	
Male	7
Female	0
Applications by patients subject to restricted orders	
Male	0
Female	0
Total	**139**

Figure 6: Application gender breakdown by type of application.

These figures are illustrated in the following graph:

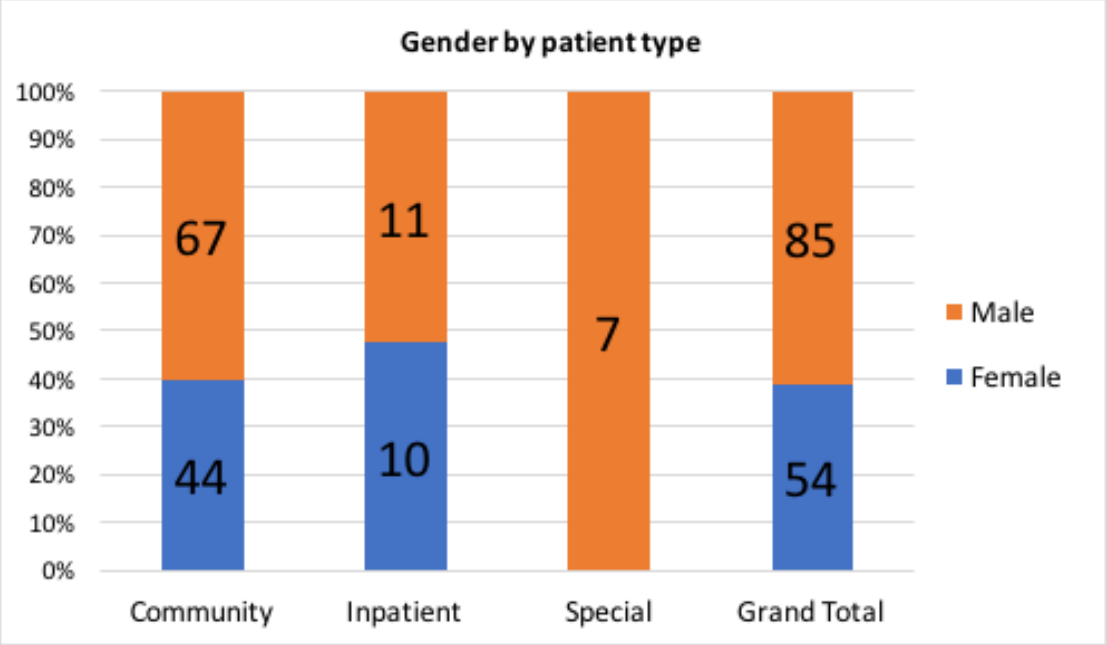


Figure 7: Patient gender ratio.

Ethnicity

8.7 Of the 139 applications received, 128 (92%) presented an identifiable ethnicity through their applications. The 128 applicants for whom data has been recorded have been broken down in Figure 8. The percentages will not necessarily reflect the actual ethnic breakdown over the year because the data is incomplete. The comparative figures in the final column are derived from Statistics New Zealand figures as per the 2013 census for the age 20 – 69 (inclusive) population range into which nearly all applicants fall.

Ethnicity	Number	Percentage %	Population Comparison
European/Pakeha	81	58%	67%
Maori	26	19%	13%
Pacific Island	8	6%	7%
Asian	3	2%	11%
Other	10	7%	2%
Unknown	11	8%	NA
TOTALS	**139**	**100%**	**100%**

Figure 8: Patient ethnicity comparison.

These figures are illustrated in the following graph:

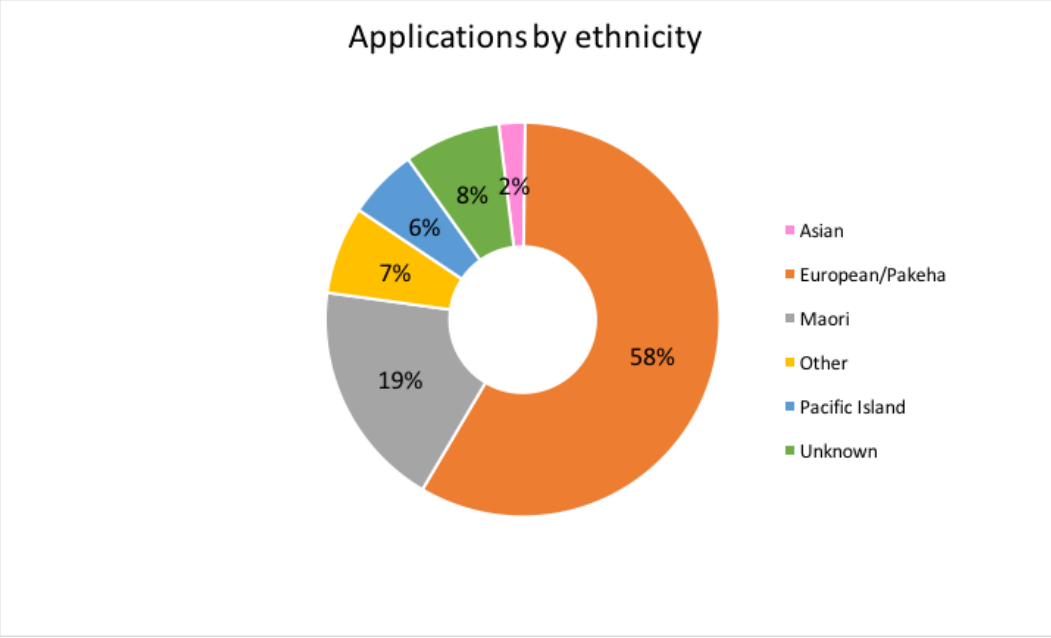


Figure 9: Patient ethnicity comparison graph.

Hearings held during the report year

Section 79 applications

From previous year:		6
From report year:		60
	Total	69

Section 80 applications

From previous year:		0
From report year:		3
	Total	3

Section 81 applications

From previous year:		0
From report year:		0
	Total	0

Section 75 applications

From previous year:		0
From report year:		0
	Total	0
	Grand Total	**72**

Summary of hearings held

From previous year:		6
From report year:		63
	Grand Total	**69**

Numbers Found Fit to be Released

8.8 Of the 69 s79 applications determined by the Tribunal during the report year the Tribunal certified that 6 patients (8.7%) were fit to be released from compulsory status and 63 patients (91.3%) were not fit to be released from compulsory status.[9]

Year	No. Of Cases Determined	Remain on order	%	Released from order	%
2002-2003	96	93	96.9	3	3.1
2003-2004	79	72	91	7	8.9
2004-2005	69	65	94.2	4	5.8
2005-2006	90	85	94.4	5	5.6
2006-2007	68	64	94.3	4	5.7
2007-2008	94	87	92.6	7	7.4
2008-2009	95	88	93	7	7
2009-2010	76	75	99	1	1
2010-2011	72	70	97.3	2	2.7
2011-2012	80	76	95	4	5
2012-2013	102	97	95.1	5	4.9
2013-2014	80	72	90	8	10
2014-2015	62	57	92	5	8
2015-2016	62	56	90	6	10
2016-2017	69	63	91.3	6	8.7
Total	**1185**	**1120**	**93.8**	**74**	**6.3**

Figure 10: s79 Applications heard compared with releases.

These figures are illustrated in the following graph:

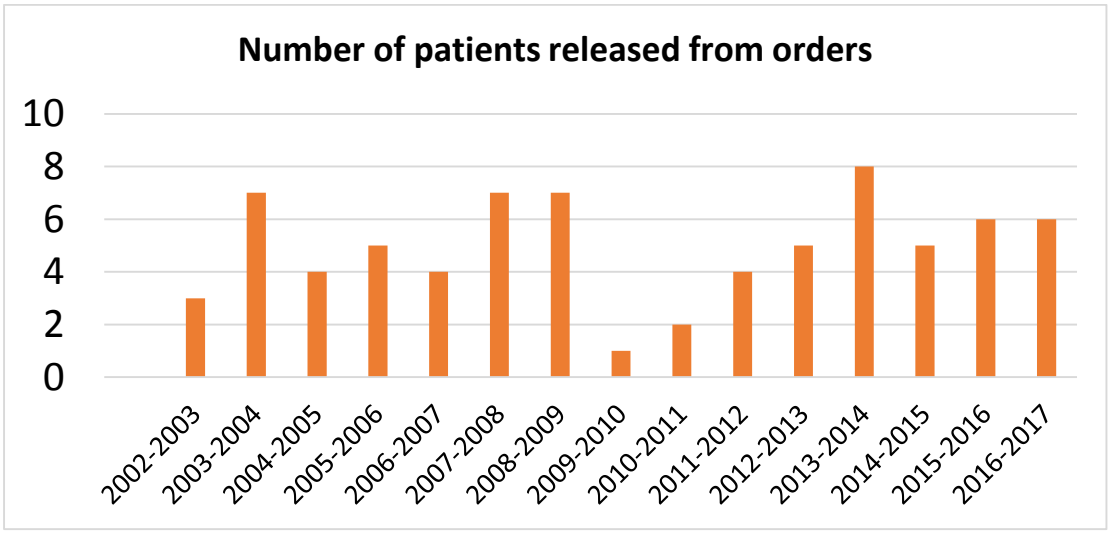


Figure 11: Number of s 79 patients released from orders.

[9] Originally, there were two Mental Health Tribunals, a Northern Tribunal and a Southern Tribunal. From 1 July 2002, they were united, resulting in the current Tribunal. The data from the former two Tribunals has been merged.

Special Patients

8.9 Recommendations for a change in status were made in 0 of the 7 hearings held during the report year. The equivalent figures since the Act came into force are:

Year	No. Of Cases	Status Should Continue	%	Status Should Not Continue	%
1993	6	6	100	0	0
1993-1994	9	7	78	2	22
1994-1995	7	6	86	1	14
1995-1996	14	12	86	2	14
1996-1997	6	5	83	1	17
1997-1998	5	4	80	1	20
1998-1999	10	10	100	0	0
1999-2000	4	3	75	1	25
2000-2001	6	6	100	0	0
2001-2002	7	6	86	1	14
2002-2003	9	6	67	3	33
2003-2004	11	6	55	5	45
2004-2005	4	4	100	0	0
2005-2006	2	1	50	1	50
2006-2007	2	2	100	0	0
2007-2008	8	7	87.5	1	12.5
2008-2009	5	5	100	0	0
2009-2010	1	1	100	0	0
2010-2011	6	4	67	2	22
2011-2012	6	6	100	0	0
2012-2013	6	4	66.6	2	33.3
2013-2014	9	6	66.6	3	33.3
2014-2015	6	4	66.6	2	33.3
2015-2016	6	5	83.3	1	16.7
2016-2017	7	7	100	0	0
Total / average	**162**	**133**	**83**	**29**	**18**

Figure 12: s80 Applications heard compared with releases.

Applications by region

8.10 The district health boards from which applications were received over the past year together with the number of applications and the number of withdrawals prior to determination are shown in the following charts:

Location	No. of Apps.	Heard	W/D and Ineligible	Carried over to 17/18
Northland	4	2	1	1
Waitemata	12	3	8	1
Auckland	20	11	7	2
Counties Manukau	10	6	4	0
Waikato	10	6	4	0
Bay of Plenty	5	3	2	0
Lakes	4	0	4	0
Taranaki	1	1	0	0
Hawkes Bay	6	3	3	0
Whanganui	1	0	1	0
Mid Central	1	0	1	0
Wairarapa	2	1	1	0
Hutt Valley	3	1	2	0
Capital & Coast	30	13	17	0
Nelson Marlborough	4	1	1	2
West Coast	3	1	2	0
Canterbury	18	8	10	0
South Canterbury	1	0	1	0
Southern	4	3	1	0
TOTALS	139	63	70	6

Figure 13: Regional application and hearing table.

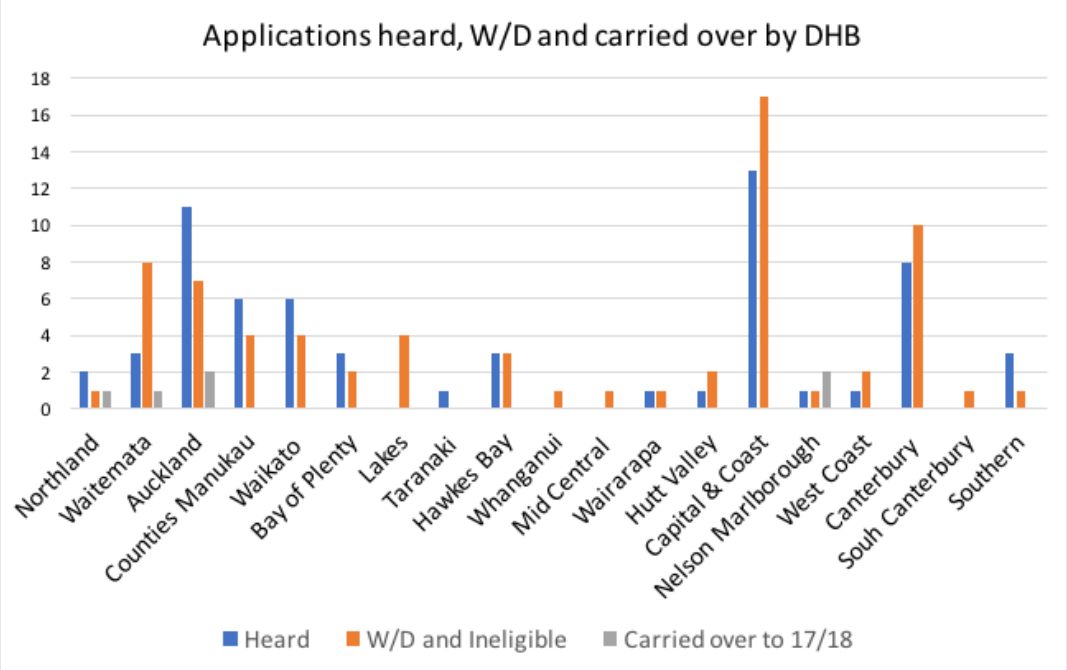


Figure 14: Number of applications heard compared with withdrawn by DHB.

Video Conferences and Telephone Conferences

8.11 Figure 15 illustrates the proportion of hearings (of all descriptions) heard by way of video conference during the report year. Of the 63 hearings, two were held by video conference. None were held by teleconference.

The comparative figures since 2002/3 are as follows:

Year	*Number of video-conferences and telephone conferences*	**Proportion to total number of hearings**
2002/2003	5	5%
2003/2004	10	11%
2004/2005	3	4.2%
2005/2006	4	3.6%
2006/2007	6	8.6%
2007/2008	2	1.9%
2008/2009	3	3%
2009/2010	4	5.5%
2010/2011	2	2.5%
2011/2012	1	1.2%
2012/2013	2	2.6%
2013/2014	0	0%
2014/2015	2	2.9%
2015/2016	3	4.2%
2016/2017	2	3.2%

Figure 14: Number of applications held by way of video conference.

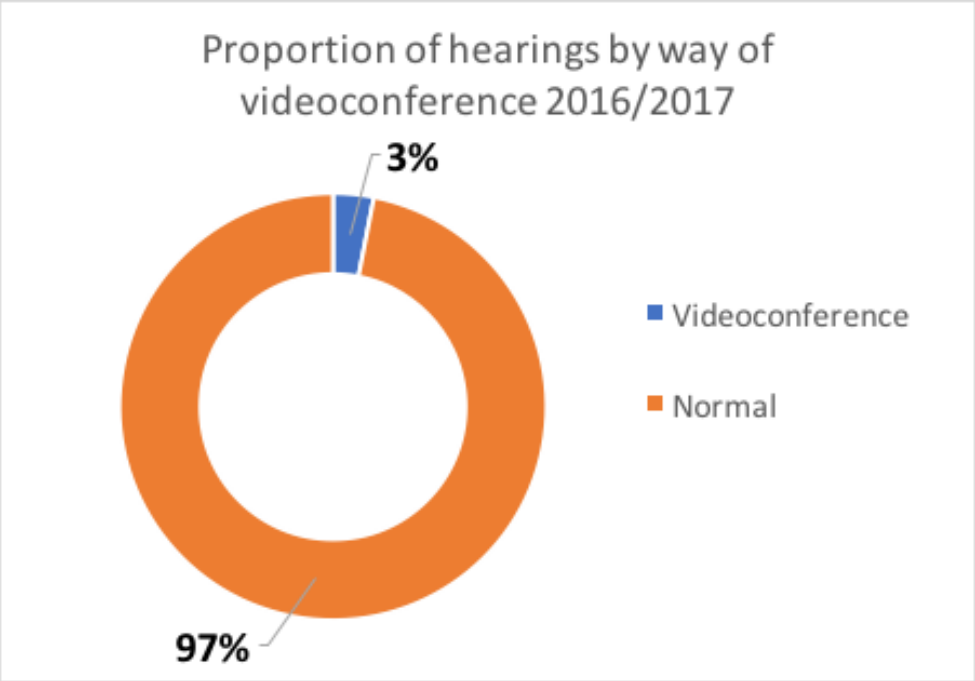


Figure 15: Number of applications held by way of video conference compared to regular hearing.

Appointments Pursuant to ss 59 and 60

8.11 This reporting period 13 psychiatrists were appointed by the Tribunal to give opinions that the proposed treatment of patients' without consent (including electro-convulsive treatment) is in their interests.

9. Timeliness

9.1 During this reporting period there was significant focus on improving timeliness in the hearing of applications. This has involved effort by many, including patients, their counsel, health professionals, the Secretariat and all Tribunal members, and the support of the Ministry.

9.2 Reviews are required to commence within 21 days, or a further 7 days if the Tribunal extends that timeframe. There is no specific timeframe for their conclusion, but the Tribunal endeavours to conclude cases efficiently.

9.3 Factors identified that undermined timeliness included:

- scheduling difficulties. This results from the need to ensure that the patient, the psychiatrist, another health professional, any other witnesses, a lawyer (if any) and the Tribunal are all available on a particular day;
- the workload and existing commitments of those involved in the hearing process;
- the time involved in a patient arranging legal representation, obtaining advice and any second opinion and then preparing for the hearing;
- statutory holidays, particularly Christmas; and
- geographic factors.

9.4 In some cases delay may be sought or consented to by a patient, for example so that he or she can arrange a lawyer or obtain a second opinion, or to prepare more fully.

9.5 Sometimes additional time allows the patient and responsible clinician to resolve issues that gave rise to the application, for example the type and level of medication and patient leave, which fall outside of the Tribunal's jurisdiction.

9.6 There will always be a percentage of hearings that fall outside of the timeframes, for example because a patient is not ready to proceed or an emergency. There is merit in minor legislative change to provide flexibility in such circumstances.

9.7 Currently, over 75% of applications are heard within 28 days (See figure 16, grey line). We are grateful to all involved for their commitment to addressing timeliness.

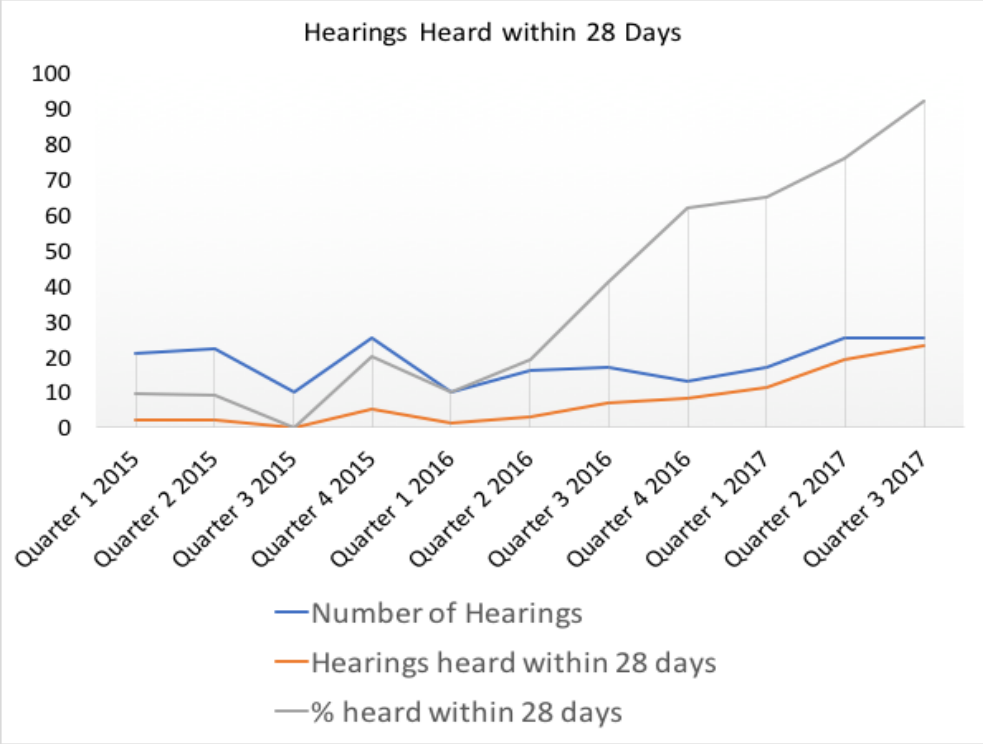


Figure 16: Trend showing number of hearings heard within 28 days.

Report Quarter	Total Applications	Withdrawn	Heard/ Going Ahead	Heard Within 28 Days	%
1 Jan 2015 - 31 Mar 2015	41	20	21	2	**9.5**
1 Apr 2015 - 30 Jun 2015	35	13	22	2	**9**
31 Jul 2015 - 30 Sep 2015	19	9	10	0	**0**
1 Oct 2015 - 31 Dec 2015	48	23	25	5	**20**
1 Jan 2016 - 31 Mar 2016	29	19	10	1	**10**
1 Apr 2016 - 30 Jun 2016	38	22	16	3	**19**
31 Jul 2016 - 30 Sep 2016	34	17	17	7	**41**
1 Oct 2016 - 31 Dec 2016	23	10	13	8	**62**
1 Jan 2017 - 31 Mar 2017	40	23	17	11	**65**
1 Apr 2017 - 30 Jun 2017	42	17	25	19	**76**
31 Jul 2017 - 30 Sep 2017	37	12	25	23	**92**

Figure 17: Trend showing percentage of hearings heard within 28 days.

10. Publication of Decisions

10.1 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/or in publications of a bona fide professional or technical nature.

10.2 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 fact specific and anonymisation may not prevent identification.

10.3 The Tribunal is cognisant of the fact that those receiving compulsory treatment under the Act may 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.

10.4 Patients, their families and clinicians who provide private information during the course of Tribunal hearings may be alarmed that reports of those hearings could find their way on to the worldwide web. Publishers of professional and technical journals now publish journals online.

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

10.6 In April 2010 the Tribunal and the Ministry of Health 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 is sent to publishers.
- those cases will be anonymised.
- they will be sent only to three established professional and responsible publishers, namely Brookers (Thomson Reuters), LexisNexis and the New Zealand Legal Information Institute.

10.7 The Tribunal's intention is that cases are made available to these publishers if they would enable the work of the Tribunal to be better understood, and assist the public at large with its understanding of mental health law and practice.

10.8 As at the date of this report forty-two cases can be found on line on the New Zealand Legal Information Institute website: www.nzlii.org/nz/cases/NZMHRT/ . Those will be added to in the year to 30 June 2018.

10.9 These cases can now be accessed through the Tribunal's website. The website also provides a brief précis of each case and an index listing the issues involved.

11. Website

11.1 The Tribunal has a dedicated 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

11.2 That website contains relevant information, including a suite of Policy and Practice notes and Guidelines, that were updated in 2015. The guidelines for reports writers (responsible clinicians) are currently being updated.

12. Conclusion

12.1 Many applications made to the Tribunal are unsuccessful. A better measure of success is the role the Tribunal plays in helping to support and protect relevant rights and interests, including:

- 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;
- the interests that arise in the case of special and restricted patients.

12.2 By those measures, the Tribunal considers that it has operated effectively, with the support of the Secretariat and all involved in the hearing process.

12.3 For the year to 30 June 2018 the Tribunal wishes to maintain its progress in addressing delay and to turn its attention to other issues that arise in this challenging field.

6 October 2017.

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A.J.F. Wilding
Convener
Mental Health Review Tribunal

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Ms P. Tangitu
Mental Health Review Tribunal

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Dr N. Judson
Mental Health Review Tribunal