2017/18

Annual Report

Mental Health
Review Tribunal

The Hon Tanya Davies MP
Minister for Mental Health
Parliament House
Macquarie Street
SYDNEY NSW 2000

30 October 2018

Dear Minister

I enclose the Annual Report of the Mental Health Review Tribunal for the period from 1 July 2017 to 30 June 2018, as required by section 147 of the *Mental Health Act 2007*.

Yours sincerely

His Honour Judge Richard Cogswell SC
PRESIDENT

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THE VALUES WE BRING TO OUR WORK

The Mental Health Review Tribunal is an independent Tribunal that plays an important role in safeguarding the civil liberties of persons under the Mental Health Act, 2007 and in ensuring that people living with mental illness receive the least restrictive care that is consistent with safe and effective care. In exercising its functions and its jurisdiction under the law, the Tribunal adopts the following values:

- *Our independence as a decision maker is paramount and our decisions shall at all times be arrived at independently and free from improper influence;*
- *We acknowledge the importance of the objects of, and principles for care and treatment contained in, the Mental Health Act, 2007 and of our role in promoting and giving effect to those objects and principles;*
- *We acknowledge and respect the dignity, autonomy, diversity and individuality of those whose matters we hear and determine, and our important role in protecting their civil liberties;*
- *Procedural fairness is to be accorded to all persons with matters before the Tribunal;*
- *Courtesy and respect are to be extended at all times to all persons that we deal with;*
- *We acknowledge the importance of our procedures being transparent to the public;*
- *We acknowledge the importance of open justice and also the need to balance this with considerations of individual privacy and confidentiality where appropriate;*
- *Our work is specialised and requires a high level of professional competence as well as ongoing training, education and development for members and staff;*
- *We value our members and staff and will continually strive to maintain a supportive, efficient and enjoyable working environment where the dignity and the views of all are respected and where appropriate development opportunities are available;*
- *As a key stakeholder in the mental health system in New South Wales we shall, where appropriate, seek to promote, and to engage collaboratively with other stakeholders and agencies in promoting, the ongoing improvement of mental health services in New South Wales.*

THE WORK THAT WE DO

The Tribunal has some 47 heads of jurisdiction, considering the disposition and release of persons acquitted of crimes by reason of mental illness; determining matters concerning persons found unfit to be tried, and prisoners transferred to a mental health facility for treatment; reviewing the cases of detained patients (both civil and forensic), and long-term voluntary psychiatric patients; hearing appeals against an authorised medical officer's refusal to discharge a patient; making, varying and revoking community treatment orders; determining applications for certain treatments and surgery; and making orders for financial management where people are unable to manage their own financial affairs.

In performing its role the Tribunal actively seeks to pursue the objects of the Mental Health Act 2007, including delivery of the best possible kind of care to each patient in the least restrictive environment; and the requirements of the United Nations principles for the protection of persons with mental illness and the improvement of mental health care, including the requirement that 'the treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff'.

PRESIDENT'S REPORT

Our staff and members

Members often say to me how much they enjoy working for this Tribunal. They are also very complimentary about the support they receive from our staff. The Tribunal's staff have had to cope with more challenges than usual over the last year. They have included an upgrade to our client database, staff changes, staff shortages, the Review of the Forensic Division as well as preparing to hand over the Forensic Victims Register to the new victims' support unit. Our staff are cheerful, responsible and committed. They are led by a Registrar renowned for his efficiency. I have observed first hand a great integrity and clarity in his dealings with staff, members, patients and others who come into the Tribunal's orbit. We have two outstanding Deputy Presidents who bring to the Tribunal extensive legal experience, intellectual rigour and a very sound understanding of the mental health sector's people, policy and patients. They are daily a great support to me.

I am hardly an unbiased bystander, but I see a Tribunal that is efficient, flexible, balanced and effective. This is because the people who make it up do their best to act with integrity, fairness and compassion. We do not claim to be perfect. But we do work well.

Our members bring to the Tribunal commitment, engagement in a cause they value, professional expertise, life experience and an appreciation of the role they are playing and its impact on people's lives. Some put aside other more remunerative work they could be doing. This financial year we worked hard with the Minister for Mental Health for an increase in their fees - the first since 2010! (It is gratifying to see that shortly after the end of the financial year, the increase was approved.) Our members are mature, well qualified and experienced citizens offering themselves to this public service.

Our work

The work we do touches people's lives in terms of basic freedom and public expectations of security. People don't want unwell loved ones deteriorating, taking their own lives or threatening the safety of the family or other people. On the other hand, none of us welcomes detention or compulsory medication with unpleasant or hazardous side effects. But such decisions are made on a daily basis by panels of Tribunal members. They make orders compelling fellow citizens to remain separated from their loved ones, to be monitored in the community by a case manager or to have treatment such as antipsychotic medication or electroconvulsive therapy that most of us would regard as quite extreme. Members make these orders after a robust process of information-gathering, questioning, listening, consultation and consideration. They draw on their own professional expertise as psychiatrists and lawyers or their life and professional expertise as other members.

The Review and Victims

The Review of our Forensic Division by the Honourable Anthony Whealy QC was completed comprehensively and efficiently. We welcomed the Review, as should any institution exercising the powers that we do. We provided material, data and submissions. We cooperated as fully as we could in the Review. It is fair to say that the main recommendations concerned victims. That is hardly surprising, given what prompted the Review was expressed dissatisfaction by victims concerning leave and release decisions.

Let me make some observations about the outcome of the Review. First, one of the major recommendations was the establishment of a victims' support unit separate from the Tribunal. This idea was proposed by us to the Review. Indeed, the idea originated from Deputy President Anina Johnson after a visit to Queensland in 2016. We are delighted that this recommendation has been given priority by the Government.

Secondly, the Review found that the "legislative test for leave and release is appropriate and that the Tribunal applies a rigorous approach to assessing risk and safety, making decisions on leave and release conservatively and responsibly." The Review also found, however, that the "system is weighed too heavily towards the interests of patients without adequate consideration for the safety and interests of the victims." There is a natural tension here. The legislation requires us (appropriately) to focus on the wellness, rehabilitation and any risks posed by patients. On the other hand, the event that brought the forensic patient into the system has often had a substantial impact on the lives of others. Many lives can be affected by an event that can itself be a tragedy: one is the life of a very unwell person who needs treatment and rehabilitation; the others are the lives of innocent persons (sometimes a stranger and sometimes an intimate) who have been drawn into the other's web of unwellness. In a jurisdiction whose statutory mandate is to foster recovery, rehabilitation and wellness of the patient, others may feel aggrieved if the process goes on without their suffering being at least acknowledged.

Speaking for myself as a presiding member on panels, I am conscious of the experience of registered victims who choose to sit in on hearings. They hear references to the "index event" that for them involved the death or injury of a loved one at the hands of the patient being reviewed. They are there to observe and not comment on discussions of the progress and rehabilitation of that patient. I am describing and acknowledging the natural tension in the process our hearings involve, not advocating for any changes beyond those recommended by the Review. I am pleased to see that one recommendation of the Review is an opportunity, when appropriate, for victims to ask questions at hearings. Such an opportunity, managed with discretion and moderation by presiding members, acknowledges the reality of a suffering human being, linked intimately to the events, but now a passive observer to the process.

Not all victims ask for this recognition. Some want nothing further to do with the patient or the Tribunal processes. Others become involved, but in support of the patient who is a member of their family or in some other way intimately connected.

The integrating into our processes of more acknowledgement to victims throws up the issue of procedural fairness. Some victims will want to see the impact of the event on them reflected in orders made by the Tribunal. A victim will want the Tribunal to make orders which restrict the patient's movement or associations within the community. This is appropriate. But some victims may wish the Tribunal to make such an order impacting on the patient without the Tribunal disclosing to the patient the victim's submission. That is a decision which would be made in each instance by the particular panel. It is sometimes straight forward: a victim will not want a patient to know where they live and work. At other times, it will be less obvious and will involve considering the inherent fairness of providing an opportunity for a patient to comment on the terms of an application for an order restricting their freedom. People who exercise public power are expected to provide to a person who will be unfavourably impacted by the exercise of that power an opportunity to have their say. We feel aggrieved if the local council, without checking with us first, exercises its power in a way that impacts on our amenity.

Occasionally (and, again, understandably) victims expect from the Tribunal a "guarantee" that a patient's leave or release will go without any hitch. The Tribunal is not in the business of offering guarantees; we are in the business of making orders based on the likelihoods shown by tested evidence and expert opinions to a rigorous statutory standard. Gone are the days when society "guaranteed" its own safety by locking up the unwell indefinitely.

Public and press access

We are one of the few (if not the only) Mental Health Review Tribunals in the nation to hold open hearings. Patients and participants (including victims) are protected by laws prohibiting them being identified. Openness

and transparency comprise a healthy context for the exercise of power. They encourage intellectual honesty, procedural fairness, accountability in the decision-makers and confidence in the process by the participants.

This includes press scrutiny of proceedings. On one occasion I permitted a journalist to attend a hearing by telephone where the patient requested it. Courts are used to striking the balance between public access and not identifying the individuals in proceedings. As I have pointed out on occasion, often the act that brought about a forensic patient's charging by the police and movement through the courts into our jurisdiction involved a very significant and, at times, tragic public breach of the peace. The press have a legitimate interest in such events and in the ongoing monitoring of the patient by the Tribunal and any leave or release of such a patient. On the civil side of our jurisdiction, open Tribunal hearings also guard against the potential abuse of power in the name of psychiatry, which has tragically occurred in this State's past. Just as police officers can be asked to explain in a public forum why they exercised their power to detain a citizen, so should psychiatrists be liable to explain to the public and loved ones why they scheduled a patient and are now asking the Tribunal to exercise its power to further detain that citizen. As well as these public interests, there is also of course the interest all of us have in maintaining the privacy of our personal health information.

Parliament has struck a balance between the public interest of transparency in dealing with such issues and the public interest of the wellness, rehabilitation and reintegration into the community of the patient. The balance struck by Parliament to accommodate these interests is that people (including the press) may view the proceedings, but not identify the patient. The Tribunal is not a private unaccountable institution. Its accountability is supported by open hearings and articulated reasons for its decisions. One role of the press is to hold public bodies accountable for the exercise of their power. In acknowledgement of this role, the Tribunal has added a more user-friendly page to its website on public and press access to hearings.

Tribunal's role in reviewing treatment

Deputy President Maria Bisogni is developing a paper emphasising the importance of patient-focused and trauma-informed hearings. She has also, with the Executive's support, examined on a statutory and common law basis, the role of the Tribunal to critically review the treatment, including medication, being offered to a patient. The Tribunal's health professionals are not treating the patients; but they do have an important role in assessing or testing the efficacy of the treatment that patients are required by our orders to undergo.

Farewell

The three year term I was appointed to serve will expire on 28 February 2019. Earlier this year I advised Minister Davies that I would not be seeking a further term. She has undertaken in a timely way the process of finding my successor.

As I have made clear, my retirement has to do with embracing the next stage of my life. Such a decision comes with a cost. I have loved the job, the work I do and the people I work with. It has been a real privilege to lead this Tribunal. Its work is challenging and important. It concerns fundamental issues for any society: How will it deal with its members who are ill or disabled (or both)? How will it manage them if they are a risk to themselves or others? How will it respond when the risk materialises to a serious transgression? We should be proud of how our State has answered those questions and how the NSW Mental Health Review Tribunal enacts those answers. I am proud to have been part of that process for the last three years.

His Honour Judge Richard Cogswell SC
President
9 October 2018

FORENSIC DIVISION REPORT

It has been a busy but positive year in the Forensic Division.

Report of the Hon Anthony Whealy QC

President Richard Cogswell SC has already referred to outcomes of the Report of the Review of the Mental Health Review Tribunal in respect of forensic patients (the Forensic Review) undertaken by the Hon Anthony Whealy QC at the request of Minister Davies. The Tribunal was regularly consulted in the course of the Review and welcomed this independent scrutiny of its work.

The Tribunal will be working with the Ministries of Health and Department of Justice to consider and implement the recommended changes in the coming year, and to respond to any legislative changes.

The Tribunal has improved the information available on its website, as recommended by Mr Whealy. The Tribunal is also actively overseeing the technology available at venues where the Tribunal sits. If the technology does not allow victims and members of the public to see and hear Tribunal hearings, the Tribunal will request that it be upgraded.

Victims

The Forensic Division assumed responsibility for managing the Forensic Patient Victims Register in September 2008, taking over from the Forensic Executive Support Unit of Justice Health. The Tribunal took on the role of notifying victims of upcoming hearings, facilitating their attendance at hearings, and advising the outcomes of those hearings. Over the years, victims have often developed good relationships with Registry staff, although the Tribunal acknowledges that some victims have been very disappointed in the decisions and work of the Tribunal.

There has always been an inherent tension in the Tribunal's registry staff being the liaison point with victims. Some victims see registry staff as the decision makers or at least able to influence the decision makers. Registry staff are unable to provide victims with advice on the likely outcome of Tribunal hearings or what to include in submissions. As a result, despite the best efforts of victims advocacy groups, some victims have felt unsupported.

As Judge Cogswell SC has said, the Tribunal is delighted that the Specialist Victims Support Service (SVSS), recommended by the Forensic Review, will commence operation in the next financial year. The Tribunal has been a consistent advocate for a service of this kind. The SVSS will offer holistic advice and support to victims, including facilitating victim involvement in Tribunal hearings, and victim understanding of the forensic system generally. Offering reassurance, information and support to victims will also have positive outcomes for forensic patients as they continue their journey of recovery.

In the next financial year, the Tribunal's Forensic Division will work closely with Victims Services, to arrange a hand over of the Victims Register and to develop the arrangements for the SVSS to support victim participation in Tribunal hearings and throughout the Court processes which occur prior to the Tribunal's involvement.

The Tribunal is also delighted that the government has supported legislative changes to allow a victim impact statement to be made where an accused person is dealt with under the *Mental Health (Forensic Provisions) Act 1990*. This is an important reform, originally recommended by the Law Reform Commission in 2013.

As these changes unfold, the Tribunal will continue to meet regularly with representatives from victim support groups, the Victims of Crime Interagency Forum and Victims Services.

Recovery is possible

The Tribunal's Forensic Division sees many positive stories of people with forensic histories who have worked hard to build contributing lives.

Forensic Case Study - Mr A

In 2006, Mr A was found not guilty by reason of his mental illness of a serious violent offence. He had first received psychiatric care nearly 30 years previously. He grew up in difficult circumstances and had a long history of using substances.

During the court process, he was detained in custody and was then transferred to the forensic unit of Morisset Hospital. He engaged in the programs available at the Hospital, including drug and alcohol counselling. Over the next few years, he had increased access to the community through incremental grants of leave ordered by the Tribunal. In 2011, a request was made for overnight leave in the community, with housing and support offered by a NGO. In 2013, the Tribunal allowed Mr A to live in his own Housing NSW accommodation full time, with the support of the local community mental health team.

Mr A has now been clean for 13 years and mentally well. He continues to work closely with the community mental health team psychiatrist and case manager. He displays good insight into his mental health and the need to take medication. He has reconnected with his aunt and uncle and sees them regularly. He has also made friends amongst his neighbours. Mr A is a keen member of a local craft club and is passionate about the live music scene. In the past two years, he has managed to save enough for an overseas holiday – his first in 30 years. Mr A told the Tribunal that he now has the best life that he has ever had.

Mr A continues to be reviewed regularly by the Tribunal.

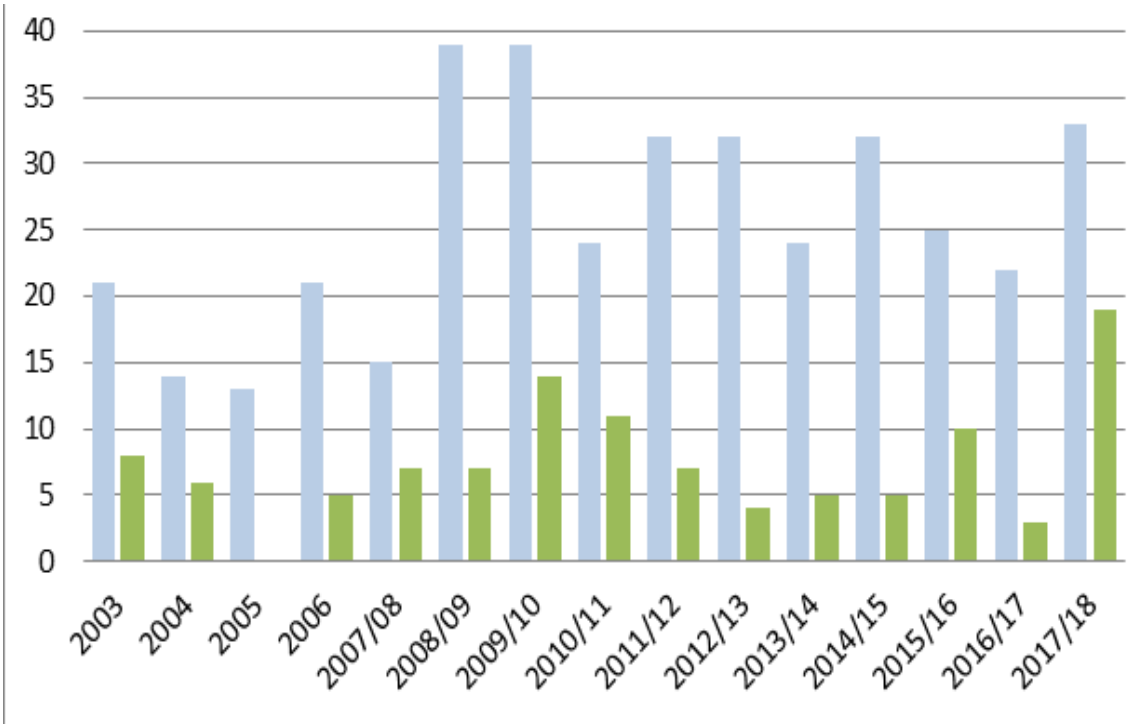
Forensic patients and their whereabouts

There were 33 new findings of Not Guilty by Reason of Mental Illness (NGMI) made in this financial year (50% more than the 22 new NGMI forensic patients last year). See Table 16.

As at 30 June 2018, there were 616 forensic and correctional patients in NSW, an increase of 8.8% from 2016-2017 (see Table 33).

The information in Table 30 relates to forensic and correctional patients. When looking at the information for the 448 forensic patients alone, about 36% live in the community under conditions of release approved by the Tribunal. About 48% of the forensic patients are detained in a mental health facility and about 16% remain in custody.

The other noticeable change this financial year was a significant increase in the number of unconditional release orders. This year 19 unconditional release orders were made, in contrast to 3 such orders made in 2016/17 and 10 unconditional release orders in 2015/16. The numbers fluctuate significantly as the graph shows. In all forensic patient numbers continue to increase.



The reasons for the increase in unconditional release applications this year are likely to be a combination of factors, including a more assertive approach on the part of the Mental Health Advocacy Service and case managers in bringing applications. The Tribunal is also regularly making Community Treatment Orders (CTO) as part of unconditional release applications (13 of the 19 unconditional release orders involved a CTO). Where appropriate, a CTO offers a step down from a forensic order to a compulsory treatment regime under the *Mental Health Act 2007*.

Each Tribunal decision is based on the individual aspects of a person's case, so that general comments about those who were unconditionally released are difficult to make.

Of those unconditionally released, two had been found not guilty by reason of mental illness of the offence of murder. For these patients, the act occurred more than 17 years ago. A further four people had been found not guilty of acting with an intention to murder. On average it was more than 13 years since the forensic act for these patients. The remaining 14 forensic patients were found not guilty by reason of mental illness of offences such as robbery, a sexual assault, dangerous driving or cause malicious damage by fire.

All patients had recovered to the point where the Tribunal was satisfied, with the benefit of an independent expert report, that the person would not seriously endanger themself or the public.

Lengthy waits in custody for forensic mental health beds

There are often lengthy delays before the court process is finalised. Historically in NSW, mentally ill people who are refused bail spend this time in custody, rather than in a mental health facility. Even after the Court proceedings have concluded, there are still lengthy waits for forensic patients to be admitted to a mental health facility.

Delays in admission to a mental health facility mean that patients struggle to maintain optimism and hope for the future, which are key components to a successful recovery. Patients learn prison coping mechanisms that can take years to unlearn. For a forensic patient, time spent in prison is not merely treading water. All too often, the forensic patient is going backwards. Where a person has not been convicted of an offence, this is unconscionable.

There are currently 27 male forensic patients waiting in custody for a bed in the Forensic Hospital. This is an increase from 25 patients last year and 20 in 2015-2016.

Justice Health has acknowledged that on average, 15 male forensic patients and six female patients are admitted to the Forensic Hospital every year.

It is no surprise then that many patients wait between 18 months to two years for admission to the Forensic Hospital after their court proceedings have finished. Nine people were still in custody on 30 June who had waited more than 18 months for admission to the Forensic Hospital after their court proceedings had finished.

Waiting times for admissions to the medium or low secure beds had improved since the last financial year. As at 30 June, only 10 patients were waiting for a bed, a significant drop from the 17 patients assessed as ready for a less restrictive setting last year. Two patients had been waiting for a place at a medium secure unit since January 2018, while the balance were found to be suitable for transfer in April or May 2018.

Time limited orders

When the clinical evidence suggests that a transfer of a forensic patient to a less restrictive environment would be appropriate, the Tribunal's usual order is to transfer when a bed becomes available, and in the meanwhile to order the patient's detention in the more restrictive setting.

However the Tribunal retains the power to make an order that a forensic patient be transferred within a specified time frame ("a time limited order").

In the last financial year, 11 time limited orders have been made for patients to be transferred to the Forensic Hospital and a further three orders have been made for patients to be transferred to other facilities. In all, this is 31.8% of the transfer orders made by the Tribunal during the year (Table 21).

Other improvements to the forensic mental health system needed

The Tribunal notes that the government has committed to extra beds for the forensic mental health network (Minister Davies media release 19 June 2018) and looks forward to hearing more about this. Issues of how to best accommodate the increasing numbers of forensic patients requires a well thought out approach.

The development of a NSW Forensic Mental Health Strategic Plan has been on foot for two years. This Plan should include not just extra mental health beds, but also extra support for forensic patients in the community. The HASI+ program, for example, has proven itself to be one way of safely and cost effectively supporting forensic patients to live in a less restrictive environment, freeing up mental health beds for those with greater need.

Interstate arrangements for forensic patients

For a number of years, the Tribunal has noted in its Annual Report that there are no interstate arrangements for the transfer of forensic patients. This means that patients whose family and cultural connections are in another State are disadvantaged, as they cannot move to another State (whilst still under their forensic order) to continue their recovery.

A National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty By Reason of Cognitive or Mental Health Impairment is now being considered by the Council of Attorneys-General, and it is hoped that this work will lead to a national strategy for the transfer of forensic patients.

Since 2014, forensic patients who have absconded interstate have not been able to be returned to NSW via a health pathway. Instead they have been detained interstate in police or correctional custody and their return to NSW has been under police escort.

Interstate arrangements with other states remain under negotiation between the Ministry of Health and their interstate counterparts. The Tribunal looks forward to re-establishing arrangements with Victoria and Queensland that allow forensic patients to be returned via health services rather than police.

The National Disability Insurance Scheme (NDIS)

The NDIS holds considerable potential for the true funding of recovery supports for forensic patients. This is particularly so as NDIS funding is based on supporting people's functional needs, regardless of the source of their disability.

However, there has also been considerable uncertainty about:

- The transition of the Community Justice Program ("CJP") previously run by the NSW Family and Community Services to the non-government sector and whether the tertiary support and case management provided by this program to forensic patients would continue.
- Whether the NDIS would recognise and fund the complex disability needs of forensic patients; and
- Whether the NSW government would fund the gap between the NDIS funding and the statutory obligations imposed on forensic patients by the Tribunal.

There has been increasing recognition of the importance of working out answers to these questions. The Tribunal is concerned that the issues should be resolved as quickly as possible. Proper funding of forensic patients living in the community supports people's recovery and independence and also ensures the community's safety.

Improvements to Tribunal documents

The Tribunal has continued to update its Forensic Guidelines, Practice Directions and website to assist the public to understand the work of the Tribunal. The Guidelines were updated again in response to the Forensic Review recommendations.

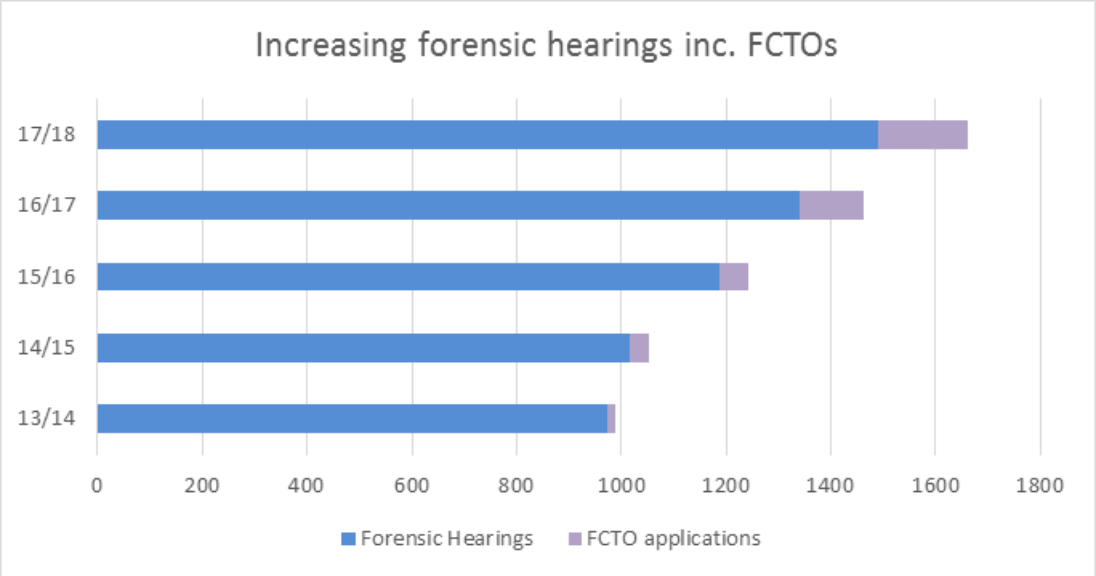
The Tribunal has also drafted new templates for its orders, which use simpler language and avoid referring to the forensic patient's forensic acts. These new orders will be progressively rolled out over the 2018/19 financial year.

Increased Workload in the Forensic Division

This financial year has seen yet another significant increase in the number of forensic hearings. The Division held 1490 hearings this year, up by (11%) from 1340 last year.

There has again been a significant increase in the number of Forensic Community Treatment Orders ("FCTO") applications made. This financial year, 173 applications were made, compared with 122 last year and 56 the previous year.

As the graph below shows, the number of hearings held by the Forensic Division has increased by more than 50% in the last five years.



There has been no increase in staffing during this time and this increased workload can no longer be absorbed by the current Tribunal staff. A request for has been made to the Ministry of Health to fund an additional staff member for the forensic team.

Research and Presentations

The Tribunal is delighted that in the 2017/18 year, the long running research into the forensic files held by the Tribunal has begun to show results. This research project is conducted through the University of NSW, led by A/Prof Kimberlie Dean and funded by the Mental Health Commission. It involved the collection of 250 items of data from 500 forensic patients' files over a 25 year period. The database has now been linked to the criminal justice dataset, and will shortly be linked to the administrative health dataset. The Commission has funded analysis using this dataset which will provide important evidence about the care pathways and outcomes for forensic patients in NSW. The Tribunal has seen some early results, which reflect very favourably on the effectiveness of the recovery programs offered post custody through the forensic system in NSW. We look forward to the published results.

In 2018, the Tribunal participated in the National Roundtable on the Mental Health of People with Intellectual Disability, held on 27 March 2018 at UNSW. This was the culmination of the work of the successful National Health and Medical Research Council (NHMRC) Partnership Project "Improving the Mental Health Outcomes of People with Intellectual Disability". A set of recommendations was developed and broadly communicated in August 2018. The Tribunal will work to implement them within its own sphere in the next financial year.

As always, the Deputy President and staff of the Forensic Division continue to be involved in formal and informal presentations on the work of the Tribunal. In particular in the last year, Deputy President Anina Johnson was an invited speaker at the 2017 International Conference on the Community Living of Persons Living with Disabilities, Seoul, Republic of Korea.

Thanks

Shortly after the end of the 2017/18 financial year, the Forensic Team Leader Siobhan Mullany retired from the Tribunal. Siobhan made a valuable contribution to the work of the Forensic Division and was tireless in her advocacy for vulnerable members of society. We wish her well with her retirement.

In responding to the Forensic Review and other developments, the Forensic Division has drawn on its positive working relationships with key stakeholders including the Ministry of Health, Department of Justice, the Justice and Forensic Mental Health Network, Legal Aid NSW, Corrective Services NSW, Premier and Cabinet, Family and Community Services and victims' organisations.

Despite the increasing workloads, staff and members of the Forensic Division maintain a thoughtful and compassionate approach to every hearing. We thank them warmly.

Anina Johnson
Deputy President

Nadia Sweetnam
Team Leader

CIVIL DIVISION REPORT

Hearing standards

A key function of the Tribunal is to make decisions for involuntary care and treatment, whilst safeguarding the civil rights of consumers. Decisions that curtail a consumer's right to refuse treatment involve the following: an assessment of the nature of the mental illness; its impact on the well-being and safety of the consumer; the protection of the community from serious harm; and scrutiny of the care and treatment being offered. Later iterations of the *Mental Health Act 2007* ("the Act") make it clear that decisions about care and treatment should take into account, where possible, the expressed views of consumers, as well as carers.

How well the Tribunal performs this decision making depends on a variety of factors including the quality of the evidence provided by treating teams, the skill of Tribunal panels, the active participation of consumers and carers, effective legal representation and the availability of appropriate and effective treatment.

Over the years, we have undertaken a number of initiatives to improve hearing standards. This has continued in the reporting year.

Evidence of treating teams

We continue to have regular contact with mental health facilities to reinforce the Tribunal's standards including its expectations in relation to the quality of evidence provided by treating teams. We have issued Practice Directions and given training on the legal and procedural aspects of the Act, emphasising its strong focus on carer and consumer engagement. The Tribunal's website is regularly updated and provides a great deal of information to assist clinicians and other parties. Clinicians often telephone the Tribunal to seek advice and clarification. Their queries are answered by members of the Executive or staff in the Civil Division who have a very good understanding of the Act's requirements. This ongoing collaboration is critical to the efficiency and effectiveness of the Tribunal.

The standard of evidence provided by treating teams is generally high. However, clinicians work in a public mental health system with often limited resources and competing demands. Clinicians within this system, amongst their other duties, are expected to prepare comprehensive written reports and attend Tribunal hearings to give evidence. Sometimes a busy facility will send a junior doctor or a registrar to a hearing, who may have only just commenced their rotation at the facility and may not be familiar with the consumer or their matter. This means that those clinicians may not be in a position to answer the Tribunal's queries or those of the consumer's lawyer. This situation may result in protracted hearings that also may be ultimately adjourned.

It is clearly desirable that a consumer's matter be dealt with expeditiously. However, in the interests of making decisions based on cogent evidence, hearings may be postponed and in the interim, the Tribunal panel may give detailed instructions as to what is required at the resumed hearing. To avoid unnecessary delay, we have requested that consultants make themselves available, at least by telephone, to participate in hearings, if required. Case Study 1, which follows later, is an example of a complex matter that was adjourned with a request for further information and the input of the consultant.

Reviewing care and treatment

The investigation and assessment of care and treatment is central to the Tribunal's reviewing role. This year we have developed a draft paper on the Tribunal's specific role in relation to medication, in the context of patient focussed hearings. This paper is to be considered by the Executive. The aim of this paper is to provide guidance to Tribunal members as to the nature and extent of the Tribunal's role in relation to reviewing treatment and to promote a more consistent approach in decision making.

Legal representatives

Consumers in the reporting year were legally represented in 80 per cent of Tribunal civil matters. There is an automatic right of representation from the Mental Health Advocacy Service (MHAS), a branch of Legal Aid NSW, for the following: mental health inquiries; during the first 12 months of being an involuntary patient subject to review; ECT administration inquiries for assessable person; review of persons on Community Treatment Order (CTO) breaches; any matters for a person under the age of 16; and financial management orders under the *NSW Trustee and Guardian Act 2009*. The MHAS applies a merit test for appeals against the authorised medical officers' decisions to refuse discharge, appeals against Magistrates CTO's, long-term involuntary patient reviews and CTO hearings. Having a lawyer test the evidence is an important review mechanism on the exercise of significant powers.

Allowing lawyers a proper opportunity to consider evidence and represent the views of their clients is a fundamental aspect of Tribunal reviews. In 2016 the Tribunal issued a Practice Direction for the attention of mental health facilities setting out a representative's right to access a consumer's file and medical reports in a timely manner. The Practice Direction was issued after some lawyers had reported longstanding difficulties in accessing reports in a timely way. This problem appeared to worsen after some facilities commenced 'E-Records' for consumers. We are pleased to report that the Practice Direction has generally resulted in more timely access to reports for hearings.

Civil Case Study 1 - Gathering Evidence

The first case study is an example of adjourning a matter owing to a lack of information at a hearing and the Tribunal panel referring the matter to the Executive for its consideration.

XR, an involuntary patient was presented by the Registrar for a CTO. The Tribunal panel noted that the treatment plan did not have the correct case manager's name and on further inquiry discovered that in fact no case manager had been allocated.

The Registrar gave evidence that XR had only received two depot medications since his admission. The medical report noted some improvement but at the hearing there was evidence that XR was experiencing active symptoms of a mental illness, although XR had not responded to internal stimuli for a week. At the hearing XR appeared as thought disordered.

The panel did not consider that it had adequate evidence as to XR's mental state and queried if the CTO was 'consistent with safe and effective care'. Other concerning aspects were that the Registrar was unable to advise with any precision what medications XR was to take on discharge. When the panel asked if leave had been given to test XR's readiness for discharge the response was that it had been refused because of a concern that he might abscond.

The panel adjourned the hearing for two weeks and outlined its concerns in a member feedback form available to the Tribunal Executive. A request was made for the consultant to review XR and to give an opinion as to XR's readiness for discharge. It was also requested that the consultant be available, by telephone to give evidence to the Tribunal. There was also a request for clarification of XR's medications on discharge; the allocation of a case manager prior to discharge; and a request to meet with XR prior to the hearing. This is a standard requirement in all Tribunal CTO hearings. As XR had not had CTOs in the past, such a meeting was particularly necessary and an important aspect of effective discharge planning. There was also a request that the team consult with XR's mother, his Principal Care Provider regarding discharge as this is a requirement of section 72B of the Mental Health Act.

Some systemic issues

For many years now, Tribunal panels have alerted the Tribunal Executive as to individual and systemic issues of concern via a Member Feedback Form. As seen in Case Study 1 such concern may relate to the standard or quality of treatment and care plans for individual consumers.

A recent 'systemic issue' raised by panels is the requirement of some mental health facilities that consumers on CTOs pay for their medication. In some cases, the cost of medication is deducted from the consumer's pension. We were also made aware that some mental health facilities have sought a financial management order to recoup the cost. We understand that payment depends on the policy of each mental health facility.

We have responded to this issue by writing to all mental health facilities in the State and asking that each advise of their practice. This information will then be relayed to Tribunal panels who may discuss this issue during the hearing and consider its impact on the consumer's financial position and overall wellbeing.

The President of the Tribunal has also raised this issue with the Ministry of Health as it raises the question of equitable access to care and treatment. There is also a concern that many consumers, who rely on a Centrelink benefit and are financially vulnerable, are required to pay for medication that they will often resent taking. There is also the question of whether Government should bear the cost of treatment, as it is imposed for the wellbeing and safety of the consumer and the safety of the community.

Tribunal panels have correctly rejected the request by some facilities that payment be made a condition of a treatment plan. We have made it clear to facilities that payment of medication cannot be a condition of a treatment plan, as the Tribunal needs to know with certainty at the time of the hearing that any proposed treatment will be given if a CTO is made and is not contingent on a consumer's willingness or capacity to pay.

Another recurring issue raised by Tribunal members is the lack of appropriate accommodation and support for long-term patients with complex needs. In last year's Annual Report, we noted the good work of the Pathways to Community Living Initiative (PCLI) in placing long-term consumers in more appropriate community-based accommodation. The Initiative has now successfully transitioned many more consumers and its good work continues. However, notwithstanding the aims of the PCLI to place long term consumers into appropriate community accommodation with supports, some consumers have had difficulty in transitioning successfully because of funding shortfalls in their NDIS plans. It is often necessary to involve several agencies such as the NSW Public Guardian, the MHAS, and increasingly, the National Disability Insurance Agency (NDIA), to facilitate transitions.

The Tribunal has communicated these systemic issues to the Chief Psychiatrist, the Mental Health Commissioner, and the Principal Official Visitor.

Case Study 2 is an example of a consumer whose placement in a group home has been delayed because of a NDIS package that did not reflect his needs. Similarly, Case Study 3 illustrates the case of a consumer witih complex needs, who faced barriers to finding appropriate accommodation in the community, as well as a NDIS plan that was not initially responsive to her circumstances.

Civil Case Study 2 - NDIS Issues

Mr XT is a 36-year-old voluntary patient with a diagnosis of schizophrenia and a neurodegenerative disease. He was originally admitted to a mental health facility under a schedule, following the exacerbation of psychotic symptoms, including derogatory and command auditory hallucinations. With treatment, his signs of mental illness resolved. At the first Tribunal review the treating team recommended that he undergo a period of rehabilitation as an involuntary patient with a plan to step him down to less restrictive care in the community. Unfortunately, XT had a fall related to his neurodegenerative disease and he required a high level of nursing support for his aspects of daily living because of his impaired physical and mental condition.

XT was made a voluntary patient by the treating team. He was reviewed by the Tribunal, after which the Tribunal panel alerted the Executive of their concern that no-one was advocating for XT to be placed in appropriate alternative accommodation, such as a group home setting, to continue his rehabilitation for his fracture due to his fall and underlying disease.

The Tribunal wrote to the mental health facility and relayed the panel's concerns, requesting: an update of the plan to explore appropriate accommodation; the steps taken to advocate on XT's behalf; and advice as to who was responsible for securing NDIS funding.

Some months later the Tribunal contacted the facility who advised that XT had secured a place in a group home and had obtained an NDIS package. However, the package was insufficient to meet his needs. The facility had lodged an appeal with the NDIA for an increase in funding. With the available NDIS funds a transition plan had been put into place for XT to be taken out by workers from the group home, twice a week, for four hours. The treating team reported that XTs mental state had remained stable and he no longer had auditory hallucinations. The team considered that it was inappropriate for XT to be kept in a more restrictive environment than was necessary, and "he had fallen through the cracks". The Tribunal has since written to the NDIA expressing concerns about XT's ongoing hospitalisation at the facility and has requested that the Mental Health Advocacy Service attend his next Tribunal review hearing.

Improving consumer participation

Overall the participation of consumers in civil hearings is very high. Except for CTO hearings, the attendance rate is close to 90%. However, only 72% of consumers attended their CTO hearings last year. This figure does not include CTOs made at mental health inquiries, where attendance is mandatory.

We have sought to improve consumer attendance at CTO hearings by making it a standard practice for panels to telephone consumers who do not otherwise wish to attend hearings in the company of their case manager. This practice allows consumers to freely give their views and perspectives. We have asked that facilities themselves reach out to consumers and encourage their attendance. Consumers may also complete a Self-Report Form to present their views to the Tribunal.

The Tribunal considers that consumers who are consulted about their care and treatment are more likely to feel empowered and are more likely to express satisfaction with the Tribunal process even if the outcome is not what they had hoped for. Importantly, consumers can share with the Tribunal their opinions about what assists in their recovery. Whilst medication has a role to play in a consumer's recovery there are a range of other interventions that may contribute to well-being and should form part of a holistic treatment plan.

We welcome the Minister for Mental Health, Tanya Davies' announcement in November 2017 committing $2.7 million to expanding the mental health peer workforce. The aim of this increased funding is to offer consumers greater support during their hospital admission and in their transition to the community.

In terms of supporting consumers at hearings and increasing their participation in CTO hearings, we have written to mental health facilities and Local Health Districts (LHD's) asking for data in relation to their peer work force. We believe that peer support for consumers attending Tribunal hearings could be of great

practical and psychological assistance to consumers as many consumers find hearings distressing and confronting. The presence of peer workers would also assist to address any perceived power imbalances. This would be especially important in CTO cases where consumers are not usually represented by the MHAS. Moreover, in cases where consumers have been on successive CTOs and have given up attending hearings, having a peer available might increase their participation.

Case Study 3 - Complex needs and the NDIS

XX is 53 years of age and has frontal lobe syndrome (arising from a traumatic brain injury), schizoaffective disorder, chronic pain, obesity and multiple physical health problems. She has limited family support and relapsed in 2016 after discharge from the facility. Between 2008-2015 she had 26 admissions to hospital with some admissions lasting a few days to a few months. She had been managed on a CTO for 15 years due to a history of refusing medication. The CTO lapsed in 2014. She has been imprisoned several times. At the involuntary patient review hearing in August 2017 the Tribunal was advised that efforts to place her in suitable accommodation have been prevented as the NDIS will not approve the funding until a discharge address is identified. XX has aggressive behaviour and owing to her complex presentation she requires 24 - hour support. XX had been on the ADHAC accommodation support register. XX has the Public Guardian, a financial manager and an NDIS co-ordinator of supports acting on her behalf. XX's social worker had contacted 25 services to try to source appropriate 24 hour supported accommodation, without any success. The Tribunal listed XX's matter for early review for September 2017, to reconsider her position.

The Tribunal wrote to the NDIA stating that the funding model for XX was a major problem, as any accommodation (which is necessarily scarce) identified by the treating team, might well be lost by the time the NDIS approved the funding. The effect of this was the following: XX's detention in the facility was prolonged; she was denied access to a less restrictive alternative, consistent with safe and effective care; and her recovery was also put in jeopardy. The Tribunal also urged a more flexible, responsive and patient centred approach from the NDIA.

Thereafter, XX was reviewed in September 2017, October 2017 and November 2017 with the treating team reporting that a behaviour management plan was being implemented, that a suitable house had been found, and that modifications to the house were taking place. There was a plan to trial XX at the home with the assistance of the NDIS and an NGO. The Public Guardian supported the plan. In December 2017, XX was successfully discharged from the facility on a CTO with extensive support. She remains in the community.

Involving carers

Although the Act requires the mandatory notification of carers for mental health inquiries, ECT and renewed CTO applications, it is unknown how many carers are in fact notified. In 2015 the Act was amended to create a new category of carer, that is, "the principal care provider", a person identified by the authorised medical officer or Director of Community Treatment as someone who is primarily responsible for providing the consumer with care or support. The amendment also changed the term "primary carer" to "designated carer" and allows the nomination of up to two designated carers. However, as noted in last year's Annual Report, the role of the principal care provider appears not to be well understood in the community or by some stakeholders. Unfortunately, this continues to be the case.

Our experience is that many clinicians are not aware of this new requirement or do not take it into account. Some clinicians believe erroneously that the attendance of a carer requires the consumer's consent. It is quite common, when carers have been identified, that they are not notified in sufficient time to allow them to participate. This is clearly a problem that undermines the legislative intention. The recent amendments emphasise the centrality of consumers and carers in decisions about treatment and discharge planning. Carers will often have information that is relevant to decisions of the Tribunal. Improving their participation in hearing remains a priority for the Tribunal.

From 1 July 2018, amendments to the Act will require that notice be given to all carers in relation to all Tribunal hearings conducted at mental health facilities. We plan to keep a statistical record of their attendance at hearings. We continue in our efforts to improve awareness of the rights of carers by contacting facilities who fail to contact carers or give timely notification. Having said this, the Tribunal can only do so much. There is a strong case for LHD's and Speciality Health Networks to implement comprehensive and regular training of clinicians who work under the Act that includes information and training about the role of carers.

Key statistics

As the Registrar's report shows, there were 18,538 hearings in the reporting year, representing an increase of 2.4 % since the previous year. In the Civil Division there were 16,904 hearings, 315 more than last year. There were 144 hearings relating to financial management orders. The statistics in relation to each head of jurisdiction in the Civil Division have remained largely stable over the last few years. Civil hearings account for almost 91% of the Tribunal's work.

There was a marginal increase in mental health inquiries of 0.7% from the previous year, (i.e. 49 more hearings) and a total of 6,806. There was an increase in Involuntary Patient Review hearings from 2725 in the previous year to 2831 (up 3.9% or 106 hearings), relating to 1780 consumers.

Appeal hearings against the authorised medical officer's refusal to discharge a patient decreased by five, to a total of 685, with 574 of the appeals (or 83.8%) being dismissed, and 12 orders for discharge (16 such orders were made in the previous year) and one patient was reclassified as a voluntary patient.

There were 812 applications for ECT hearings in relation to involuntary patients (including two forensic patients), and ECT was approved in 708 cases (or 87.2%) and not approved in 12 cases (or 1.5%). In 35 matters, the Tribunal found that the patient had capacity and had given consent to ECT. A small proportion of hearings (7%) were either withdrawn, adjourned or did not proceed for lack of jurisdiction. None of these hearings involved children under the age of 16.

Under the *NSW Trustee and Guardian Act 2009*, the Tribunal conducted 144 hearings for Financial Management Orders (down from 169 in 2016/17). Interested parties were responsible for 81 applications for a financial management order and 32 were considered at mental health inquiries. The Tribunal made 47 financial management orders, five of which were interim orders; 11 were made at mental health inquiries; 30 were made on the application of interested parties; and one was made at the review of an interim order. There were 49 applications for the revocation of financial management orders, a decrease of two from the previous year. The Tribunal revoked 20 of the orders.

CTO applications increased slightly by 26, (or 0.5%) to 5357 this year. These CTO determinations were made in relation to 3599 individuals.

Internal and external training

In the reporting year, the professional development program for Tribunal members included a training event concerning the accounts of a consumer, carer and clinician (working in a recovery model) about their interactions with the mental health system. The speakers spoke poignantly and candidly about their experiences of Tribunal hearings and what they considered was helpful or unhelpful. This event emphasised the importance of taking a person-centred approach in hearings, and on the use of language as a way of empowering consumers and reducing stigma.

Linked to this theme, our next training event was a workshop on 'Fair, Therapeutic and Consumer focused hearings' co-hosted with the Health Education Training Institute (HETI). With the aid of videos (filmed especially for the evening) the session was led by a facilitator who explored how to engage consumers better in their hearings and how to deal with cases where there is conflict between the consumer and carer. The sessions highlighted tensions in the administration of the Act that are not easily resolved; for example, a carer's right to be notified of hearings, a consumer's right to autonomy, and the public interest in open hearings.

We also have a regular training program for clinicians who appear before the Tribunal. We have undertaken several education sessions for Emergency Department doctors who are frequently required to treat persons who have symptoms of mental distress. Whilst these clinicians generally have a broad understanding of the Act's requirements, they will often not have an in-depth understanding of the provisions and how they apply in an Emergency Department setting.

Deputy President Maria Bisogni undertook training at the following venues: Blacktown, Cumberland and Hornsby Hospitals.

Ms Danielle White, the Civil Team Leader, continued to support and provide training to the Volunteers Program at Cumberland Hospital which supports family and carers of people attending Tribunal hearings at Cumberland Hospital.

Future directions

We are looking at ways to increase efficiencies as inpatient facilities move to electronic records and the Tribunal's hearing load increases each year. To that end, this year a pilot commenced at Bloomfield Hospital for Tribunal members to have computer access to consumers' progress notes in forensic hearings. The preliminary feedback from members is positive, so we expect that this will eventually become standard practice for all forensic and civil hearings.

We are also working towards paperless hearings, in the sense that we hope to be able to access all Tribunal files electronically. This will be a mammoth project. However, it will be a much-needed change as in some parts of the State, Tribunal panel members reside in the region of the hearing and they may not always have access to the Tribunal's file.

In the meantime, in relation to complex cases, we have undertaken a pilot study of identifying key reports from a consumers' file to be sent to the Tribunal panel, clinicians and the consumer's lawyers as a way of ensuring that there is ready access to a consumer's complete history. As noted above, the quality of Tribunal decisions is significantly influenced by the breadth and quality of the information it receives at hearings from clinicians. It is clear that clinicians do not always have access to a consumer's complete psychiatric history. This means that there are often gaps in information which can affect the quality and accuracy of decision making.

Frequently, the Tribunal's file will have a great deal of information, such as discharge summaries medical reports and second opinions. This information should be readily accessible to all parties.

Tribunal membership

The full-time Presidential members appraise every four years the performance of Tribunal members. This is an important tool in assessing the skill and competence of the Tribunal's 140 (approximately) part-time members. This process commenced in early 2018 and is due to be completed in 2019. The Tribunal expects that it will recruit again in 2020, in accordance with its four year recruitment cycle.

Law Reform

Last year, we reported that in October 2016 the Tribunal had changed its practice and required the attendance of consumers at involuntary reviews and ECT hearings, in order for those hearings to proceed. The Tribunal accepted that this practice of mandatory attendance had caused a number of very unwell consumers some distress. As a consequence, the Tribunal recommended that the Act be amended to allow for a consumer's non-attendance in defined circumstances.

We are pleased to report that the Act was amended on 20 February 2018 (with a commencement date of 1 July 2018) allowing for ECT and involuntary reviews to take place in the consumer's absence, if they are too unwell to attend, or refuse to attend, hearings. The legislative changes include a number of safeguards including the following: the Tribunal must be satisfied that the consumer will not be well enough to attend within a reasonable period; carers must be notified of the hearing; the Tribunal is to consider the views of the consumer, their representative and carers; and that holding the hearing in the absence of the patient is desirable for the safety or welfare of the patient.

Carer groups, consumer groups and the Mental Health Advocacy Service (MHAS) were consulted about this issue and their responses were taken into account in developing a new Practice Direction. We issued a new Practice Direction specifying the procedure to be followed by the Authorised Medical Officer (AMO) applying for hearings without the presence of the consumer.

We anticipate that this discretion to permit non-attendance will be used in a limited number of cases. The Tribunal intends to keep a record of the number of applications made and its determinations.

As part of the same legislative changes, (and as noted above) the Act now requires that notice be given to all carers for all Tribunal hearings conducted at mental health facilities.

Submissions and reports

The Tribunal made a submission to the Chief Psychiatrist on the review of Seclusion, Restraint and Observation in NSW.

A submission was made to the NSW Mental Health Commission on the Inside Out Recovery Research Discussion Paper. The Paper examined the application of trauma informed care and recovery to justice settings.

The Tribunal commented on the draft proposals of the NSW Law Reform Commission's (LRC) Review of the *Guardianship Act 1987*. The review explored whether supported decision making should be introduced as a major concept in the Guardianship Act. The Tribunal had, in the preceding years made submissions about the interaction of its governing legislation and the Guardianship Act.

An acknowledgement of members and staff

We have been most fortunate to have the measured and sterling guidance of Richard Cogswell over the last few years. Richard will retire in February 2019. His intellectual rigour, compassion and wisdom have left their mark on the Tribunal. He will be greatly missed and we wish him well for the future.

As always, we are indebted to the skill, dedication and hard work of core staff (whose work is unrelenting) and our Tribunal members without whom the Tribunal could not meet its duties and responsibilities.

Maria Bisogni
Deputy President

Danielle White
Team Leader

REGISTRAR'S REPORT

This has been another busy and challenging year for the Tribunal. The total number of hearings conducted by the Tribunal increased by 2.4% from 18,098 hearings in 2016/17 to 18,538 in 2017/18 (440 additional hearings). This means that the number of hearings conducted by the Tribunal has more than doubled (an increase of 104%) since June 2010 when the Tribunal assumed the responsibility for conducting mental health inquiries. Further details about this increase are discussed below.

Under s147 of the *Mental Health Act 2007* ("the Act") a number of matters are required to be included in this Annual Report. Each of the following matters is reported on in Appendix 1:

a) the number of persons taken to mental health facilities and the provisions of the Act under which they were so taken;
b) the number of persons detained as mentally ill persons or mentally disordered persons;
c) the number of persons in respect of whom a mental health inquiry was held;
d) the number of persons detained as involuntary patients.

The Report is also to include any matters the Minister may direct or that are prescribed by the regulations. No Regulations have been made for additional matters to be included nor has the Minister given any relevant direction.

In addition to the statutory requirements I report on the following:

Caseload

In 2017/18 the Tribunal conducted 18,538 hearings including 6,806 mental health inquiries. These 440 more hearings represent a 2.4% increase in the total number of hearings compared to 2016/17. There were 315 more hearings conducted in the Tribunal's civil jurisdiction (1.9% increase) and 150 more hearings in the forensic jurisdiction (11.2% increase). There were 25 fewer Financial Management hearings (14.8% decrease) in 2017/18.

The number of forensic hearings has consistently increased over recent years – from 972 in 2013/14 to 1490 in 2017/18. This represents a 53% increase in four years (518 more hearings).

2017/18

Civil Patient hearings (for details see Tables 1-14) (* includes 6806 mental health inquiries)	*16904
Financial Management hearings (for details see Table 15)	144
Forensic Patient reviews (for details see Tables 16 - 33)	1490
	18538

Details for each area of jurisdiction of the Tribunal are provided in the various statistical Tables contained later in this Report.

Table A shows the number of hearings conducted each year since the Tribunal's first full year of operation in 1991 when 2,232 hearings were conducted.

Table A

Total number of hearings 1991 - 2017/18

	Civil Patient Hearings	*Financial Management Hearings*	*Forensic Patient Hearings*	*Totals per year*	*% Increase over previous year*
1991	1986	61	185	2232	%
1992	2252	104	239	2595	+16.26%
1993	2447	119	278	2844	+9.60%
1994	2872	131	307	3310	+16.39%
1995	3495	129	282	3906	+18.01%
1996	4461	161	294	4916	+25.86%
1997	5484	183	346	6013	+22.31%
1998	4657	250	364	5271	-12.34%
1999	5187	254	390	5831	+10.62%
2000	5396	219	422	6037	+3.48%
2001	6151	304	481	6936	+14.8%
2002	6857	272	484	7613	+9.8%
2003	7787	309	523	8619	+13.2%
2004	8344	331	514	9189	+6.6%
2005	8594	293	502	9389	+2.2%
2006	9522	361	622	10505	+11.9%
2007	8529	363	723	9615	-8.5%
2007-08	8440	313	764	9517	N/A
2008-09	7757	224	771	8752	-8.1%
2009-10	8084	193	824	9101	+4.0%
2010-11	12413	221	870	13504	+43.4%
2011-12	13501	219	928	14648	+8.5%
2012-13	15510	225	943	16678	+13.9%
2013-14	15416	191	972	16579	-0.6%
2014-15	16035	170	1017	17222	+3.9%
2015-16	16596	168	1186	17950	+4.2%
2016-17	16589	169	1340	18098	+0.8%
2017-18	16904	144	1490	18538	+2.4%

Mental health inquiries

This was the eighth full year of the Tribunal's jurisdiction to conduct mental health inquiries under s34 of the Act. Until 21 June 2010 this role had been carried out by Magistrates. During 2017/18 the Tribunal held 6,806 mental health inquiries – 49 more than the previous year (a 0.7% increase). These mental health inquiries related to 5629 individual patients.

Of the mental health inquiries conducted in 2017/18, 5,676 (83.4%) resulted in an involuntary patient order being made. This percentage is much the same as in 2016/17 (83.5%) but quite a bit higher than the 79.3% in 2011/12 when changes were made to the timing of mental health inquiries and could reflect the shorter period for which patients have received treatment when presented for an inquiry at an earlier stage.

There was a small decrease in the percentage of Community Treatment Orders made at a mental health inquiry during 2017/18 (4.9% - 335) compared to 2016/17 – 6.4% (362), 2014/15 – 5.1% (336), 2015/16 - 4.9% (336) and to 2014/15 - 5.1% (336), 2013/14 - 5.8% (360) and to 2012/13 - 5.4% (339) but this is still

significantly lower than in 2011/12 – 11.8% (581). This is again a possible consequence of the earlier presentation of patients for a mental health inquiry in that there is less time for a person's condition to stabilise and for an appropriate Community Treatment Plan to be developed. Twenty three (23) of the Community Treatment Orders made at a mental health inquiry had the discharge from the mental health facility deferred for up to 14 days - an increase from 14 such orders in 2016/17. This option was provided for as one of the 2015 amendments to the *Mental Health Act 2007* and allows for proper discharge arrangements to be made or finalised following the making of a Community Treatment Order.

A total of 68 orders were made at a mental health inquiry for the patient to be discharged or for deferred discharge (1%). This included 12 patients who were discharged into the care of their designated carer, seven of which had the discharge deferred for up to 14 days.

There was a slight increase in the number of mental health inquires that were adjourned – 677 (9.9%) compared to 657 (9.7%) in 2016/17. Both these years were less than the 787 adjournments (11.4%) in 2015/16.

See Tables 1-3.

In 2017/18, 16.2% of initial mental health inquiries were commenced during the first week of a person's detention (compared to 15.9 in 2016/17, 16.6% in 2015/16, 15% in 2014/15, 16% in 2013/14, 15.1% in 2012/13 and 5.5% in 2011/12), 55.7% during the second week (57.3% in 2016/17, 58.6% in 2015/16, 58.1% in 2014/15, 56.8% on 2013/14, 56.9% in 2012/13 and 22.2% in 2011/12), 26.7% in week three (26.1% in 2016/17, 24.3% in 2015/16, 26% in 2014/15, 26.5% in 2013/14, 36.6% in 2012/13 and 45.1% in 2011/12) and 1% in the persons fourth week of detention (0.6% in 2016/17 and 2015/16, 0.7% in 2014/15, 0.4% in 2013/14, 1.2% in 2012/13 and 26.5% in 2011/12).

In a small proportion of cases, 0.5%, the inquiry was commenced sometime after four weeks (0.1% in 2016/17, 0.2% in 2015/16 and 2014/15, 0.3% in 2013/14, 0.2% in 2012/13 and 0.8% in 2011/12). Each such case was looked into and where appropriate followed up with the facility involved. Many of these cases involved patients who were AWOL; on approved leave; or were receiving medical treatment or too unwell to be presented for a mental health inquiry at the time they were due.

Other than for some minor variations these figures have been relatively consistent for the last five or six years and reflect the Tribunal's expectation that assessable persons are presented for a mental health inquiry within three weeks of the person being detained in a mental health facility.

Involuntary patient reviews

The total number of hearings for the review of involuntary patients under s37(1) of the Act increased by 106 in 2017/18 to 2831 from 2725 in 2016/17 – a 3.9% increase. These reviews related to 1780 individual patients.

The Tribunal is required to review the case of each involuntary patient on or before the end of the patient's initial period of detention ordered at a mental health inquiry s37(1)(a), then at least once every three months for the first 12 months that the person is an involuntary patient s37(1)(b), and then at least every six months while the person continues to be detained as an involuntary patient s37(1)(c). The number of initial reviews under s37(1)(a) increased by 84 (5.7%) and under s37(1)(b) by 66 (9.9%) while the number of reviews under s37(1)(c) decreased by 44 (-7.5%).

See Tables 1, 2 and 6.

Appeals against a refusal to discharge

The number of hearings held under s44 of the Act to consider an appeal against an authorised medical officer's refusal to discharge a patient decreased by 5 to 685 in 2017/18 compared to 690 in 2016/17 – a 0.7% decrease. These appeals related to 558 individual patients.

Of the appeal hearings conducted in 2017/18 574 were dismissed (83.8%). Of these 15 appeals were dismissed and an order made that there be no further right of appeal before the next review by the Tribunal.

The patient was ordered to be discharged on 12 occasions (1.8%) and one patient was reclassified as a voluntary patient. The remaining 98 appeals were either adjourned, withdrawn or the Tribunal had no jurisdiction to deal with them.

Regulation 19(3) of Mental Health Regulation 2013, which came into effect on 1 September 2013, allows for appeals lodged by persons other than involuntary patients to be heard by the President, a Deputy President or a member qualified for appointment as a Deputy President. This means that an appeal lodged by an assessable person (a person who has not yet had a mental health inquiry) is able to be heard by an experienced single legal member of the Tribunal. In 2017/18 253 appeals were heard by a single member (36.9% of the total number of appeals held). This is a slightly higher percentage than last year (33.9%).

See Tables 1, 2 and 7.

Community Treatment Orders

The number of hearings to consider applications for Community Treatment Orders under s51 of the Act increased by 26 from 5331 in 2016/17 to 5357 in 2017/18 (a 0.5% increase). These hearings related to 3599 individuals.

Including 335 Community Treatment Orders made at a mental health inquiry there were a total of 5362 Community Treatment Orders made in 2017/18 – exactly the same number as in 2015/16. Excluding those made at a mental health inquiry the number of Community Treatment Orders made by the Tribunal under s51 of the Act increased by 27 from 5000 in 2016/17 to 5027 in 2017/18 –0.5% increase.

As mentioned above, one of the consequences of the change to the timing of mental health inquires in July 2012 is that fewer Community Treatment Orders are made at a mental health inquiry and in more cases a separate application and subsequent hearing are required for a person to be discharged on a Community Treatment Order.

Under s56(2) of the Act the maximum duration of a Community Treatment Order is 12 months. However of the 5362 Community Treatment Orders made in 2017/18 only 351 were for a period of more than six months (usually 12 months). This is 6.5% of the orders made, which is a slightly higher percentage than in 2016/17 (6.4%). Although the Act provides that the Tribunal is able to make Community Treatment Orders for up to 12 months, the vast majority of orders continue to be made for periods of up to six months. Longer orders are generally only made in circumstances where there are clearly established reasons for justifying a longer period.

See Tables 1, 2 and 8-10.

Electro Convulsive Therapy (ECT)

The Tribunal conducted 812 ECT administration inquiries in 2017/18 under s96 of the Act to consider the administration of ECT to involuntary patients (including two hearings concerning forensic patients). This is 89 more hearings than the 723 hearings conducted in 2016/17 (12.3% increase). Of these hearings the administration of ECT was approved in 708 hearings (87.2%) and not approved in 12 (1.5%). The Tribunal

found that the person was capable and had consented in 35 hearings (4.3%). The remainder (57 – 7%) of the hearings were either adjourned, withdrawn or the Tribunal had no jurisdiction.

These ECT administration hearings related to 492 individual patients – none of whom were under the age of 16 years.

The Tribunal also conducted four ECT consent inquiries in 2017/18 to consider a voluntary patient's capacity to give informed consent to the administration of ECT. This is one more than in 2016/17 when three such consent inquiries were conducted.

These consent inquiries related to four individual patients.

See Tables 1, 2 and 11-12.

Financial management hearings

Under the *NSW Trustee and Guardian Act 2009* (TAG Act) the Tribunal can make a financial management order appointing the NSW Trustee and Guardian of a person's estate in the following circumstances:

- after a mental health inquiry if ordering that a person is to be detained in a mental health facility (s44 TAG Act);
- after reviewing a forensic patient if ordering that a person is to be detained in a mental health facility (s45 TAG Act);
- on application for a patient in a mental health facility (s46 TAG Act).

The Tribunal is also able to review interim financial management orders (s48 TAG Act) and consider applications to revoke financial management orders made under the TAG Act (s88 TAG Act) or the former Protected Estates Act.

In 2017/18 the Tribunal conducted 144 hearings in relation to financial management and made a total of 47 financial management orders (including five Interim Financial Management Orders) and revoked 20 orders (including two revocations relating to forensic patients). These figures are slightly lower than in 2016/17 when 169 hearings were held, 65 orders made and 30 revoked (including one relating to a forensic patient).

See Table 15.

Forensic Hearings

There was an 11.2% increase in the number of hearings held by the Forensic Division in 2017/18 compared to the previous year, 1490 in 2017/18 compared to 1340 in 2016/17. This follows a 13% increase the previous year and means that the number of forensic hearings has increased by 25.6% in the last two years (304 more hearings).

Many of these additional hearings were regular reviews of forensic patients however a significant number were for the Tribunal to consider an application for a Forensic Community Treatment Order (FCTO). The number of these hearings has increased from 59 in 2015/16 to 122 in 2016/17 and now to 173 in 2017/18 – an increase of 193% over the last two years (41.8% increase last year). The Tribunal is required to conduct three monthly reviews of each person subject to a FCTO who is detained in a correctional centre. The number of these reviews increased by 112% from 59 in 2016/17 to 125 in 2017/18. There were only 12 of these reviews in 2015/16. From 1 July 2018 an amendment to s61(3) of the *Mental Health (Forensic Provisions) Act 1990* will require these reviews to be conducted no later than three months after the community treatment order is made and at least once every six months during the term of the order. The impact of the increase in FCTOs is discussed more fully in the Forensic Division report (see pages 4-10).

In terms of the release of Forensic Patients in 2017/18, the Tribunal ordered the conditional release of 29 forensic patients and the unconditional release of 19 forensic patients (including 13 patients for whom a Community Treatment Order was also made to have effect on the date of unconditional release). This compared to 29 conditional releases and 10 unconditional releases in 2016/17. The Tribunal made one order revoking conditional release of a forensic patient in 2017/18 compared to two in 2016/17.

See Tables 16-33

Hearing locations and types

The Tribunal has regular rosters for its mental health inquiries, civil and forensic hearing panels. In addition to the hearings held at the Tribunal's premises in Gladesville, in person hearings were conducted at 38 venues across the Sydney metropolitan area and regional New South Wales in 2017/18.

Although the Tribunal has a strong preference for conducting its hearings in person at a mental health facility or other venue convenient to the patient and other parties, this is not always practical or possible. The Tribunal has continued to use telephone and video-conference hearings where necessary and conducted hearings by telephone and/or video conference to 253 inpatient or community venues across New South Wales.

In 2017/18, 8,927 hearings and mental health inquiries were conducted in person (48.2%), 8,362 by video (45.1%) and 1,249 by telephone or "on the papers" (6.7%). The numbers and percentages are very similar to recent years.

If mental health inquiries are excluded from the figures then 4,057 hearings were conducted in person (34.6%), 6,426 by video (54.8%) and 1,247 by telephone or on the papers (10.6%). These numbers and percentages are varied only slightly from 2016/17 and 2015/16 and show continuing decrease in the percentage of hearings conducted by telephone. This continued reduction in telephone hearings is particularly pleasing as telephone hearings are only used where an in person hearing is not practicable and where no video conference facilities are available.

The vast majority of hearings conducted by telephone or on the papers related to Community Treatment Orders (88.9%), most often for people in the community on an existing Community Treatment Order (58.3%). This includes 20.5% for hearings to vary the conditions of existing Community Treatment Orders (the majority of these hearings involved varying the order to reflect a change in treatment team following a change of address by the client and were usually conducted 'on the papers').

Mental health inquiries are conducted 'in person' at most metropolitan and a number of rural mental health facilities. Video conferencing is only used at those facilities where in person inquiries are not practical. Of the 6806 mental health inquiries this year, 71.5% were held in person and 28.5% by video. These percentages are very similar to previous recent years but vary significantly from when the Tribunal first commenced conducting mental health inquires in 2010/11 when 35.6% were conducted in person and 64.4% by video.

Number of Clients

The Tribunal is responsible for making and reviewing all involuntary patient orders and all Community Treatment Orders (apart from a small number of orders made by Magistrates under s33 of the *Mental*

Health (Forensic Provisions) Act 1990). This means that the Tribunal is now able to get a fairly accurate picture of the actual number of people subject either to an involuntary patient order or to a Community Treatment Order at any given time.

As at 30 June 2018 there were 1,316 people for whom the Tribunal had made an involuntary patient order either at a mental health inquiry or at a subsequent review (this compares to 1,295 at the same time in 2017, 1,295 in 2016, 259 in 2015, 1195 in 2014 and 1250 in 2013). However, it should be noted that a number of these patients may, without reference to the Tribunal, have been discharged or reclassified as voluntary patients since the making of the order.

There were 72 individuals who had been voluntary patients for more than 12 months and had been reviewed by the Tribunal – again a number of these people may have been discharged or reclassified since the Tribunal review.

See Table 5 for further details including a summary of the facilities in which these individuals were detained or admitted.

In terms of Community Treatment Orders, as at 30 June 2016 there were 2,784 individuals subject to an Order made by the Tribunal. While a small number of these orders may have been revoked by the Director of the declared community mental health facility responsible for implementing the Order, this should be a fairly accurate count of the number of people subject to a Community Treatment Order at that point in time. This is slightly more than at the same date in recent years: 2017 (2768), 2016 (2733), 2015 (2715), 2014 (2705) and 2013 (2,763).

Representation and Attendance at Hearings

All persons appearing before the Tribunal have a right under s152 and s154 of the Act to be represented notwithstanding their mental health issues. Representation is usually provided through the Legal Aid Commission of NSW by the Mental Health Advocacy Service (MHAS), although a person can choose to be represented by a private legal practitioner (or other person with the Tribunal's consent) if they wish.

Due to funding restrictions the Legal Aid Commission has advised the Tribunal that legal aid cannot automatically be provided for representation for all categories of matters heard by the Tribunal. In addition to all forensic cases, representation through the MHAS is usually provided for at all mental health inquiries and reviews of involuntary patients during the first 12 months of detention; appeals against an authorised medical officer's refusal to discharge a patient and all applications for financial management orders. Representation is also provided for some applications for Community Treatment Orders and some applications for revocation of financial management orders, however this may be subject to a means and merits test. During 2011/12 the Legal Aid Commission expanded representation to include some ECT inquiries, particularly those held before an involuntary patient order has been made at a mental health inquiry.

Including mental health inquiries, representation was provided in 80% of all hearings in the Tribunal's civil jurisdiction (see Table 1) and 98.5% of all forensic hearings in 2017/18.

All persons with matters before the Tribunal are encouraged to attend the hearing to ensure that their views are heard and considered by the Tribunal and to ensure that they are aware of the application being made and the evidence that is being presented about them. This attendance and participation in hearings can be in person or by way of video or telephone. In civil matters the person the hearing is about attended in 85.7% of all hearings – this is the roughly the same percentage as in recent previous years. Included in these figures are mental health inquiries at which the patient must attend for the inquiry to proceed – for mental health inquiries the rate of client attendance was 95.9%. The mental health inquiry is usually adjourned if

the patient is not able to attend.

In forensic matters, where there is a general requirement that the person attend unless excused from doing so by the Tribunal, the rate was 91.2%. Most of the hearing where the forensic patient did not attend were reviews of Forensic Community Treatment Orders which, with the agreement of the forensic patient, were often conducted 'on the papers'.

Appeals

Section 163 of the Act and s77A of the *Mental Health (Forensic Provisions) Act 1990* provide for appeals by leave against decisions of the Tribunal to be brought to the Supreme Court of NSW. An appeal as to the release of a forensic patient may be made to the Court of Appeal.

During 2017/18 only one appeal was lodged with the Supreme Court of NSW. This appeal plus two appeals lodged in early 2017 with the Court of Appeal were all finalised in 2017/18. All three appeals were dismissed.

Section 50 of the *NSW Trustee and Guardian Act 2009* provides for appeals to be made to the NSW Civil and Administrative Tribunal (NCAT) against estate management orders made by the Tribunal. There were no such appeals lodged during 2017/18. However one appeal lodged in March 2017 was finalised in November 2017. This appeal was upheld and the Tribunal's decision to decline to revoke a Financial Management Order was set aside and the order was revoked.

Multicultural Policies and Services

The Tribunal is not required to report under the Multicultural Policies and Services Program. However, both the Act and the *Mental Health (Forensic Provisions) Act 1990* contain specific provisions designed to promote and protect the principles of access and equity. Members of the Tribunal include consumers and persons from various ethnic origins or backgrounds including Aboriginal and Torres Straight Islanders.

Persons appearing before the Tribunal have a right under s158 of the Act to be assisted by an interpreter if they are unable to communicate adequately in English. During 2017/18 interpreters in 49 different languages were used in a total of 559 hearings. This is 45 less hearings involving an interpreter than in 2015/16 – a 7.5% decrease. The most common languages used were Mandarin (121), Vietnamese (66) and Cantonese (54) followed by Arabic (51), Serb/Croatian (24) and Greek (24).

In August 2009 the Tribunal entered in to a Memorandum of Understanding with the Community Relations Commission (now called Multicultural NSW) on the provision of translation services concerning the Tribunal's official forensic orders. There were no forensic orders translated in 2017/18 and only one 2016/17.

In future years, the Tribunal will continue to arrange interpreters and translations as required and ensure that its membership includes representation from people with a multicultural background. Translated copies of some of the Statements of Rights are available from the Tribunal's website with a link to the NSW Health website.

Government Information (Public Access) Act 2009

Applications for access to information from the Tribunal under the *Government Information (Public Access) Act 2009* (GIPA Act) are made through the Right to Information Officer at the NSW Ministry of Health. The administrative and policy functions of the Tribunal are covered by the GIPA Act. However information relating to the judicial functions of the Tribunal is 'excluded information' under the GIPA Act and as such is generally not disclosed.

There was one request for disclosure of information from the Tribunal's client files during 2017/18. The

request was refused by the Ministry of Health on the basis that it sought access to "excluded information". This decision was appealed to the NSW Civil & Administrative Tribunal but was dismissed as the application was withdrawn.

Public Interest Disclosures Act 1994

Public Authorities in New South Wales are required to report annually on their obligations under the *Public Interest Disclosures Act 1994*.

There were no Public Interest Disclosures received by the Tribunal during the reporting period.

Data Collection – Involuntary Referral to Mental Health Facilities

The Tribunal is required under the Act to collect information concerning the number of involuntary referrals and the provisions of the Act under which the patients were taken to hospital and admitted or released. The Regulations to the Act provide that these details are collected by means of a form which all inpatient mental health facilities are required to forward to the Tribunal with respect to each involuntary referral (Form 9).

Although a large number of Emergency Departments (54) are now gazetted under the Act as emergency assessment facilities, most Emergency Departments have historically not completed Form 9s. This has meant that the data collected from these Forms has been incomplete and not accurately reflected the full number of involuntary referrals, particularly those taken by ambulance or police to an Emergency Department rather than directly to an inpatient mental health facility.

In September 2014 Mr Ken Whelan, then Deputy Secretary of the Ministry of Health, wrote to the Chief Executives of all Local Health Districts reminding of the requirement for Emergency Departments to comply with these reporting requirements. Despite some initial improvement in reporting from Emergency Departments, an acceptable level of compliance is yet to be achieved, with only 14.8% of gazetted Emergency Departments returning any of the required Form 9s during 2017/18 (down from 20.4% in 2016/17, 31% in 2015/16 and 25% in 2014/15).

The returns from Emergency Departments totalled 3130 involuntary referrals indicating that there remains a large number of people being involuntarily taken to emergency assessment mental health facilities that are not being recorded through this process. It is possible that some of these people are being recorded on the Form 9s submitted by mental health facilities within the same hospital, however, this is impossible to quantify.

Information from this data is contained in Table 4 and in Appendix 1.

Official Visitor Program

The Official Visitor Program is an independent statutory program under the Act reporting to the Minister for Mental Health. The Program is headed by the Principal Official Visitor and supported by three permanent staff positions, including a Program Manager. In March 2008 the Official Visitor Program relocated to share premises with the Tribunal at Gladesville and became administratively reportable to the Registrar of the Tribunal.

In late 2017 to Program relocated to new premises adjacent to the Tribunal's premises at Gladesville. While still connected to the Tribunal, these new premises offer the Program more space and greater 'separation' from the Tribunal.

Although the Program is administratively supported by the Registrar and staff of the Tribunal, it remains completely independent of the Tribunal in terms of its statutory role. Official Visitors and the Principal Official Visitor report directly to the Minister.

A Memorandum of Understanding was entered into by the Tribunal and the Official Visitor Program in 2009 setting out the agreed systems for raising issues identified by the Tribunal or the Official Visitor Program in relation to the other body. A number of matters were referred to the Official Visitor Program by the Tribunal during 2017/18 for follow up by Official Visitors.

The Registrar of the Tribunal meets regularly with the Principal Official Visitor and Program Manager to discuss issues relating to the administration of the Program.

Premises

The Tribunal continues to operate from its premises in the grounds of Gladesville Hospital.

The Tribunal has seven hearing rooms all fitted with video conferencing facilities. Video conferencing equipment has also been installed in the Tribunal's conference room. This room is now used occasionally for 'overflow' hearings when all other hearing rooms are being used. There are two separate waiting areas for use by people attending hearings and rooms available for advocates and representatives to meet with their clients prior to hearings.

One of the Tribunal's hearing rooms continues to be made available for use by the Northern Territory Mental Health Review Tribunal once or twice a week for the conduct of their hearings by video conference using psychiatrist members located in New South Wales.

Venues

Regular liaison with hearing venues is essential for the smooth running of the Tribunal's hearings. Venue coordinators or Tribunal Liaison Clerks at each site provide invaluable assistance in the scheduling of matters; collation of evidence and other relevant information for the panels; contacting family members and advocates for the hearing; and supporting the work of the Tribunal on the day. This role is particularly important in ensuring that all the necessary notifications have occurred and correct documentation is available for mental health inquiries. In most facilities this role is carried out by staff who are already very busy with their other responsibilities. The Tribunal is very appreciative of the support provided by staff at all the facilities where we conduct hearings.

The Tribunal continues to experience some difficulties with facilities at some venues:

- Many venues do not have an appropriate waiting area for family members and patients prior to their hearing.
- Essential resources such as video conference equipment or telephones with speaker capacity are sometimes unavailable or not working in some venues.
- Staff at venues are not always familiar with the video conferencing equipment used to conduct hearings or the help desk or support arrangements in place to deal with problems with this equipment. This can lead to delays in some hearings.
- There are safety and security concerns at a number of venues, with panels utilising hearing rooms without adequate points of exit or other appropriate security systems in place.

These issues are monitored and particular concerns or incidents raised with venues as they arise.

Community Education and Liaison

During 2017/18 the Tribunal conducted a number of community education sessions to inpatient and community staff at various facilities across the State. These sessions were used to explain the role and

jurisdiction of the Tribunal and the application of the *Mental Health Act 2007* and the *Mental Health (Forensic Provisions) Act 1990*.

Staff and full time members of the Tribunal also attended and participated in a number of external conferences, training sessions and events.

Staff

Although the number of hearings conducted by the Tribunal has increased more than sevenfold since the Tribunal's first full year of operation in 1991 staffing levels remained relatively the same for many years with the increased workload absorbed through internal efficiencies and the increased use of information technology. Managing the increase in the Tribunal's workload has only been possible due to the ongoing hard work and dedication of the Tribunal's staff. However, the Tribunal is now at the point where additional staffing resources are required for the Tribunal to continue to meet its statutory responsibilities, particularly in the Forensic Division.

The Tribunal has very stable staffing with many staff having worked here for a number of years. Apart from some recent turnover in staff almost all of the Tribunal's staffing positions remain occupied by permanent staff all working in their own positions. This is a very positive position and provides stability for our staff and recognises their ongoing commitment to the work of the Tribunal.

Appendix 4 shows the organisational structure and staffing of the Tribunal as at 30 June 2018. Including the President and two full time Deputy President positions, the Tribunal has a staffing establishment of 29.4 positions. All positions are filled on an ongoing basis apart for a two day per week part time position.

Tribunal Members

Appendix 3 provides a list of the members of the Tribunal as at 30 June 2018. As at this date the Tribunal had a President, two full time Deputy Presidents, seven part time Deputy Presidents and 132 part time members.

The Tribunal's membership reflects a sound gender balance. As at 30 June 2018, including Presidential members, there were 81 female and 61 male members. There are a number of members who have indigenous or culturally diverse backgrounds as well as a number who have a lived experience with mental illness and bring a valuable consumer focus to the Tribunal's hearings and general operations.

Part time Tribunal members are generally appointed for four year terms with the last recruitment carried out in 2016. Our next planned recruitment is not until 2020.

One part time Deputy President, the Hon Terry Buddin SC and one part time psychiatrist member, Dr Sheila Metcalfe both resigned from their appointments during 2017/18. Their contribution to the important work of the Tribunal is greatly appreciated.

Members of the Tribunal sit on hearings in accordance with a roster drawn up to reflect members' availability, preferences and the need for hearings. Most members sit between two and four times per month at regular venues.

The Tribunal has a large number of dedicated and skilled members who bring a vast and varied backgrounds, qualifications and perspectives. The experience, expertise and dedication of these members is enormous and often they are required to attend and conduct hearings in very stressful circumstances at inpatient and community mental health facilities, correctional centres and other venues.

In 2017/18 the Tribunal continued its program of regular professional development sessions for its members. These sessions involve presentations from Tribunal members and staff as well as guest speakers. Topics covered during the reporting period included: Drug screening – what it tells us and what it doesn't; Journey to Home: Hospital is not home - Pathways to Community Living; Consumer, Carer and Clinician perspectives on person centered care; Current best practice prescribing for major mental disorders; Poly-pharmacy, what is it, and what do we do about it.

In February 2018 the Tribunal also conducted a facilitated workshop for our Tribunal members on fair, therapeutic and consumer focussed hearings. Funding and support for this workshop was provided by the Health Education and Training Institute (HETI). The workshop was held at Flourish Australia's Figtree Conference Centre at Olympic Park. The Tribunal is most appreciative of the support and assistance of both HETI and the staff at Figtree.

The Tribunal continues to regularly distribute practice directions, circulars and information to our members to support their work in conducting hearings. Presidential members are also available on a day-to-day basis to assist and respond to enquiries from members and other parties involved in the Tribunal process.

Financial Report

In recent years the Tribunal had received its funding through the Mental Health Branch, Ministry of Health. A change was made to this arrangement last financial year and the Tribunal was funded directly from Finance Branch of the Ministry.

The budget allocation for 2017/18 was $6,968,567. Total net expenditure for the year was $7,001,945 – a budget deficit of $33,378.

A Treasury Adjustment of $400,000 was provided to the Ministry of Health being the agreed amount transferred for the Department of Attorney General and Justice to fund the mental health inquiries role. An additional $400,000 was provided by the Ministry of Health in 2012 to fund the changes to the mental health inquiry system discussed above. The actual expenditure related to this role for the financial year was $775,964. This included the cost of additional three member Tribunal panels required to deal with the increased number of appeals lodged by patients against an authorised medical officer's refusal to discharge.

See Appendix 5 for further detail.

The Tribunal is most appreciative of the support provided by the Minister for Mental Health and the Mental Health Branch and Finance Branch to enable the Tribunal to meet the obligations of its core business in the statutory review of patients under the *Mental Health Act 2007* and the *Mental Health (Forensic Provisions) Act 1990*.

Thank You

The Tribunal is very fortunate to have such great staff and fantastic and committed members. I would like to thank the staff and members of the Tribunal for their continued hard work and commitment to the very important work that we do. I would also like to thank those staff in the inpatient and community based mental health facilities with whom the Tribunal has had contact over the last 12 months. The successful operation of the Tribunal in conducting more than 18,500 hearings would not have been possible without their ongoing co-operation and support.

Rodney Brabin
Registrar

5. STATISTICAL REVIEW

5.1 CIVIL JURISDICTION

Table 1

Summary of statistics relating to the Tribunal's civil jurisdiction under the *Mental Health Act 2007* for the period 1 July 2017 to 30 June 2018

Section of Act	*Description of Review*	*Hearings (Including Adjournments)*			*% Reviewed by Sex*		*Legally Represented*	*Client Attended*
		M	*F*	*Total*	*M*	*F*		
s9	Review of voluntary patients	46	33	79	58	42	44 (56%)	65 (82%)
s34	Mental Health Inquiry	3838	2968	6806	56	44	6727 (99%)	6606(97%)
s37(1)(a)	Initial review of involuntary patients prior to expiry of initial period of detention as a result of mental health inquiry	898	657	1555	58	42	1410 (91%)	1405(90%)
s37(1)(b)	3 monthly review of involuntary patients after initial 12 month period	468	267	735	64	36	659 (90%)	645 (88%)
s37(1)(c)	Continued review of involuntary patients after initial 12 month period	336	205	541	62	38	342 (63%)	479 (89%)
s44	Appeal against an authorised medical officer's refusal to discharge	391	294	685	59	41	562 (82%)	642 (94%)
s51	Community treatment orders	3467	1890	5357	65	35	2987 (56%)	3855 (72%)
s63	Review of affected persons detained under a community treatment order	9	6	15	60	40	14 (93%)	13 (87%)
s65	Revocation of a community treatment order	7	5	12	58	42	4 (33%)	4 (33%)
s65	Variation of a community treatment order	159	83	242	66	34	26 (11%)	7 (3%)
s65	Variation of Forensic CTO	40	5	45	89	11	34 (76%)	20 (22%)
s67	Appeal against a Magistrate's community treatment order	-	-	-	-	-	-	-
s96(1)	Review of voluntary patient's capacity to give informed consent to ECT	1	3	4	25	75	3 (75%)	3 (75%)
s96(2)	Application to administer ECT to an involuntary patient with or without consent	331	479	810	41	59	633 (78%)	717 (89%)
s96(3)	Application to administer ECT to person under 16 - voluntary patient	-	1	1	-	-	-	-
s101	Application to perform a surgical operation	8	2	10	80	20	3 (30%)	9 (90%)
s103	Application to carry out special medical treatment	-	1	1	-	100	- (0%)	1 (100%)
s151(4)	Procedural order	2	3	5	40	60	4 (80%)	4 (80%)
s162	Application to publish or broadcast name of patient	-	1	1	-	-	100	100
TOTAL		**10001**	**6903**	**16904**	**59**	**41**	**13453 (80%)**	**14476 (86%)**

Note: The Tribunal received notification of two emergency surgeries for involuntary patients (s99) - see Table 13.

Table 2

Summary of statistics relating to the Tribunal's civil jurisdiction under the *Mental Health Act 2007* for the periods 2014/15, 2015/16, 2016/17 and 2017/18

	2014/15	*2015/16*	*2016/17*	*2017/18*
Reviews of assessable persons - Mental Health Inquiries (s34)	6633	6887	6757	6806
Reviews of persons detained in a mental health facility for involuntary treatment (s37(1))	2585	2695	2725	2831
Appeal against authorised medical officer's refusal to discharge (s44)	643	641	690	685
Applications for orders for involuntary treatment in a community setting (s51)	5141	5357	5331	5357
Variation and Revocation of Community Treatment Orders (s65)	196	227	248	299
Review of those persons detained in a mental health facility following a breach of the Community Treatment Order (s63)	4	6	7	15
Appeal against a Magistrate's Community Treatment Order (s67)	-	-	-	-
Review of those in a mental health facility receiving voluntary treatment who have been in the facility for more than 12 months (s9)	62	69	98	79
Consent to Surgical Operation (s101)	7	5	9	10
Consent to Special Medical Treatment (s103)	2	-	1	1
Review voluntary patient's capacity to consent to ECT (s96(1))	1	6	3	4
Application to administer ECT to an involuntary patient	758	698	719	810
Application to administer ECT to a person under 16 - voluntary patient	-	-	-	1
Procedural order	-	4	1	2
Application for representation by non legal practitioner	1	-	-	3
Application to publish or broadcast	2	1	-	1
TOTALS	**16035**	**16596**	**16589**	**16904**

Table 3

Summary of outcomes for reviews of assessable persons at a mental health inquiry for the period 1 July 2017 to 30 June 2018

M	*F*	*T*	*Adjourn*	*Invol Patient Order*	*Discharge*	*Deferred Discharge*	*Discharge on CTO*	*Discharge to Carer*	*Declined to deal with/ withdrawn*	*Reclass to Voluntary*
3838	2968	6806*	677	5676	15	41	335**	12***	50	-

Note: * These determinations related to 5629 individuals.
** Includes 23 deferred discharge on making of a CTO.
*** Includes 7 deferred discharge to carer.

Table 4

Flow chart showing progress of involuntary patients admitted during the period July 2017 to June 2018

Persons taken to a mental health facility involuntarily

Total involuntary referrals

Involuntary admissions (11,430 mentally ill and 4,446 mentally disordered persons)

Mental health inquiries commenced under s34 (includes 677 hearings that were adjourned)

Involuntary patient orders made at a mental health inquiry (35.8% of total involuntary admissions; 83.4% of mental health inquiries commenced)

Involuntary patient reviews by Tribunal under s37(1)(a) (9.8% of total involuntary admissions; 27.4% of persons placed on involuntary orders at a mental health inquiry)

Involuntary patient orders made by Tribunal pursuant to s37(1)(a) review (8.4% of total involuntary admissions; 85.9% of patient reviews under s37(1)(a))

Involuntary patient review unders s37(1)(b) (4.6% of total involuntary admissions; 55% of patients placed on involuntary orders by Tribunal under s37(1)(a))

Involuntary patient orders made by Tribunal pursuant to s37(1)(b) reviews (4% of total involuntary admissions; 87.1 of patient reviews under s37(1)(b)).

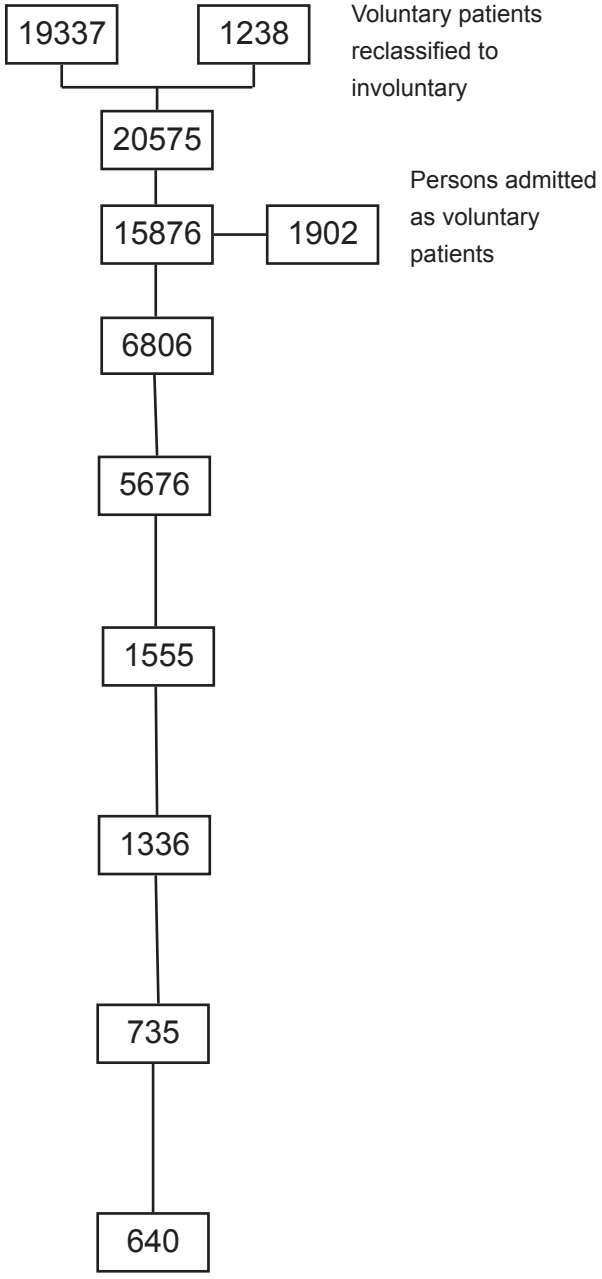


Table 5

Summary of patients subject to involuntary patient orders or voluntary patient review as at 30 June 2018

Hospital	*s34*	*s37(1)a*	*s37(1)b*	*s37(1)c*	*Total Involuntary*	*Voluntary*	*Total*
Albury	6	2	-	-	8	-	8
Bankstown	12	5	-	-	17	-	17
Blacktown	11	6	3	-	20	-	20
Bloomfield	25	13	12	34	84	6	90
Blue Mountains	4	3	-	-	7	-	7
Braeside	8	1	1	-	10	-	10
Broken Hill	1	-	-	-	1	-	1
Campbelltown	18	13	1	-	32	-	32
Coffs Harbour	13	5	4	1	23	-	23
Concord	50	35	17	15	117	6	123
Cumberland	35	20	12	64	131	17	148
Dubbo	3	1	-	-	4	-	4
Forensic Hospital	1	1	1	7	10	-	10
Gosford	16	4	1	-	20	-	20
Goulburn	13	1	3	-	17	-	17
Greenwich	4	4	-	-	8	-	8
Hornsby	23	8	4	-	35	-	35
John Hunter	4	-	-	-	4	-	4
Kenmore	3	2	-	-	5	1	6
Lismore	11	7	1	-	19	-	19
Liverpool	24	18	3	2	47	10	57
Macquarie	3	8	30	88	129	25	154
Maitland	4	1	-	1	6	-	6
Manly	14	8	1	-	23	-	23
Mater MHC	46	18	10	10	84	3	87
Morisset	-	-	21	35	56	3	59
Nepean	14	9	3	1	27	1	28
Prince of Wales	30	16	9	1	56	-	56
Port Macquarie	8	1	-	-	9	-	9
Royal North Shore	17	11	-	-	28	-	28
Royal Prince Alfred	27	13	-	-	40	-	40
Shellharbour	25	15	2	1	43	-	43
South East Regional	7	3	-	-	10	-	10
St George	15	11	1	1	28	-	28
St Joseph's	3	2	-	-	5	-	5
St Vincent's	18	6	2	-	26	-	26
Sutherland	12	9	3	-	24	-	24
Tamworth	9	7	-	2	18	-	18
Taree	6	3	1	-	10	-	10
Tweed Heads	5	3	2	-	10	-	10
Wagga	8	6	1	-	15	-	15
Westmead Adult Psych	7	1	1	1	10	-	10
Westmead Child/Adolesc	2	1	1	-	4	-	4
Westmead PsychGeriatric	1	1	-	-	2	-	2
Wollongong	11	2	3	-	16	-	16
Wyong	13	5	-	-	18	-	18
Total	**590**	**309**	**153**	**264**	**1316**	**72**	**1388**

Note: This table represents a 'snap shot' as at 30 June 2018 of the number of people subject to involuntary patient orders, CTOs or reviewed as long term voluntary patients. A number of these people may have been discharged from the facility or order. There will also be other voluntary patients who have not been reviewed by the Tribunal as they have not been a voluntary patient for 12 months.

Table 6

Involuntary patients reviewed by the Tribunal under the *Mental Health Act 2007* for the period 1 July 2017 to 30 June 2018

		M	*F*	*T*	*Adjourn*	*Withdrawn No Jurisdic-tion*	*Discharge/ voluntary*	*Discharge on CTO*	*Continued detention as involuntary patient*
s37(1)(a)	Review prior to expiry order for detention as a result of a mental health inquiry	898	657	1555	179	7	25	8	1336
s37(1)(b)	Review at least once every 3 months during first 12 months person is an involuntary patient	468	267	735	75	8	10	2	640
s37(1)(c)	Review at least once every 6 months while person is an involuntary patient after first 12 months	336	205	541	29	-	2	-	510
Total		1702	1129	2831	283	15	37	10	2486

Note: The 1555 reviews under s37(1)(a) related to 1408 individuals.
The 735 reviews under s37(1)(b) related to 430 individuals.
The 541 reviews under s37(1)(c) related to 305 individuals.
The total of 2486 reviews under s37(1) related to 1780 individuals.

Table 7

Summary of outcomes of appeals by patients against an authorised medical officer's refusal of or failure to determine a request for discharge (s44) during the periods 2009/10 - 2017/18

	M	F	T	Adjourned	Withdrawn no jurisdiction	Appeal Dismissed	Dismissed and no further Appeal to be heard prior to next scheduled review	Discharged	Reclass to Voluntary
July 09 - June 10	137	118	255	27	14	192	18	3	1
July 10 - June 11	336	272	608	50	43	471	18	25	1
July 11 - June 12	413	362	775	49	62	613	20	26	5
July 12 - June 13	304	287	591	46	28	461	26	29	1
July 13 - June 14	365	284	649	56	25	521	25	22	-
July 14 - June 15	365	278	643	38	74	492	28	11	-
July 15 - June 16	339	302	641	54	77	481	12	17	-
July 16 - June 17	404	286	690	60	59	533	21	16	1
July 17 - June 18	391	294	685*	43	55	559	15	12**	1

Note: * These determinations related to 558 individuals..
** Includes 10 orders for discharge where discharge was deferred.

Table 8

Community Treatment Orders for declared mental health facilities made by the Tribunal for the periods 2015/16, 2016/17 and 2017/18

Health Care Agency	*2015/16 Total CTOs*	*2016/17 Total CTOs*	*2017/18 Total CTOs*	*Health Care Agency*	*2015/16 Total CTOs*	*2016/17 Total CTOs*	*2017/18 Total CTOs*
Albury CMHS	30	33	30	Inner City MHS	87	78	73
Auburn CHC	45	49	46	Kempsey CMHS	28	48	43
Bankstown MHS	141	117	149	Lake Illawarra Sector MHS	7	1	-
Bega Valley Counselling & MHS	30	22	28	Lake Macquarie MHS	99	79	70
Blacktown and Mt Druitt PS	217	268	246	Lismore MHOPS	89	97	112
Blue Mountains MHS	98	89	59	Lithgow MHS	-	-	5
Bondi Junction CHC	5	8	6	Liverpool MHS	87	125	127
Bowral CMHS	16	9	11	Macquarie Area MHS	81	76	81
Byron MHS	-	2	15	Manly Hospital & CMHS	153	171	140
Campbelltown MHS	159	129	169	Maroubra CMH	148	164	185
Camperdown CMHS	176	166	158	Marrickville CMHS	102	121	121
Canterbury CMHS	173	118	100	Merrylands CHC	128	97	74
Central Coast AMHS	367	361	401	Mid Western CMHS	109	133	123
Clarence District HS	56	26	-	Mudgee MHS	8	13	11
Coffs Harbour MHOPS	80	77	93	Newcastle MHS	162	186	209
Cooma MHS	22	17	24	Northern Illawarra MHS	8	1	-
Cootamundra MHS	1	1	-	Orange C Res/Rehab Services	8	8	5
Croydon CMHS	161	197	236	Parramatta CHS	98	87	98
Deniliquin District MHS	22	26	29	Penrith MHS	130	140	78
Dundas CHC	43	45	35	Port Macquarie CMHS	46	32	30
Eurobodalla CMHS	46	49	32	Queanbeyan MHS	51	34	34
Fairfield MHS	156	162	156	Redfern CMHS	59	57	36
Far West MHS	25	32	20	Royal North Shore H & CMHS	137	128	157
Goulburn CMHS	31	37	37	Ryde Hospital & CMHS	96	103	135
Grafton MHS		22	37	Shoalhaven MHS	59	47	72
Granville MHS	18	24	25	Springwood MHS	-	-	8
Griffith (Murrumbidgee) MHS	29	35	38	St George Div of Psychiatry & MH	228	238	221
Hawkesbury MHS	15	22	20	St Mary's MHS	-	-	44
Hills CMHC	69	63	47	Sutherland C Adult & Family MHS	97	98	80
Hornsby Ku-ring-gai Hospital & CMHS	113	125	152	Tamworth CMHS	2	1	10
Hunter	-	-	1	Taree CMHS	56	56	70
Hunter NE Mehi/McIntyre	34	24	29	Temora CMH	10	8	10
Hunter NE Peel	50	37	39	Tumut CMHS	5	4	8
Hunter NE Tablelands	19	14	20	Tweed MHS	125	129	106
Hunter Valley HCA	73	99	82	Wagga Wagga CMHS	52	71	57
Illawarra CMHS	296	203	139	Young MHS	15	23	20

Total Number of Community Treatment Orders (CTOs) 2015-16 - 5386 (includes 336 CTOs made at mental health inquiries).
Total Number of Community Treatment Orders (CTOs) 2016-17 - 5362 (includes 362 CTOs made at mental health inquiries).
Total Number of Community Treatment Orders (CTOs) 2017-18 - 5362 (includes 335 CTOs made at mental health inquiries).

Table 9

Number of Community Counselling Orders and Community Treatment Orders made by the Tribunal and by Magistrates for the period 2007/8 to 2017/18

	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total	1318	997	806	-	-	-	-	-	-	-	-
Mental Health Inquiry CTOs			10	566	581	339	360	336	336	362	335
Total TribunalCCO/ CTOs	4706	4058	3956	4128	4426	4882	4824	4806	5050	5000	5027*
Total CCO/ CTOs made	**6024**	**5055**	**4772**	**4694**	**5007**	**5221**	**5184**	**5142**	**5386**	**5362**	**5362**

Note 1: The capcaity to make Community Counselling Orders (CCOs) ceased in November 2007 with the introduction of the *Mental Health Act 2007*

Note 2: Magistrates ceased making Community Treatment Orders (CTOs) at mental health inquiries in June 2010 when the Tribunal took over responsibility for conducting mental health inquiries.

* Includes 10 CTOs made at s37 reviews of involuntary patients

Table 10

Summary of outcomes for applications for Community Treatment Orders (s51) 2017/18

	M	F	Total	Adjourned	Withdrawn No Jurisdiction	Application Decline	CTO Made
Application for CTO for a person on an existing CTO	1466	764	2230	41	2	23	2164**
Application for a CTO for a person detained in a mental health facility	1012	637	1649	111	10	18	1510***
Application for a CTO not detained or on a current CTO	989	489	1478	104	2	29	1343****
Totals	**3467**	**1890**	**5357***	**256**	**14**	**70**	**5017**

Note: * These determinations related to 3599 individuals.
** Includes 2 CTOs when discharge was deferred.
*** Includes 44 CTOs where discharge was deferred.
**** Includes 4 CTOs where discharge was deferred.

Table 11

Tribunal determinations of ECT consent inquiries for voluntary patients for period 2017/18	
Adjourned	-
Capable and has consented	2
Capable but refused consent	1
Incapable of consent	1
Total	**4***

Note: * These determinations relate to four individuals.

Table 12

Tribunal determinations of ECT administration inquiries for the periods 2013/14, 2014/15, 2015/16, 2016/17 and 2017/18

Outcome	2013/14	2014/15	2015/16	2016/17	2017/18
Capable and has consented	30	42	34	25	35
ECT approved	616	649	580	610**	708**
ECT not approved	15	19	24	13	12
No jurisdiction/withdrawn	6	10	8	9	6
Adjourned	49	48	58	66	51
Totals	**716**	**768**	**704**	**723***	**812***

Note: * These determinations related to 492 individual patients (including six hearings involving three forensic patients)

** Includes two forensic patient determinations.

Table 12A

Tribunal determinations of ECT inquiries for persons under the age of 16 years for the period 2017/18

Outcome	Vountary Patient	Involuntary Patient
Capable and consented	1	-
ECT approved	-	-
ECT not approved	-	-
No jurisdiction/withdrawn	-	-
Adjourned	-	-
Totals	**1**	**-**

Table 13

Summary of notifications received in relation to emergency surgery (s99) during the periods 2011/12, 2012/13, 2013/14, 2014/15, 2015/16, 2016/17 and 2017/18

	M	F	T	Lung/Heart/ Kidney	Pelvis/Hip/ Leg/Spinal	Tissue/Skin	Hernia	Gastro/ Bowel/ Abdominal	Brain
2011/12	3	5	8	4	-	1	-	1	1
2012/13	1	2	3	1	1	-	1	-	-
2013/14	3	2	5	1	-	-	-	4	-
2014/15	4	-	4	2	1	-	-	1	-
2015/16	1	1	2	-	1	-	-	1	-
2016/17	2	2	4	1	2	1	-	-	-
2017/18	2	-	2*	-	1	1	-	-	-

Note: * These notifications related to two patients.

Table 14

Summary of outcomes for applications for consent to surgical procedures (s101) and special medical treatments (s103) for the period 2017/18

	M	F	T	Approved	Refused	Adjourned	Withdrawn/No Jursidcition
Surgical procedures	8	2	10	7	3	-	-
Special medical treatment	-	1	1	1	-	-	-

Note: * These determinations related to nine individuals.

5.2 FINANCIAL MANAGEMENT

Table 15

Summary of statistics relating to the Tribunal's jurisdiction under the *NSW Trustee & Guardian Act 2009* for the period July 2017 to June 2018

Section of Act	*Description of Reviews*	*Reviews*			*Adjourn-ments*	*With-drawn no jurisdic-tion*	*Order made*	*No Order made*	*Interim Order under s20*	*Revoca-tion Ap-proved*	*Revo-cation Declined*	*Legal Repres.*
		M	*F*	*T*								
s44	At a Mental Health Inquiry	22	15	37	13	1	11	9	3	-	-	34
s45	After reviewing a forensic patient	-	-	-	-	-	-	-	-	-	-	-
s46	On application to Tribunal for Order	35	22	57	10	1	30	14	2	-	-	55
s48	Review of interim FM order	-	1	1	1	-	1	-	-	-	-	1
s88	Revocation of Order	24	25	49*	9	1	-	-	-	20**	19***	24*
Total		**81**	**63**	**144**	**33**	**3**	**42**	**23**	**5**	**20**	**19**	**114**

Note: * Includes three forensic patient hearings.

** Includes determinations for two forensic patients.

*** Includes a determination for one forensic patient.

5.3 FORENSIC JURISDICTION

Table 16

Number of Tribunal reviews of forensic patients under the *Mental Health (Forensic Provisions) Act 1990* for 2016/17 and 2017/18

Description of Review	***2016/17 Reviews***			***2017/18 Reviews***		
	M	F	T	M	F	T
Review after finding of not guilty by reason of mental illness (s44)	18	4	22	25	8	33
Review after detention or bail imposed under s17 following finding of unfitness (s45(1)(a))	-	-	-	1	-	1
Review after limiting term imposed following a special hearing (s45(b))	8	1	9	3	3	6
Regular review of forensic patients (s46(1))	772	89	861	781	89	870
Application to extend period of review of forensic patients (s46(4))	-	-	-	-	-	-
Regular review of correctional patients (s61(1))	9	1	10	7	-	7
Review of a forensic patient following their apprehension due to an alleged breach of a condition of leave or release (s68(2))	71	7	78	45	7	52
Application by a victim of a forensic patient for the imposition of a non contact or place restriction condition on the leave or release of the forensic patient (s76)	2	1	3	5	-	5
Initial review of person transferred from prison to MHF (s59)	66	12	78	94	11	105
Review of person awaiting transfer from prison (s58)	17	7	24	17	3	20
Application for a forensic community treatment order (s67)	114	8	122	162	11	173
Application to vary forensic community treatment order (s65)	6	-	6	1	-	1
Regular review of person subject to a forensic community treatment order and detained in a correctional centre (s61(3))	58	1	59	115	10	125
Request to suspend operation of an order pending determination of an appeal (s77A(11))	1	-	1	-	-	-
Application for ECT (s96)[1]	3	1	4	2	-	2
Application for surgical operation (s101)	1	-	1	-	-	-
Application to revoke Financial Management Order (s88)	2	-	2	2	1	3
Review of interim Financial Management Order	-	1	1	-	-	-
Application to allow publication of names (s162)	-	-	-	2	-	2
Approval of change of name (s31D)	-	2	2	4	-	4
Total	**1148**	**135**	**1283**	**1266**	**143**	**1409***
Determinations						
Fitness s16	45	4	49	65	9	74
Following limiting term s24	9	1	10	8	2	10
Total	**54**	**5**	**59**	**73**	**11**	**84**
Combined Total	**1202**	**140**	**1342**	**1339**	**154**	**1493***

* Includes three Financial Management hearings under s88 *NSW Trustee & Guardian Act 2009*.

Table 17	
Outcomes: s16 Determination of fitness to be tried for period 2017/18	
s16 person is likely to become fit to be tried and is suffering from a mental illness	9
s16 person is likely to become fit to be tried and is suffering from neither a mental illness nor a mental condition	1
s16 person will not become fit to be tried	50
Adjournment	14
Total	**74***

* These hearings related to 61 patients.

Table 18	
Outcomes: s24 Determination following nomination of limiting term for period 2017/18	
s24 preson is mentally ill. Referring court to be notified	3
s24 person is suffering from a mental condition and does object to detention in hospital	1
s24 person is suffering from a mental condition and does not object to detention in hospital	3
Adjournment	3
Total	**10***

* These hearings related to eight patients.

Table 19	
Outcomes: s44 First review following finding of not guilty by reason of mental illness for period 2017/18	
Court order for conditional release replaced by Tribunal order	5
Current order for conditional release to continue	2
Current order for detention to continue	5
Transfer to another facility	15
Release - conditional	1
Release - conditions varied	1
Revocation of conditional release	1
No financial management order made	3
Adjournment	3
Total	**36**

* These hearings related to 30 patients.

Table 20	
Outcomes: s45(1)(a) and (b) First review following detention under s17 or s27 for period 2017/18	
s45 person has become fit to be tried	-
s45 person has not become fit and will not become fit within 12 months	5
Adjournment	2
Total	**7***

* These hearings related to six patients.

Table 21	
Outcomes: s46 Review of forensic patients for period 2017/18	
Current order for conditional release to continue	148
Current order for detention to conintue	336
Current order for apprehension to continue	1
Directons issued	1
s46(5) extension of period of review granted	69
Grant of leave of absence	123
s151(4) that hearing be conducted wholly or partly in private	1
s47(4) person is fit to be tried	7
s47(4) person is not fit to be tried	77
s46(5) extension of period of review not granted	2
Transfer to another facility	30
Release - conditional	29
Release - conditions varied	98
Release - unconditional	6
Release - unconditional, CTO also made	13
Revocation of conditional release	-
Current orders for transfer and detention to continue	44
Transfer to another facility - time limited order	14
Variation to current order for transfer and detention	2
Adjournment	68
Decision reserved	1
s47(4) Decision reserved	2
s45 Financial management order made	1
Total	**1073***

* These hearings related to 442 patients

Table 22	
Outcomes: s58 Limited review of correctional patients awaiting transfer to a mental health facility for period 2017/18	
Transfer to another facility	18
Adjournment	2
Total	**20***

* These hearing realted to 17 patients

Table 23	
Outcomes: s59 First review following transfer from a correctional centre to a mental health facility for period 2017/18	
Ordered to be detained in a mental health facility	92
s65(1) classified involuntary patient - correctional patient status expires	-
s59 person is a mentally ill person, continue in a mental health facility	91
s59 is a mentally ill person and appropriate care is available in a correctional centre under a FCTO	6
s59 is a mentally ill person and appropriate care is available in a correctional centre	-
s59 person is not a mentally ill person, continue in a mental health facility	1
s59 person is not a mentally ill person, and should not continue in a mental health facility	-
Transfer to another facility	3
s45 No financial management order made	80
s45 Financial management order adjourned	1
Adjournment	7
Total	**281***

* These hearings related to 96 patients.

Table 24	
Outcomes: s61(1) Review of correctional patients for period 2017/18	
Ordered to be detained in a mental health facility	7
s65(1) classified involuntary patient - correctional patient status expires	-
Total	**7***

* These hearing related to six patients.

Table 25	
Outcomes: s67 Application for a forensic CTO for period 2017/18	
Forensic CTO made	154
CTO made to have effect on date of unconditional release	11
Forensic CTO not made	2
Application withdrawn at hearing	1
Adjournment	5
Total	**173***

* These hearings related to 154 patients.

Table 26	
Outcomes: s61(3) Review of person subject to a CTO in gaol for period 2017/18	
Forensic CTO to continue	122
Forensic CTO varied	1
Adjournment	2
Total	**125***

* These hearings related to 86 patients.

Table 27	
Outcomes: s65 Application to vary a forensic CTO for period 2017/18	
Forensic CTO varied	1
Tribunal has no jurisdiction	-
Adjournment	-
Total	**1***

* These hearings related to one patient.

Table 28	
Outcomes: s68(2) Review of person apprehended under s68 for period 2017/18	
Confirm order for conditional release	10
Grant of leave of absence	1
Confirm order granting leave of absence	2
Transfer to another facility	1
Revocation of conditional release	1
Decision reserved	-
Adjournment	39
Total	**54***

* These hearings related to 23 patients.

Table 29	
Outcomes: Procedural hearings for period 2017/18	
s76 Application of registered victim for non-association or place restriction	
Impose non-association condition for leave of absence	1
Vary a place restriction and non-association order on leave of absence	1
Application refused	2
Adjourned	1
s162 Application to publish or broadcast name	
Application granted	2
s31D Approval of change of name	
Application granted	4
Application refused	-
Total	**11***

* These hearings related to 10 patients.

Table 30			
Location of forensic and correctional patients as at 30 June 2016, 30 June 2017 and 30 June 2018			
	30 June 2016	**30 June 2017**	**30 June 2018**
Bankstown Hospital	1	-	-
Bathurst Correctional Centre	1	1	-
Blacktown Hospital	1	2	3
Bloomfield Hospital	23	21	18
Cessnock Correctional Centre	-	1	2
Community	132	186	182
Concord Hospital	6	7	8
Correctional Centre	1	3	32
Cumberland Hospital - Bunya Unit and Cottages	36	32	31
Forensic Hospital	111	119	109
Goulburn Correctional Centre	2	2	-
Grafton Correctonal Centre	-	-	2
Junee Correctional Centre	1	4	2
Juvenile Justice Centre	2	-	4
Lismore Hospital	1	1	1
Lithgow Correctional Centre	1	5	4
Liverpool Hospital	1	2	2
Long Bay Prison Hospital	46	46	57
Macquarie Hospital	8	9	9
Mater Mental Health Facility	-	-	1
Metropolitan Remand and Reception Centre	41	70	83
Metropolitan Special Programs Centre	12	16	18
Morisset Hospital and Cottages	30	27	31
Nepean Hospital	1	-	-
Parklea Correctional Centre	3	2	1
Prince of Wales Hospital	-	-	1
Shellharbour	1	2	1
Silverwater Womens Correctional Centre	3	5	7
South Coast Correctional Centre	1	1	3
South East Regional Hospital	-	-	1
St George Hospital	1	-	-
Wagga Wagga	-	-	1
Wollongong Hospital	1	1	1
Wyong	1	1	1
TOTAL	**468**	**566**	**616**

Table 31

Location of hearings held for forensic and correctional patients during 2015/16, 2016/17 and 2017/18

	2015/16	2016/17	2017/18
Bloomfield Hospital	33	46	46
Concord Hospital	3	10	15
Cumberland Hospital - Bunya Unit	94	92	95
Forensic Hospital	262	261	281
Long Bay Prison Hospital	216	209	251
Macquarie Hospital	11	19	19
Metropolitan Remand and Reception Centre	93	104	133
Morisset Hospital	65	68	54
Tribunal Premises	411	533	599
TOTAL	**1188**	**1342**	**1493**

Table 32

Category of forensic and correctional patients as at 30 June 2017 and 30 June 2018

Year	**2017**			**2018**		
Category	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Not Guilty by Reason of Mental Illness	330	42	372	339	47	386
Fitness/Fitness Bail	38	7	45	39	1	40
Limiting Term	22	2	24	22	3	25
Extension/Interim Extension orders	9	-	9	10	-	10
Correctional Patients	42	5	47	29	1	30
Forensic CTO	64	5	69	115	10	125
Total	**505**	**61**	**566**	**554**	**62**	**616**

Table 33

Number of forensic and correctional patients 2000 - 30 June 2018

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Patients	193	223	247	279	277	284	310	309	315	319	348	374	387	393	422	448	468	566	616

NOTES: Figures for 1997-2001 taken from MHRT Annual Reports as at 31 December of each year. Figures from 2002 - 2017 were taken as at 30 June of those years. Figures for 2009 - 2017 include correctional patients. Figures for 2011 - 2016 include one Norfolk Island forensic patient. Figures for 2011-1017 include Forensic CTOs.

Mental Health
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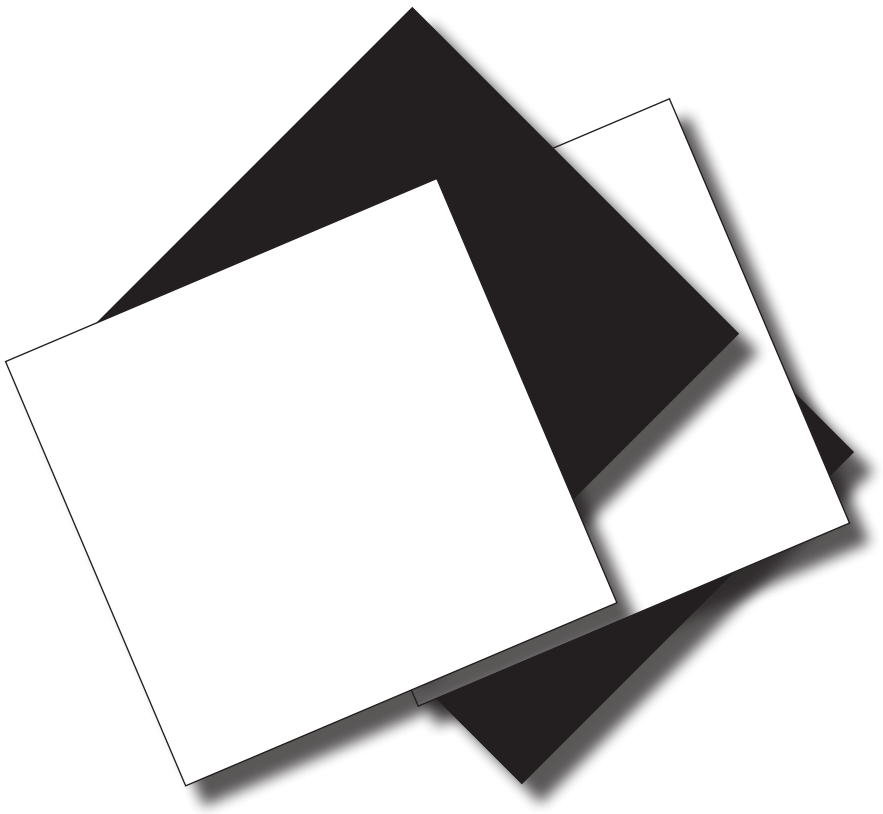
APPENDICES



Patient statistics required under MHA s147(2) concerning people taken to a mental health facility during the period July 2017 to June 2018

(1) s147(2)(a)

The number of persons taken to a mental health facility and the provisions of the Act under which they were so taken.

	Method of referal	*Admitted*	*Not Admitted*	*Total*
MHA				
s19	Certificate of Doctor	10623	497	11120
s22	Apprehension by Police	2071	1301	3372
s20	Ambulance Officer	1219	738	1957
s58	Breach Community Treatment Order	90	15	105
s26	Request by primary carer/relative/friend	1840	32	1872
s24	Order of Court	396	106	502
s23 via s19	Authorised Doctor's Certificate	397	12	409
Total Admissions		**16636**	**2701**	**19337**
Reclassified from Voluntary to Involuntary		1142	96	1238
TOTAL		**17778**	**2797**	**20575**

(2) s147(2)(b)

Persons were detained as mentally ill persons on 11430 occasions and as mentally disordered persons on 4446 occasions. 1902 persons were admitted as voluntary patients.

(3) s147(2)(c)

A total of 6757 mental health inquiries were commenced relating to 5490 individuals.

Outcome of mental health inquiries conducted 1 July 2017 - 30 June 2018

	MHRT
Adjourned	657
Discharge or deferred discharge	56
Reclassify from involuntary to voluntary	1
Involuntary patient order	5640
Community treatment order	362
Declined to deal with	41
TOTAL	**6757**

(4) s147(2)(d)

In 2017/18 of the 20575 persons taken involuntarily to a mental health facility or reclassified from voluntary to involuntary: 2797 were not admitted; 1902 people were admitted as a voluntary patient and 15876 were detained as either a mentally ill or mentally disordered person - a total of 17778 admissions (including 1142 of the 1238 people who were reclassified from voluntary to involuntary).

The jurisdiction of the Tribunal as at 30 June 2018 as set out in the various Acts under which it operates is as follows:

Mental Health Act 2007 Matters

• Review of voluntary patients	s9
• Reviews of assessable persons - mental health inquiries	s34
• Initial review of involuntary patients	s37(1)(a)
• Review of involuntary patients during first year	s37(1)(b)
• Continued review of involuntary patients	s37(1)(c)
• Appeal against medical superintendent's refusal to discharge	s44
• Making of community treatment orders	s51
• Review of affected persons detained under a community treatment order	s63
• Variation of a community treatment order	s65
• Revocation of a community treatment order	s65
• Appeal against a Magistrate's community treatment order	s67
• Review of voluntary patient's capacity to give informed consent to ECT	s96(1)
• Application to administer ECT to an involuntary patient (including forensic patients) with or without consent	s96(2)
• Inspect ECT register	s97
• Review report of emergency surgery involuntary patient	s99(1)
• Review report of emergency surgery forensic patient	s99(2)
• Application to perform a surgical operation on an involuntary patient	s101(1)
• Application to perform a surgical operation on a voluntary patient or a forensic patient not suffering from a mental illness	s101(4)
• Application to carry out special medical treatment on an involuntary patient	s103(1)
• Application to carry out prescribed special medical treatment	s103(3)

NSW Trustee & Guardian Act 2009 Matters

• Consideration of capability to manage affairs at mental health inquiries	s44
• Consideration of capability of forensic patients to manage affairs	s45
• Orders for management	s 46
• Interim order for management	s47
• Review of interim orders for management	s48
• Revocation of order for management	s86

Mental Health (Forensic Provisions) Act 1990 Matters

• Determination of certain matters where person found unfit to be tried	s16
• Determination of certain matters where person given a limiting term	s24
• Initial review of persons found not guilty by reason of mental illness	s44
• Initial review of persons found unfit to be tried	s45
• Further reviews of forensic patients	s46(1)
• Review of forensic patients subject to forensic community treatment orders	s46(3)
• Application to extend the period of review for a forensic patient	s46(4)
• Application for a grant of leave of absence for a forensic patient	s49
• Application for transfer from a mental health facility to a correctional centre for a correctional patient	s57
• Limited review of persons awaiting transfer from a correctional centre to a mental health facility	s58
• Initial review of persons transferred from a correctional centre to a mental health facility	s59
• Further reviews of correctional patients	s61(1)
• Review of those persons (other than forensic patients) subject to a forensic community treatment order	s61(3)
• Application to extend the period of review for a correctional patient	s61(4)
• Application for a forensic community treatment order	s67
• Review of person following apprehension on an alleged breach of conditions of leave or release	s68(2)
• Requested investigation of person apprehended for a breach of a condition of leave or release	s69
• Application by victim of a patient for a non association or place restriction condition to be imposed on the leave or release of the patient	s76
• Appeal against Director-General's refusal to grant leave	s76F

Births, Deaths and Marriages Registration Act 1995 Matters

• Approval of change of name	s31D
• Appeal against refusal to change name	s31K

APPENDIX 3

Mental Health Review Tribunal Members as at 30 June 2018

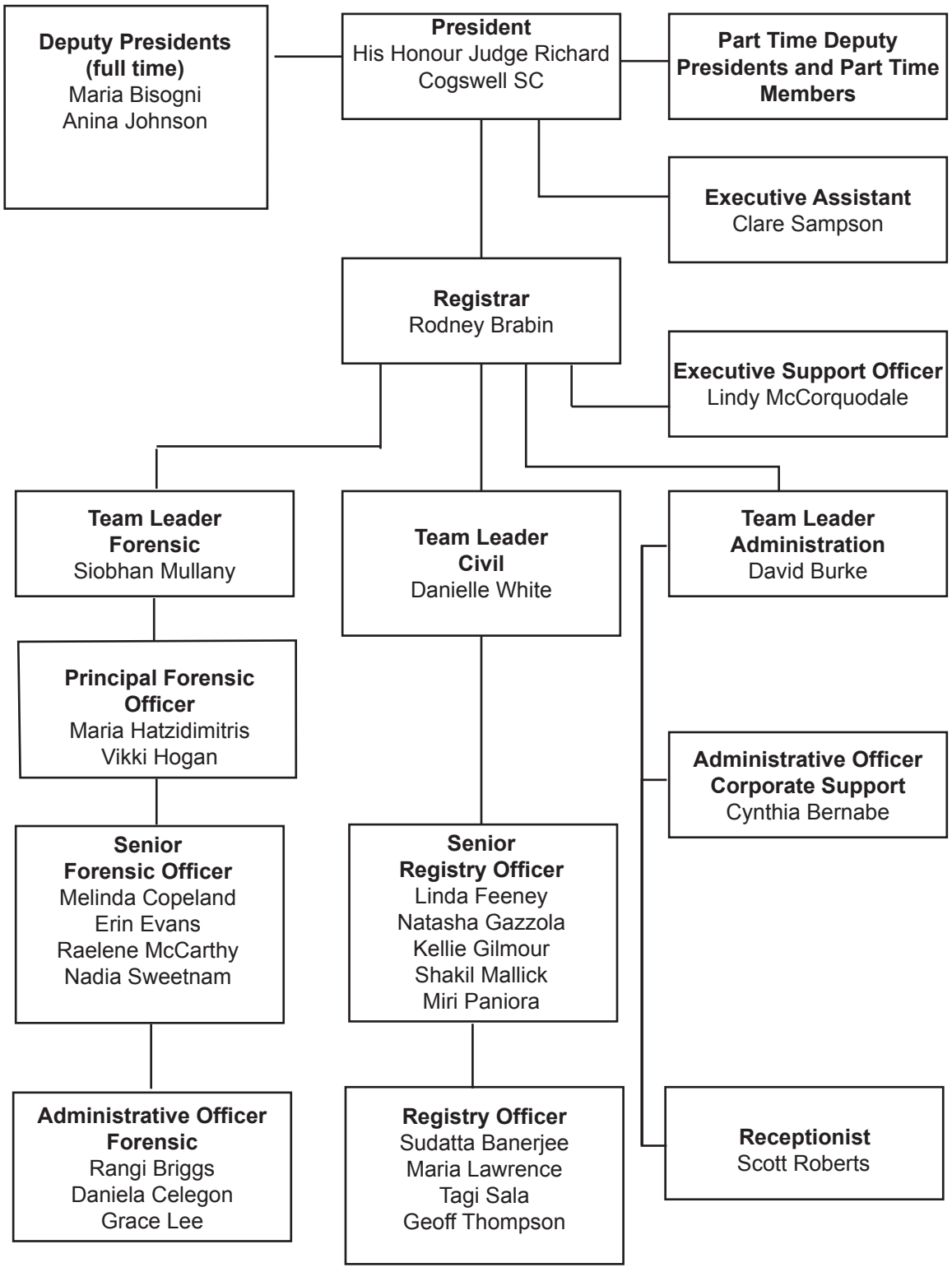
Full-Time Members	His Honour Judge Richard Cogswell SC (President)	Ms Maria Bisogni (Deputy President)	Ms Anina Johnson (Deputy President)
Part-Time Deputy Presidents	The Hon John Dowd AO QC Mr Richard Guley AM RFD The Hon Peter Hidden AM QC	Ms Mary Jerram AM Ms Angela Karpin The Hon Patricia Staunton AM	The Hon Judith Walker

	Lawyers	**Psychiatrists**	**Other**
Part-Time Members	Ms Carol Abela Ms Diane Barnetson Ms Rhonda Booby Mr Peter Braine Ms Catherine Carney Ms Jennifer Conley Ms Janice Connelly Ms Elaine Connor Mr Martin Culleton Mr Shane Cunningham Ms Jenny D'Arcy Ms Pauline David Mr William de Mars Mr Phillip French Ms Helen Gamble Ms Michelle Gardner Mr Bruno Gelonesi Mr Anthony Giurissevich Ms Yvonne Grant Mr Robert Green Ms Eraine Grotte Ms Athena Harris Ingall Mr David Hartstein Mr Hans Heilpern Mr John Hislop Ms Barbara Hughes Ms Julie Hughes Mr Michael Joseph SC Mr Brian Kelly Mr Thomas Kelly Mr Dean Letcher QC Mr Michael Marshall Ms Carol McCaskie Ms Karen McMahon Mr Mark Oakman Ms Lynne Organ Ms Anne Scahill Ms Rohan Squirchuk Mr Bill Tearle Mr Gregory West	Dr Clive Allcock Dr Stephen Allnutt Dr Josephine Anderson Dr Dinesh Arya Dr Uldis Bardulis Assoc Prof John Basson Dr Jenny Bergen Dr Andrew Campbell Dr Raphael Chan Assoc Prof Kimberlie Dean Dr June Donsworth Dr Charles Doutney Dr Michael Giuffrida Dr Robrt Gordon Dr Adrienne Gould Prof James Greenwood Dr Jean Hollis Dr Rosemary Howard Dr Greg Hugh Dr Mary Jurek Dr Kristin Kerr Dr Karryn Koster Dr Dorothy Kral Prof Timothy Lambert Dr Lisa Lampe Dr Frank Lumley Dr Rob McMurdo Dr Janelle Miller Dr Enrico Parmegiani Dr Martyn Patfield Dr Daniel Pellen Dr Sadanand Rajkumar Dr Geoffrey Rickarby Dr Vanessa Rogers Dr Satya Vir Singh Dr Kathleen Smith Dr John Spencer Dr Sarah-Jane Spencer Dr Gregory Steele Dr Victor Storm Prof Christopher Tennant Dr Paul Thiering Dr Susan Thompson Dr Jennifer Torr Dr Yvonne White Dr Rosalie Wilcox Dr Sidney Williams Dr Rasiah Yuvarajan	Ms Lyn Anthony Ms Elisabeth Barry Mr Peter Bazzana Mr Ivan Beale Ms Diana Bell Ms Christine Bishop Mr Mark Coleman Ms Felicity Cox Ms Sarah Crosby Ms Irene Gallagher Mr Michael Gerondis Mr John Hageman Ms Corinne Henderson Ms Sunny Hong Ms Lynn Houlahan Ms Susan Johnston Ms Janet Koussa Ms Rosemary Kusuma Mr John Laycock Mr John Le Breton Ms Jenny Learmont AM Ms Robyn Lewis Ms Ann MacLochlainn Dr Meredith Martin Ms Maz McCalman Ms Elizabeth McEntyre Dr Sally McSwiggan Mr Francis Merritt Assoc Prof Katherine Mills Dr Susan Pulman Mr Rob Ramjan Ms Felicity Reynolds Ms Vanessa Robb Ms Pamela Rutledge Ms Jacqueline Salmons Dr Peter Santangelo Ms Alice Shires Assoc Prof Meg Smith Dr Suzanne Stone Ms Bernadette Townsend Ms Pamela Verrall Prof Stephen Woods Ms Kathryn Worne

The Tribunal notes its appreciation for the following members whose appointments ended during 2017/18: former Deputy President the Hon Terry Buddin SC and Tribunal member Dr Sheila Metcalfe.

MENTAL HEALTH REVIEW TRIBUNAL

Organisational Structure and Staffing as at 30 June 2018



FINANCIAL SUMMARY

Expenditure 2017/18

Expenditure for 2017/18 was directed to the following areas:

Budget Allocation		6,968,567
Salaries and Wages	*6,641,421	
Goods and Services	312,156	
Equipment, repairs and maintenance	62,909	
Depreciation		
Expenditure	**7,016,486	
Less Revenue	-14,541	
		7,001,945
Budget Deficit		33,378

* Includes $3,101,261 payment of part-time member fees.

** Includes expenditure of $775,964 on the Mental Health Inquiries program.