MENTAL HEALTH REVIEW TRIBUNAL

Mental Health (Compulsory Assessment and Treatment) Act 1992

ANNUAL REPORT

1 July 2017 to 30 June 2018

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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 We are pleased to present the annual report for the Mental Health Review Tribunal for the year to 30 June 2018.

1.2 The Tribunal is established by the Mental Health (Compulsory Assessment and Treatment) Act 1992.[1] The Act enables the compulsory psychiatric assessment and treatment of people who have a mental disorder and defines and protects their rights.

1.3 The Tribunal is one of the suite of mechanisms that helps to support and protect those rights. Its principal function is to review the condition of patients who are subject to the Act and to consider whether they ought to remain subject to it. The Tribunal's functions are referred to more fully shortly.

1.4 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.

1.5 Some people welcome the support that can be made available under the Act, while 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,

[1] Herein "the Act".

family and whanau and health professionals, and to strike the balance required by the Act. This remains a challenging task.

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;[2]

(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[3] or an Official Visitor;[4]

(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, in their interests, make an application for review to the Tribunal. Consequently, the Tribunal

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

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

2.3 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*".[5] 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.

2.4 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. Depending on the outcome and whether the Attorney-General is the applicant, that 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.

2.5 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, that 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.

2.6 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,

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

after consultation with the Attorney-General, will decide whether restricted patient status should continue.

2.7 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;[6]
- 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 as Convener.

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

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

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

Deputy psychiatrist members

- Dr J. Cavney of Auckland;
- Dr H. Elder of Auckland;
- Dr M. Fisher of Auckland (resigned February 2018);
- 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 the membership of the Tribunal comprised:

- Lawyers: 5
- Psychiatrists: 7
- Community Members: 4
- Total: 16

3.5 The appointment end date for all members is 15 September 2018, but their appointments continue until a successor is appointed.[7]

3.6 This year 131 applications for review were received. In accordance with a long established pattern, a significant number were withdrawn. There were 74 review hearings, including some from applications made in the preceding year.

[7] Section 106 of the Act.

3.7 The number of cases heard by each Tribunal member 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 ensuring a suitable composition.

Members	Number of hearings	%
Legal Members		
James Wilding	16	22
Nigel Dunlop	17	23
Michelle Duggan	7	9
Robyn von Keisenberg	9	12
Robb Newberry	25	34
Total	**74**	**100**
Psychiatrist Members		
Dr Nicholas Judson	20	27
Dr James Cavney	6	8
Dr Hinemoa Elder	6	8
Dr Mark Fisher (Resigned)	4	5
Dr Margaret Honeyman	10	14
Professor Graham Mellsop	16	22
Dr Susan Nightingale	6	8
Dr Peri Renison	6	8
Total	**74**	**100**
Community Members		
Phyllis Tangitu	24	32
Francis Diver	16	22
Kathleen Rose	21	28
Anthony Spelman	13	18
Total	**74**	**100**

Figure 1: Hearings per member in reporting year.

These figures are illustrated in the following three graphs:

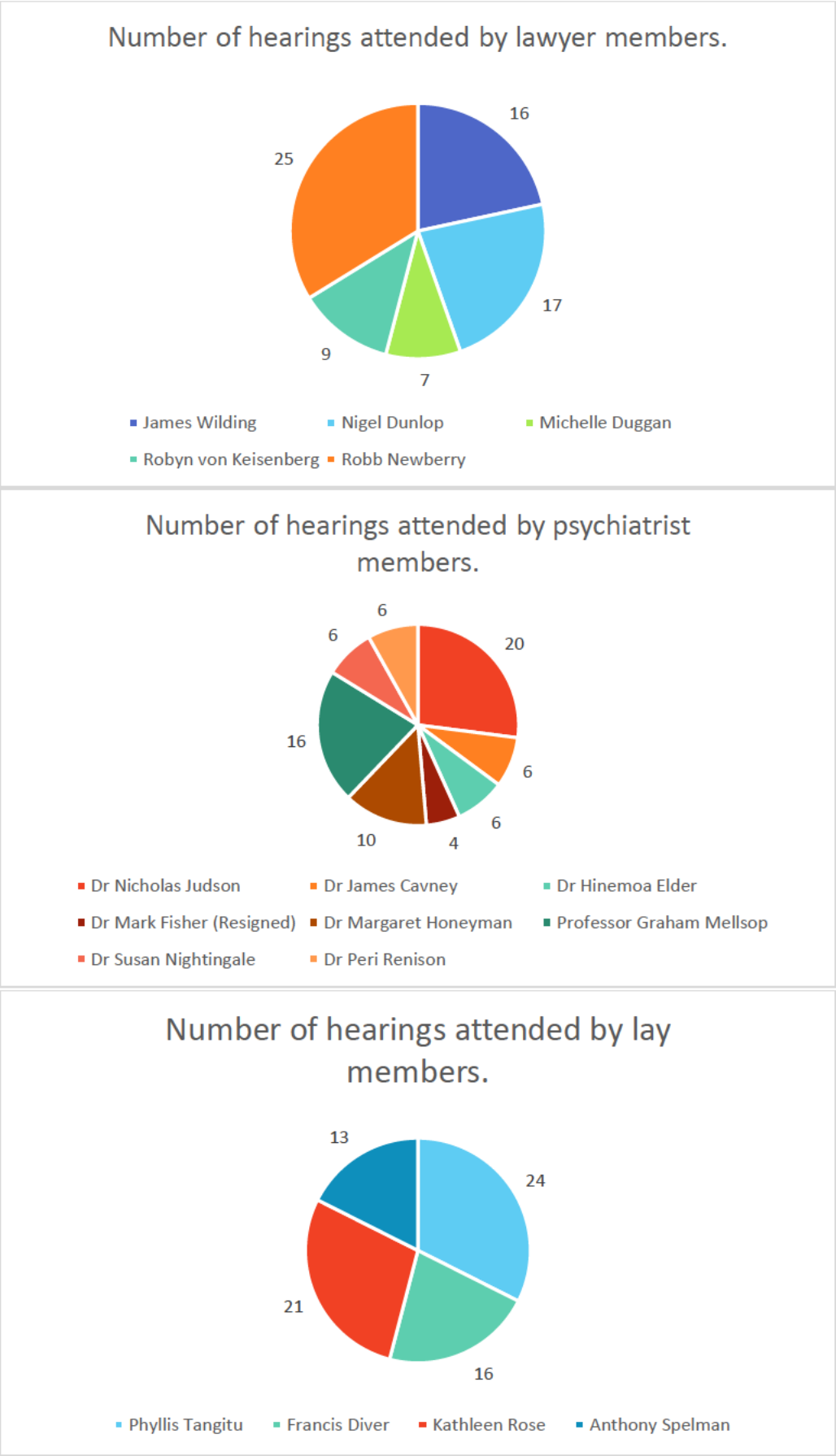


Figure 2: Hearings per member in reporting year.

3.8 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.

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

- Mr Tevita Fakaosi
- Ms Sylvia Ding.

4. The review process

4.1 The review process for ordinary patients is flexible, but is often 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 Convener, 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 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.

4.6 Hearings are conducted in accordance with natural justice. The process is flexible, but tends towards an inquisitorial not an adversarial process. An outline is below.

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

4.7 Hearings commence 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.

4.8 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.

4.9 Sometimes an adjournment will be necessary, for example to enable further medical evidence to be obtained. It may then be necessary to reconvene an in person hearing, but that is not always the so.

4.10 More commonly, a brief oral decision is given after the hearing, but if a matter is particularly complex then the decision is reserved and a written decision is later issued. This tends to be the case with applications involving special patients. When an oral decision is delivered, the Tribunal later issues written reasons.

4.11 Written decisions and reasons are posted to the patient, responsible clinician and certain others, depending on the nature of the application.

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. 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.

4.14 Sometimes, for example because of travel interruptions, a Tribunal member attends by telephone or video.

4.15 Our experience is that there is much that is positive in patients, in their lives and in the support they receive. Family and whanau tend to be very important. We take these aspects into account in our reasoning, even though they cannot all be captured in all of our written decisions.

5. Secretariat

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

5.2 This 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.

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 and a law student, Mr Matt Holden.

5.5 The Tribunal is grateful to the Secretariat for its significant effort. This includes the challenging task of ensuring that the improvements in the longstanding – for many years - delay in the hearing of applications for review is addressed. In this the Secretariat and Tribunal have been successful.

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. The Tribunal extends its thanks to Dr Crawshaw for his support, together with members of his team, in particular Mr Stephen Enright, Mr Bollinger and Ms Webster.

6.5 The Tribunal wishes to particularly record it sadness at the passage in 2018 of the late Ms Helen Wong. Ms Wong provided invaluable support to the Tribunal. It can have been no mean feat to do so for many years, with such good cheer and warmth. She will be missed.

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 and experiences.

7.2 In addition there is ongoing professional development. Plenary meetings are held at least once, sometimes twice, per year, in Wellington, with presentations and discussion regarding topical issues.

7.3 This year, with the support of the Ministry, we were particularly fortunate to receive training in decision-writing from the Honourable Patrick Keane, a former High Court Judge.

8. Statistics

8.1 Relevant statistics are set out below. 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/Ineligible/Withdrew

(a) Applications Received

Section 79

Deemed ineligible:	0
Withdrew during report year:	55
Held over to subsequent year:	0
Held during report year:	64
Total:	**119**

Section 80

Deemed ineligible:	0
Withdrew during report year:	2
Held over to subsequent year:	0
Held during report year:	9
Total:	**11**

Section 81

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

Section 75

Deemed ineligible:	0
Withdrew during report year:	0
Held over to subsequent year:	0
Held during report year:	1
Total:	**1**

Summary of Applications Received

Deemed ineligible:	0
Withdrew during report year:	57
Held over to subsequent year:	0
Held during report year:	74
Total:	**131**

(b) Ineligible Applications

Section 79

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

Section 80

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

Section 81

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

Section 75

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

Summary

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

(c) Withdrawn Applications

Section 79

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

Section 80

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

Section 81

Applications from previous year:	0
Applications from report year:	2
Total:	**2**

Section 75

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

Summary

Applications from previous year:	0
Applications from report year:	57
Total:	**57**

8.2 Figure 3 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.

Year	Applications	Withdrawn 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	44.80
1 July 2012 to 30 June 2013	207	91	44.00
1 July 2013 to 30 June 2014	157	74	47.10
1 July 2014 to 30 June 2015	156	77	49.40
1 July 2015 to 30 June 2016	134	75	56.00
1 July 2016 to 30 June 2017	139	70	50.40
1 July 2017 to 30 June 2018	131	57	43.50
Totals	4172	1692	40.56%

Figure 3. Applications compared with withdrawals during the report year.

The bar graph below illustrates the above table.

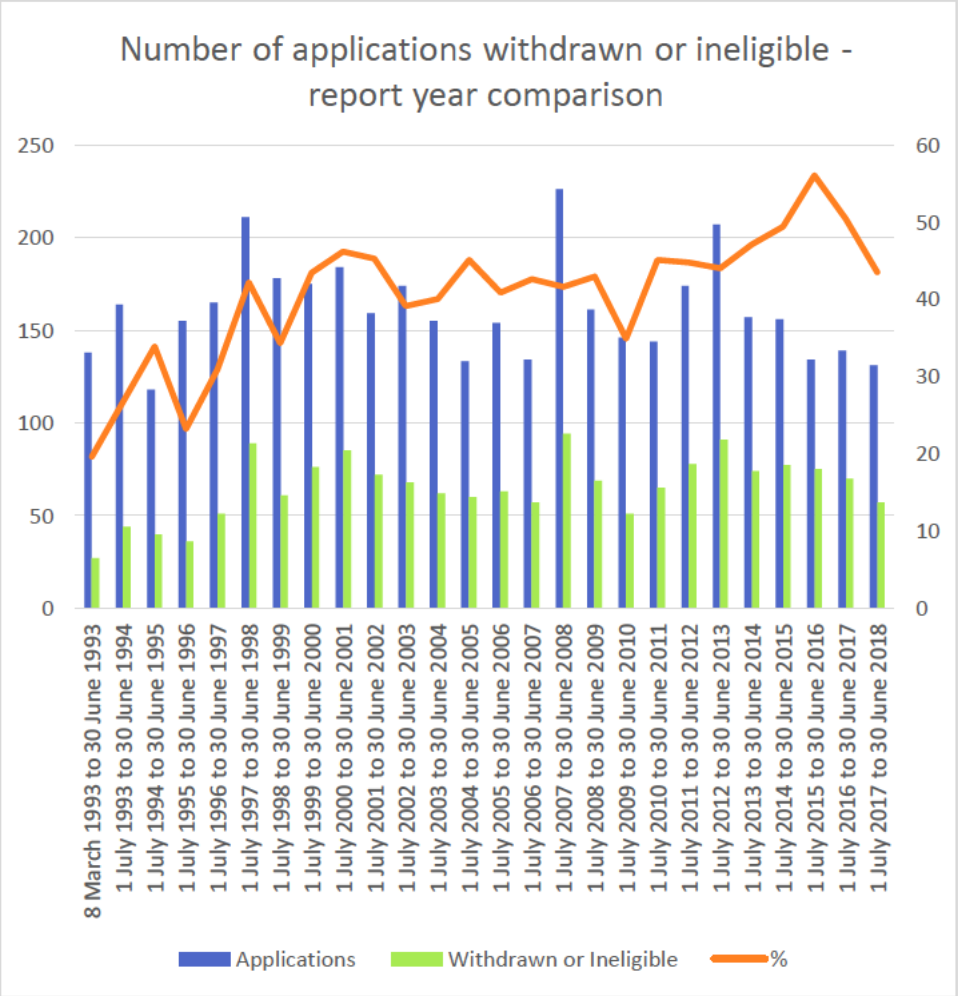


Figure 4. Total applications compared with withdrawn applications during the report year.

Breakdown Between Categories

8.3 Figure 5 illustrates the proportion of special patients, inpatients and community treatment patients for all applications received (including s75 complaint decision referrals):

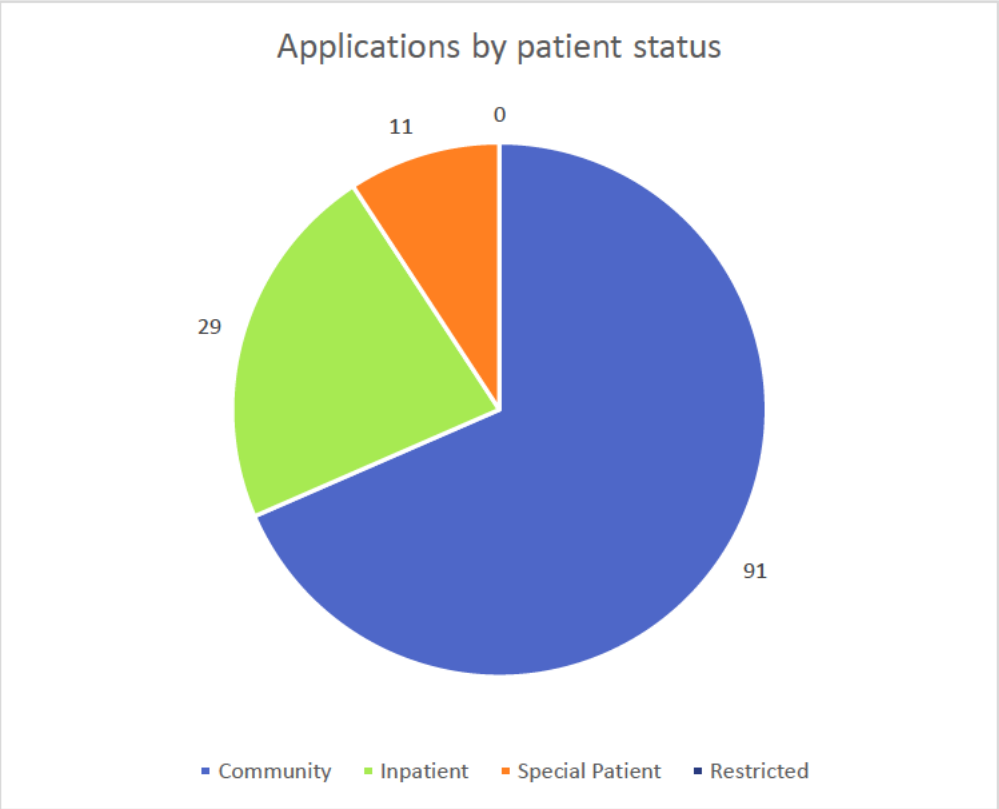


Figure 5. Applications by patient status.

The actual figures were:

Patient Type	Applications
Community:	91
Inpatient:	29
Special Patient:	11
Restricted:	0
Total:	131

Figure 6. Applications by patient status.

Gender

8.4 The number of applications of all descriptions received from male patients was 83 and the number from female patients was 48 (see Figure 7):*

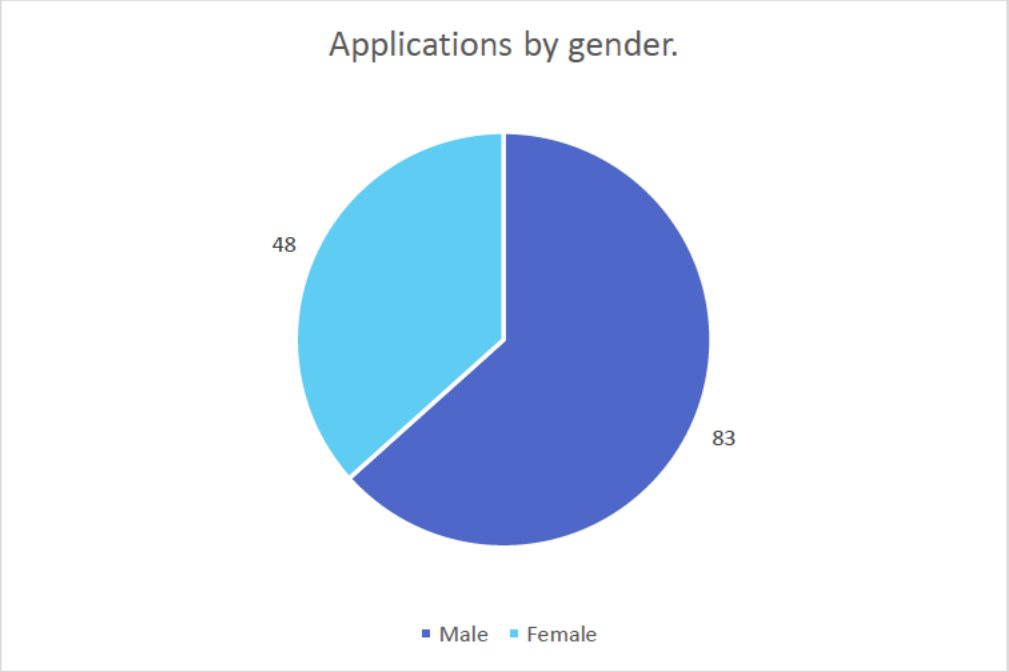


Figure 7. Applications by gender.

*NB: Some patients applied more than once.

8.5 By comparison, 2013 census data[9] of 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.

[9] At the time of writing the 2018 census data was not available.

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

Gender	Total Apps	Community Applications	Inpatient Orders	Special Patient Orders	Restricted Orders
Male	83	53	23	7	0
Female	48	38	6	4	0
Total	131	91	29	11	0

Figure 8. Applications by gender and patient type.

These figures are illustrated in the following graph:

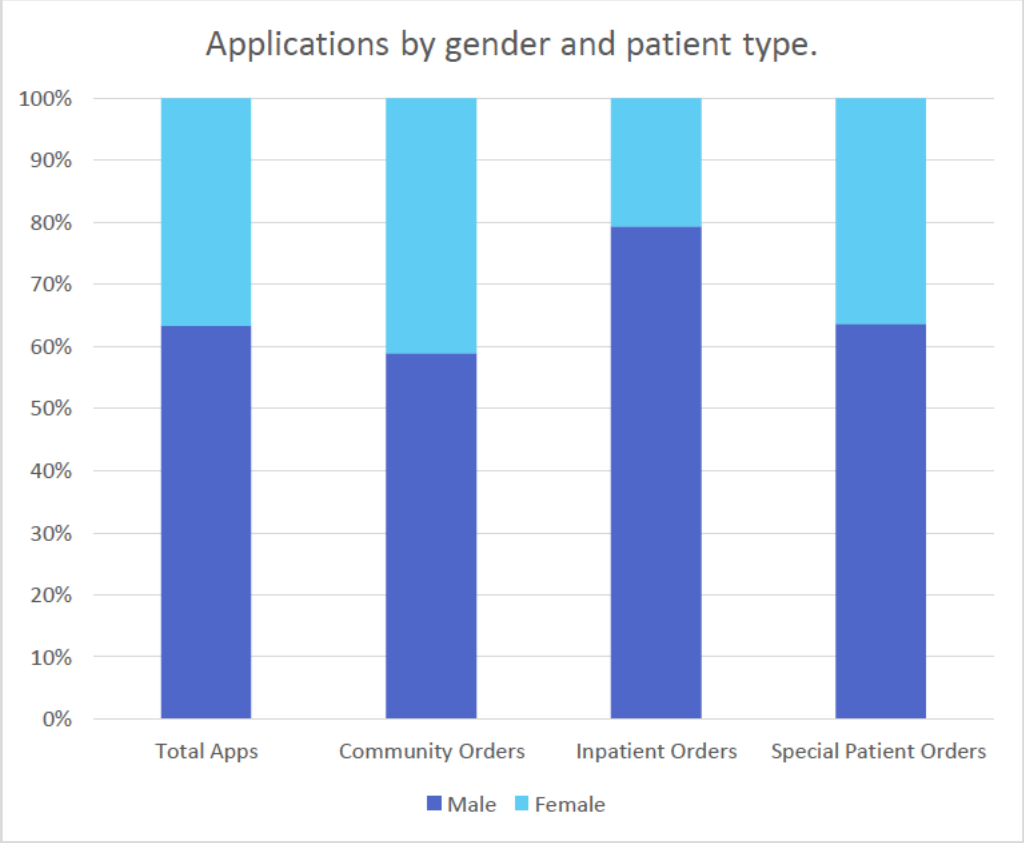


Figure 9. Applications by gender and patient type.

Ethnicity

8.7 Of the 131 applications received, 109 (83%) presented an identifiable ethnicity through their applications. The 131 applicants for whom data has been recorded have been broken down in Figure 11. The percentages do not reflect the actual ethnic breakdown over the year because some patients did not present an identifiable ethnicity.[10] The comparative figures in the final column are from 2012 Statistics New Zealand census data for the age 20 – 69 (inclusive) population range into which nearly all patients fall.

Ethnicity	Number	%	Comparison with 2013 population census data
African	6	4.58	-
Asian	5	3.817	11%
NZ European	68	51.91	67%
Maori	18	13.74	13%
Pacific Island	7	5.344	7%
Other	5	3.817	2%
Unknown	22	16.79	-
Totals	131	100	100

Figure 10. Applications by ethnicity.

[10] A person does not have to disclose his or her ethnicity.

These figures are illustrated in the following graph:

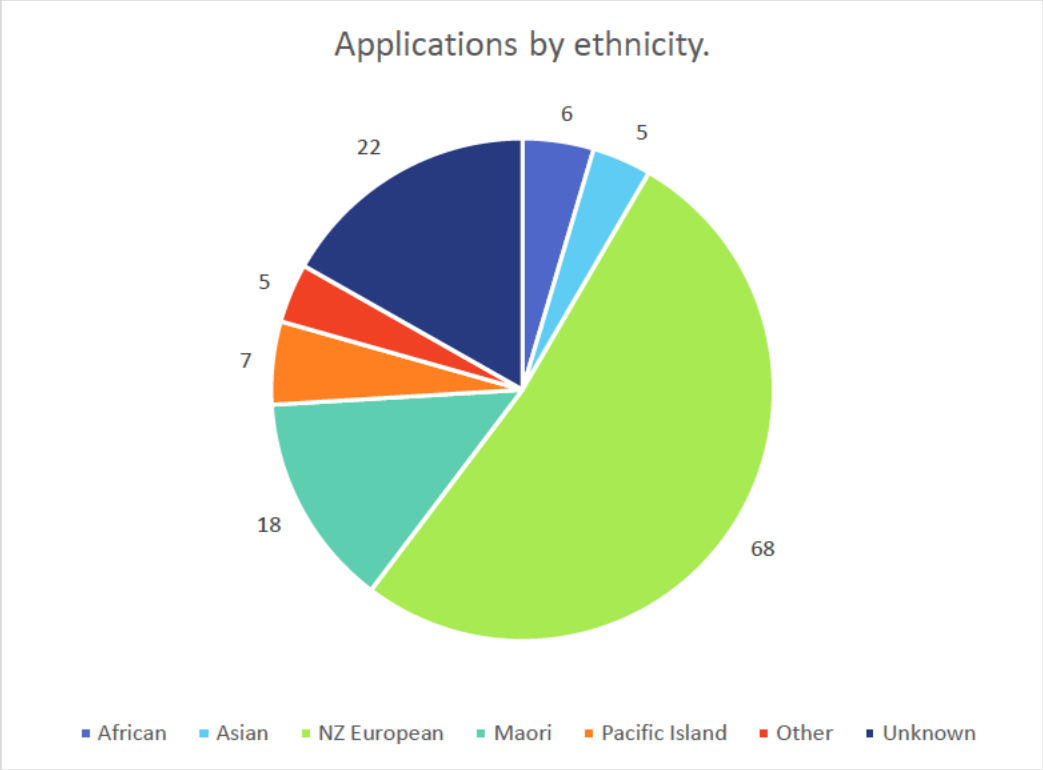


Figure 11. Applications by ethnicity.

Hearings Held during report year

Section 79 Applications:

From previous year:	5
From report year:	59
Total:	**64**

Section 80 Applications:

From previous year:	0
From report year:	9
Total:	**9**

Section 81 Applications:

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

Section 75 Applications:

From previous year:	0
From report year:	1
Total:	**1**

Summary of Hearings Held:

From previous year:	5
From report year:	69
Grand Total:	**74**

Numbers Found Fit to be Released

8.8 Of 63 s79 applications determined, 5 applicants (7.9%) were found fit for release, 58 applicants (92.1%) were not fit to be released. Of 9 Special Patient applications heard, 1 (11%) was found fit to be released, and 8 (89%) were found unfit for release.

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
2017-2018	63	58	92	5	8
Total	1248	1178	94.4	79	5.6

Figure 12. Apps heard vs apps received.

These figures are illustrated in the following graph:

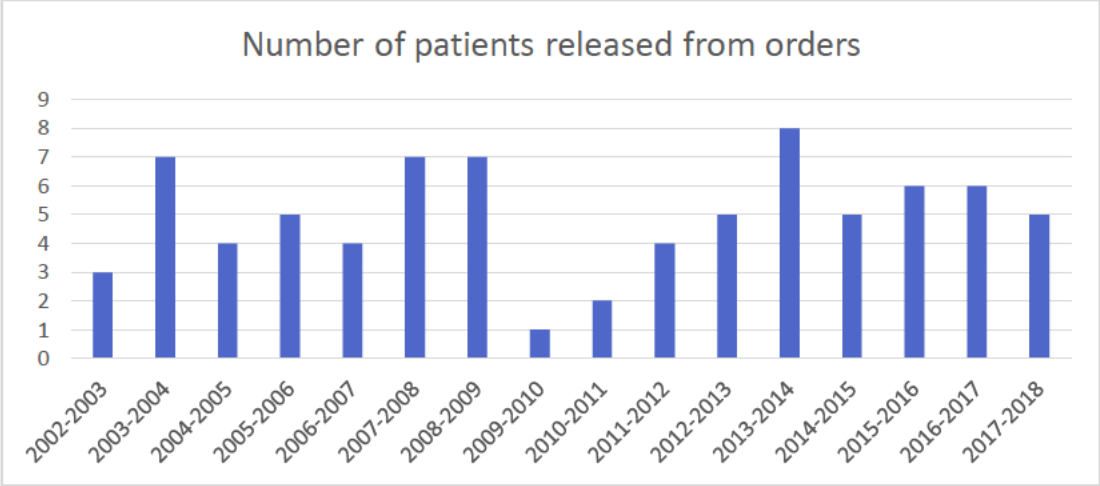


Figure 13. Patients released.

Special Patients

8.9 Recommendations for a change in status were made in 1 of the 9 hearings held during the report year. The equivalent figures since the Act came into force are:

Year	No. Of Cases	Special Patient Status Should Continue	%	Special Patient 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
2017-2018	9	8	89	1	11
Total	171	141	82.4	30	17.6

Figure 14. Special patients heard and our opinion.

Applications by region

8.10 The district health boards responsible for the care of patients in respect of whom applications were received, together with the number of applications and the number of withdrawals prior to determination, are shown in Figures 15 and 16:

Location	No. of Apps	Heard	W/D or Ineligible
Northland	4	2	2
Waitemata	15	11	4
Auckland	7	4	3
Counties Manukau	7	3	4
Waikato	11	7	4
Bay of Plenty	3	2	1
Lakes	3	2	1
Taranaki	3	3	0
Hawkes Bay	3	0	3
Whanganui	2	0	2
Mid Central	1	1	0
Wairarapa	1	1	0
Hutt Valley	5	5	0
Capital & Coast	24	12	12
Nelson Marlborough	7	2	5
West Coast	0	0	0
Canterbury	28	15	13
South Canterbury	0	0	0
Southern	7	4	3
Totals	131	74	57

Figure 15. Hearings by region.

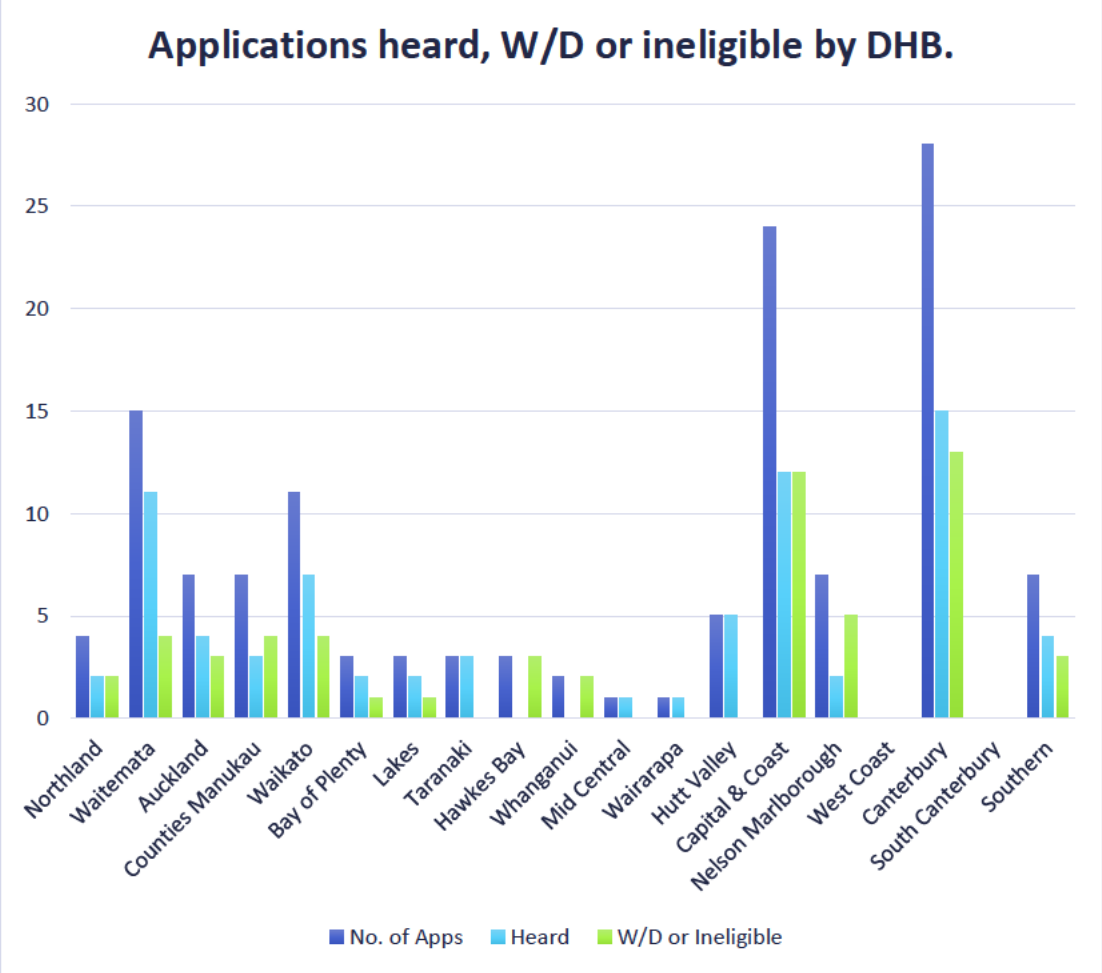


Figure 16. Hearings by region.

Video Conferences and Telephone Conferences

8.11 Figure 17 illustrates the proportion of hearings (of all descriptions) heard by way of video conference during the report year. Of the 72 hearings, one was 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	4.20%
2005/2006	4	3.60%
2006/2007	6	8.60%
2007/2008	2	1.90%
2008/2009	3	3%
2009/2010	4	5.50%
2010/2011	2	2.50%
2011/2012	1	1.20%
2012/2013	2	2.60%
2013/2014	0	0%
2014/2015	2	2.90%
2015/2016	3	4.20%
2016/2017	2	3.20%
2017/ 2018	1	1.60%

Figure 17. Hearings via video conference.

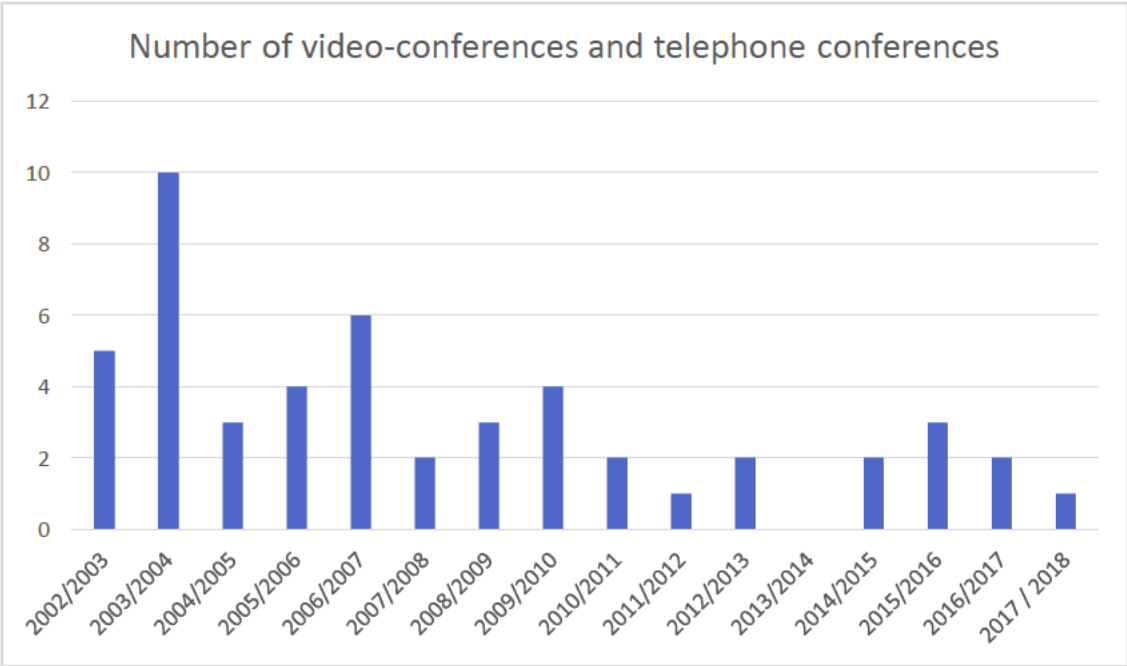


Figure 18. Hearings via video conference.

Appointments Pursuant to ss 59 and 60

8.12 This reporting period 19 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.

9. Timeliness

9.1 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.

9.2 For a long time, the Tribunal has failed to meet those timeframes, in a very significant percentage of cases. 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.

9.3 In some cases delay was sought or consented to by a patient, for example so that he or she could arrange a lawyer or obtain a second opinion, or to prepare more fully.

9.4 From July 2016 there has been major focus on addressing longstanding delay in the hearing of applications. This has involved effort by many, including patients, their counsel, health professionals, the Secretariat and all Tribunal members, and with the support of the Ministry.

9.5 Pleasingly, substantial progress has been made. Currently, over 90% of applications are heard within 28 days (See figure 20, orange line). We are grateful to all involved for their commitment to addressing timeliness.

Report Quarter	Total Applications	Withdrawn	Heard/ Going Ahead	Heard Within 28 Days	%
1 Jan 2015 - 31 Mar 2015	41	20	21	2	9.50
1 Apr 2015 - 30 Jun 2015	35	13	22	2	9.00
31 Jul 2015 - 30 Sep 2015	19	9	10	0	0.00
1 Oct 2015 - 31 Dec 2015	48	23	25	5	20.00
1 Jan 2016 - 31 Mar 2016	29	19	10	1	10.00
1 Apr 2016 - 30 Jun 2016	38	22	16	3	19.00
31 Jul 2016 - 30 Sep 2016	34	17	17	7	41.00
1 Oct 2016 - 31 Dec 2016	23	10	13	8	62.00
1 Jan 2017 - 31 Mar 2017	40	23	17	11	65.00
1 Apr 2017 - 30 Jun 2017	42	17	25	19	76.00
31 Jul 2017 - 30 Sep 2017	37	12	25	23	92.00
1 Oct 2017 - 31 Dec 2017	41	15	26	19	73.00

1 Jan 2018 - 31 Mar 2018	36	16	19	17	89.00
1 Apr 2018 - 30 Jun 2018	40	15	22	20	91.00

Figure 19. Hearings heard within 28 days.

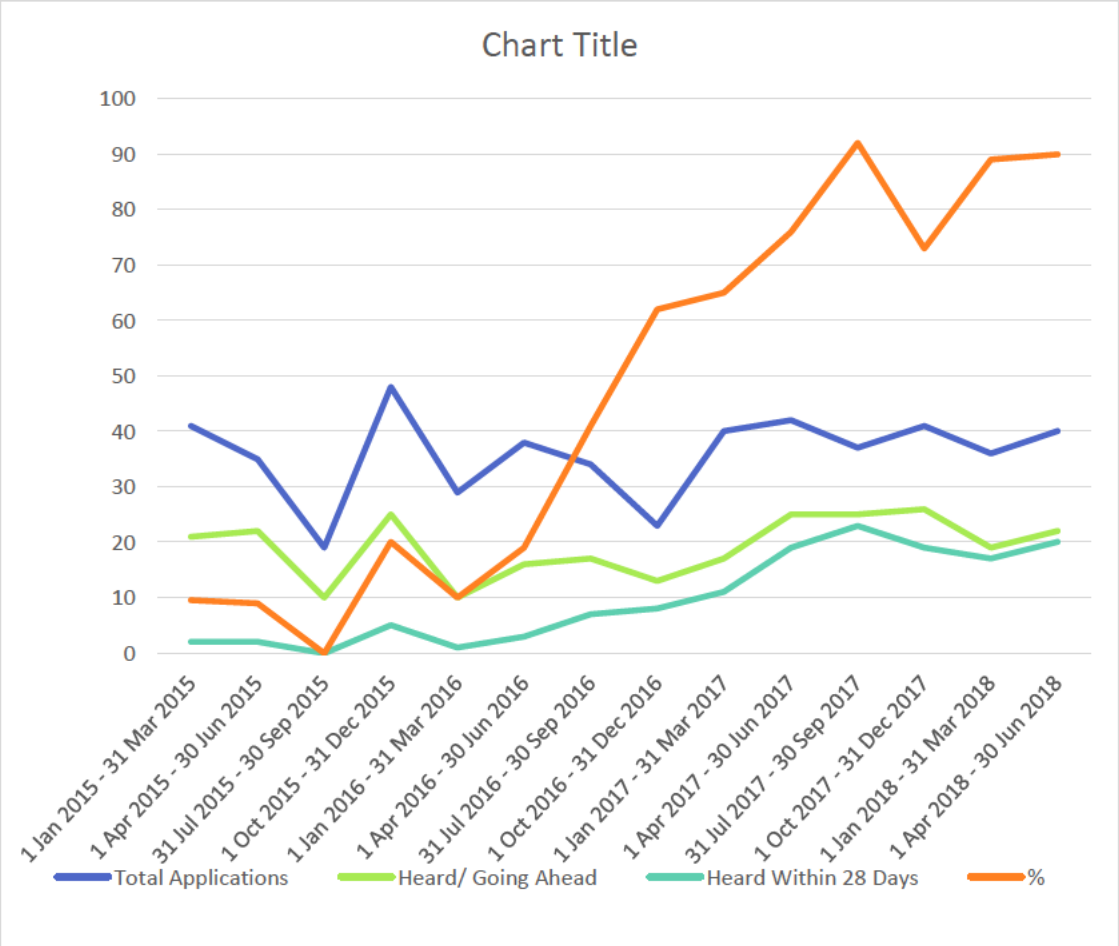


Figure 20. Hearings heard within 28 days.

10. Cultural identity and personal beliefs

10.1 The Act expressly requires those exercising powers under it to do so with proper respect for the cultural identify and personal beliefs of the patient.[11] This includes exercising powers:

- with proper recognition of the importance and significance to the person of the persons ties with his or her family, whanau, hapu, iwi and family group;
- with proper recognition of the contribution those ties make to the person's wellbeing;

[11] Sections 5 and 65 of the Act.

- with proper respect for the person's cultural and ethnic identify, language and religious or ethical beliefs.

10.2 Meeting those will also be part of ensuring that the patient receives his or her right to medical treatment and health care appropriate to his or her condition.[12]

10.3 In a number of reviews inadequate account appears to have been taken of those factors by some of those involved in a patient's care, a matter about which some patients have expressed concern. Associated with that, it is clear that, particularly for some patients in inpatient care, their ties to family and whanau who live in other regions is not well catered to.

11. Publication of Decisions

11.1 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.

11.2 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.

11.3 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.

11.4 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.

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

[12] Section 66 of the Act.

11.6 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 anonymized;
- they will be sent only to three established professional and responsible publishers, namely Brookers (Thomson Reuters), LexisNexis and the New Zealand Legal Information Institute.

11.7 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/ . A further five are soon to be published. A focus of the 2018-2019 year will be to add significantly to the body of published cases.

12. Website

12.1 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

12.2 The website contains relevant information, including a suite of Policy and Practice notes and Guidelines. Most were updated in 2015. The guidelines for report writers (responsible clinicians) were updated in 2018.

13. Conclusion

13.1 The Tribunal considers that it has operated effectively in its role of reviewing the condition of patients, and in so doing helping to protect:

- 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.

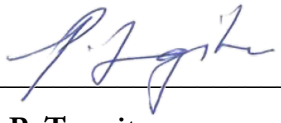
13.2 It has been able to do so in a timely manner, with the support of all of those involved in review processes.

13.3 For the year to 30 June 2019 the Tribunal wishes to, amongst other things:

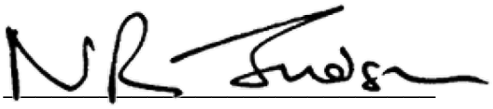
- maintain its progress in addressing delay;
- focus more closely on the cultural identity and personal beliefs of patients;
- publish cases more frequently.

24 October 2018.

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



Ms P. Tangitu
Mental Health Review Tribunal



Dr N. Judson
Mental Health Review Tribunal