

The NSW Mental Health Review Tribunal

An analysis of clients,
matters and determinations



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matters and determinations

Michael Cain, Maria Karras and Terence Beed
with Terry Carney

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Law and Justice Foundation of New South Wales

Level 14, 130 Pitt Street

Sydney NSW 2000

GPO Box 4264, Sydney NSW 2001

Phone: +61 2 8227 3200

Fax: +61 2 9221 6280

Email: publications@lawfoundation.net.au

Web: <http://www.lawfoundation.net.au>

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Foreword

This report and the much larger monograph entitled *Australian mental health tribunals: space for fairness, freedom, protection & treatment?* (Carney, Tait, Perry, Vernon & Beaupert with Beed, Karras, Cain, Coumarelos and Chappell, 2011) arose from a research project largely funded by a linkage grant from the Australian Research Council (ARC Linkage Project LP0560358) to examine Australian Mental Health Tribunals (MHTs). This linkage project received research partnership funding and support from the Law and Justice Foundation of New South Wales (the ‘Foundation’) and the industry partners: the Mental Health Review Board of Victoria, the Mental Health Tribunal ACT and the NSW Mental Health Review Tribunal (MHRT). The chief investigators for the ARC linkage project were Professor Terry Carney (University of Sydney) and Professor David Tait (University of Western Sydney; formerly of the University of Canberra); the partner investigators were the Foundation and the NSW MHRT who, together with the partner representatives, formed the Mental Health Tribunal Project Team.

During the course of the ARC linkage project, it became clear that the potential use and value of analyses of information on the NSW MHRT went well beyond those necessary and anticipated for the principal research study, and that these analyses should stand as a study in their own right. Further, from the Law and Justice Foundation’s perspective, the data collected on the NSW MHRT presented a special opportunity for the Foundation’s research agenda of understanding the legal and access to justice needs of disadvantaged people, and identifying what ‘works’ to address these needs. An analysis of the MHRT dataset from the Foundation’s perspective was not necessarily a priority for the principal study — hence two separate reports. While each report is based on substantially different perspectives of the functioning of mental health tribunals in Australia, the two reports complement each other.

This report provides a detailed description and analysis of the characteristics of a sample of mental health clients whose contacts with the NSW MHRT were tracked for a period of almost five years. The aim of this study was to provide fresh understandings about the management of people with a mental illness, especially at the point of entry to involuntary case regimes negotiated before a tribunal that has legislated, quasi-judicial powers. In pursuing this aim, the research team employed methods of quantitative data analysis to answer a number of underlying questions arising from the existing literature on therapeutic jurisprudence and mental health service delivery. These questions included a review of whether the outcome of applications to the MHRT was affected by a client attending a hearing; by a client being legally represented at the hearing; by the attendance of mental health service professionals at the hearing; by the submission of various types of professional reports to the Tribunal; by the attendance of family and other patient support figures at the hearing; and by the mode of the hearing itself. While based on clients and matters solely before the NSW MHRT, the findings presented in this report have relevance to the way that mental health tribunals operate in other Australian jurisdictions.

An expert peer reviewer of this report has noted that:

Until this study was conducted we really had no more than anecdotal information about the nature of the client group traversing through the mental health review process, or how their cases were

dealt with. That lacuna in our knowledge has now been greatly diminished by the research findings documented in the [Law and Justice Foundation's] MHRT Report.

Second, our knowledge has also been expanded in regard to the application of the principles of TJ [therapeutic jurisprudence] within the mental health review process. The MHRT Report makes specific mention of these principles in its Discussion section, suggesting that while at face value some of the outcomes of MHRT hearings may appear antithetical to TJ principles a closer analysis of the findings indicates that they are in general compliant with them although there remains room for improvement.

The Carney et al (2011) monograph, on the other hand, is the only comprehensive examination of mental health tribunal hearings in Australia. It deals with a wide and far-reaching landscape of theories and concepts and their practical application to the day-to-day operations of the various MHTs. The study was extensive and broad in its approach going beyond a critical assessment of the individual MHTs in Australia to an examination of the supporting mental health services and to the complex area of human rights as they relate to the care and treatment of people with a mental illness. The monograph also presents a considered view on the future directions for Australian MHTs in terms of commending existing 'good practices' and charting possible directions for reform of legislation and operations. It clearly documents the universal tensions between the 'pragmatic' (what is 'affordable' and 'politically acceptable'), the 'normative' (human rights and common law principles) and the 'evidence-based' (what 'works best'). The entire discourse is framed within a genuine concern for upholding the rights of those living with a mental illness and a desire to bring about paradigm-shifting changes to improve mental health processes for all stakeholders.

I therefore recommend that those with an interest in the subject matter of this report also read *Australian mental health tribunals: space for fairness, freedom, protection & treatment?*.

Geoff Mulherin
Director
Law and Justice Foundation of NSW
October 2011

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Thanks are due to key university-based members of the Mental Health Tribunal Project Team for their assistance in facilitating the collection of complex mental health data. Professor Terry Carney of the University of Sydney and Professor David Tait of the University of Western Sydney inspired the initial objectives of a far-ranging study of mental health tribunals in Australia, many of which have been pursued in this study and the other academic research projects with which it is linked. Their continuing input to this study is gratefully acknowledged. Ms Fleur Beaupert, a researcher in Professor Carney's unit at the Law School in the University of Sydney, was of considerable help in our formulation of a data collection strategy. Implementation of that strategy was the responsibility of Mr Phillip Turton, Director of Adscan Research, who assembled and supervised the data collection team whose work was carried out at the Tribunal.

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Abbreviations

ABS	Australian Bureau of Statistics
AVL	audio-visual link
CALD	culturally and linguistically diverse
CCO	Community Counselling Order
CLC	Community Legal Centre
CMS	Client Management System
CTO	Community Treatment Order
ECT	electro convulsive therapy
ESB	English-speaking background
MHAS	Mental Health Advocacy Service
MHRT	Mental Health Review Tribunal
MHT	mental health tribunals
NESB	non English-speaking background
NSW	New South Wales
PEO	Protected Estates Order
RRR	regional, rural and remote
SEIFA	Socio-Economic Indexes for Areas
TJ	(theory of) therapeutic jurisprudence
TPO	Temporary Patient order
UK	United Kingdom

Executive summary

In recent years, there has been much interest in Mental Health Tribunals (MHTs), their legislated role, functions and day-to-day operations. Much of the interest has centred on accumulating an evidence base for evaluating the role of MHTs in safeguarding and perhaps even improving access to justice for particular clients of the mental health system — specifically, those involuntary patients and other clients whose liberty, care, protection and treatment are under the control of the Authorised Medical Officers of hospitals and other mental health facilities. For mentally ill persons in New South Wales, the applications for initial or continued involuntary treatment are subject to review by the NSW Mental Health Review Tribunal (MHRT)¹ under the *NSW Mental Health Act 2007* (previously the *NSW Mental Health Act 1990*).

Attention has also focused on the role of MHTs in ensuring due process (‘natural justice’) and in conducting hearings and determining outcomes in a therapeutically beneficial manner. Much of the previous research examining MHTs was based on qualitative methods including relatively small-scale, purposive surveys and face-to-face interviews with stakeholders such as clients, tribunal members, mental health professionals, family members and carers.

This study has taken a different approach to its predecessors. It has utilised quantitative research methods to describe and analyse trends and patterns in data drawn from the records of persons who were new entrants to the NSW MHRT system in 2003. For a sample of 299 clients, each individual’s full history of hearings before the Tribunal was reconstructed for the period from their individual points of entry in 2003 to 31 October 2007 — the date that the *NSW Mental Health Act 2007* commenced. Records were extracted electronically from the MHRT’s administrative computer system and matched to information gathered manually from the Tribunal’s paper files for each of these hearings.

Aim

The aim of this research study was to provide a comprehensive description and analysis of the characteristics of a sample of mental health clients and mental health matters that came before the NSW MHRT for determination between 2003 and 2007 under the previous *NSW Mental Health Act 1990*.

Method

For each client in the sampled cohort, their complete history — hearings and other contacts (e.g. adjournments, applications to vary existing orders) — with the Tribunal was tracked up to 31 October 2007, the date that the current *NSW Mental Health Act 2007* commenced. In total, records for 1083 MHRT hearings generated by a final sample of 299 clients were constructed.

The source of the research data was the MHRT’s electronic Client Management System (CMS) and the associated paper files on each client that underpin the CMS. Access to these sources of information was both approved by the MHRT and facilitated by its staff.

¹ New South Wales Government Mental Health Review Tribunal website, <<http://www.mhrt.nsw.gov.au>>.

Great care was taken by staff of the MHRT and the Law and Justice Foundation of NSW to safeguard the privacy of clients included in the cohort. Only de-identified data was extracted from the CMS and all members of the research team who accessed the MHRT's paper files were required to sign confidentiality agreements.

Two different types of data were available from the CMS and associated paper files — *person-based* and *hearings-based* data. The findings of this study have been built from these two perspectives. The person and hearings data were merged and processed to construct unit record data. Each constructed record represents a specific contact (event) with the MHRT for a particular client within the cohort. Thus, the merged data combined information about each individual's Tribunal hearings, their mental condition and other characteristics at each point of contact with the Tribunal. The resulting new database was then used to investigate trends and to identify statistically significant associations, interactions and other points of interest amongst the variables defined for this study.

It should be noted that this study focused on the available documentary records and not the actual evidence and discussion put forward at Tribunal hearings. The data used in this study also does not include information contained in the Tribunal's audio recording or transcript of proceedings, should any such record exist. Put simply, this is a study of the available information recorded on the CMS and found to be present on the associated paper files.

It should be noted that the paper files created by the MHRT are not intended as a complete or systematic record of each hearing or proceeding and it is possible that some important pieces of information may not have found their way onto the paper file. However, while certain information may not have been found in the paper files, this does not mean that some issues that remained undocumented were not a point of consideration by the Tribunal. Nevertheless, strenuous efforts were made in the data collection and coding processes to uncover as much useful, comparative information as possible.

Underlying the analyses reported in this study are research questions arising from the literature on therapeutic jurisprudence and mental health service delivery. As questions for research, these translated to guidelines for both the electronic and manual collection of data for this study. The research questions included an examination of whether the Tribunal's determinations were affected by:

- the client attending the hearing
- the client being legally represented at the hearing
- the attendance of mental health service professionals at the hearing
- the tabling of particular types of reports (e.g. psychiatrists' reports) with the Tribunal
- the attendance of family and other client 'support' figures at the hearing
- the mode of the hearing (i.e. live hearings compared with Tribunal hearings conducted by telephone or video conference).

Major findings

Before proceeding to detail the findings, it is important to note that not every individual in the general population who has a mental health issue comes to the attention of the mental health system, let alone the MHRT. Thus, any identified differences in the demographic characteristics of Tribunal clients are likely to reflect the fact that the MHRT deals with mental health issues at the higher

end of the scale of seriousness and urgency. Conversely, clients with matters heard by the Tribunal represent a very small proportion of the population seeking mental health care.²

The study of this MHRT cohort allowed an examination of the distinguishing characteristics of those mental health patients coming into contact with the MHRT for the first time and their related event histories. It also provided insights into a range of issues central to therapeutic jurisprudence and the legally-regulated side of mental health service delivery.

Contacts: On average, each client belonging to the cohort was involved in 3.6 Tribunal hearings between 2003 and October 2007. The median number of hearings was two. The highest number of hearings for any client in the sampled cohort was 17.

Half the 299 clients first registered with the MHRT in 2003 were no longer in the system one year later. While only 15 per cent of clients remained in the system for four years or longer, they generated over one-third of all hearings for the period studied, or an average of more than eight hearings per 'long-term' client.

Mental conditions: Based on information that appeared in the clients' files, the majority of hearings involved a client diagnosed with schizophrenia (45%) or related disorder (21%). Clients diagnosed with depression were the subject of 11 per cent of hearings. Clients were diagnosed with a co-morbid drug abuse problem in 30 per cent of hearings; a co-morbid alcohol abuse problem in 15 per cent of hearings; and a co-morbid problem with both drugs and alcohol in 13 per cent of hearings.

Matters dealt with by the MHRT: Around 15 per cent of all Tribunal hearings examined in this study were subject to an adjournment. For matters that proceeded by way of a substantive hearing, around two-thirds (64%) involved an application to approve or vary a Community Treatment Order (CTO) with only one per cent of CTO applications declined by the Tribunal. Applications in relation to reviewing or extending Temporary Patient orders³ made up around 17 per cent of all Tribunal hearings. In this case, less than two per cent of such applications were not approved. There were 70 applications for Electro Convulsive Therapy (ECT) in the period, all of which were approved. These findings highlight the importance of assessments and recommendations made by medical/hospital psychiatric specialists and case managers when it comes to the treatment of involuntary patients. In particular, with applications to administer ECT there would appear to be less room to maneuver because the medical evidence to meet the relevant criteria under the Act must be especially convincing before MHRT approval is sought.⁴

Client demographics: There were more males (56%) than females (44%) in the cohort. More than half (58%) of the cohort was below 40 years of age at the time of their first hearing.

According to the 2006 Census, around 32 per cent of the State's general population lived outside the cities of Sydney, Newcastle and Wollongong, and a similar proportion (28%) of the cohort

² As Carney, Tait, Perry, Vernon & Beaupert (2011, p. 10) stated:

Generally, only the more serious or sustained episodes of symptoms of mental illness within the general community will lead to specialist attention beyond medication prescribed by general practitioners. Inpatient or outpatient care by public or private psychiatric services, or consultations with a psychiatrist or clinical psychologist, covers a comparatively small portion of the community. Only a very small fraction will encounter mental health legislation, or the mental health tribunals of interest in this study.

³ Under the later *NSW Mental Health Act 2007*, all Temporary Patient orders, including *Continued Treatment* orders, were to be 'known under the one name of Involuntary Patient Orders'. NSW Health 2007; <http://www.health.nsw.gov.au/policies/ib/2007/pdf/IB2007_053.pdf>, see Appendix A. Under the previous *NSW Mental Health Act 1990*, Division 3 set out the various directions and determinations that could be applied to temporary patients. For convenience, these will be referred to as Temporary Patient orders (or TPOs) although no specific 'Temporary Patient Order' existed under the 1990 Act. Similarly, there was no 'In-Patient Order' under the 1990 Act.

⁴ This is the case under the current *NSW Mental Health Act 2007*. It was also the case under the previous *NSW Mental Health Act 1990*.

resided outside these metropolitan areas. Around two-thirds of the general population who resided in country NSW lived in the larger country centres (such as Dubbo, Tamworth or Coffs Harbour), while the remaining one-third lived in the more rural and remote areas of NSW. This is the reverse of the pattern seen for our cohort of MHRT clients, of whom one-third lived in the larger country centres and two-thirds lived in the more rural and remote areas of NSW.

The majority (60%) of clients at the time of their first hearing lived in areas identified as being either mildly or highly advantaged as defined by the Socio-Economic Indexes for Areas (SEIFA). This is 10 per cent higher than expected given the distribution of advantage across NSW. Just over one-quarter (25%) of MHRT clients resided in areas marked by mild levels of socio-economic disadvantage and around 15 per cent lived in areas marked by high levels of socio-economic disadvantage. Together, this is about 10 per cent lower than expected given the distribution of socio-economic disadvantage across the state.

The vast majority of MHRT clients in our cohort were born in English-speaking (ESB) countries with 92 per cent born in Australia. Persons born in non English-speaking (NESB) countries made up six per cent of MHRT clients and had a higher hearing rate (5.0 hearings per NESB client) than clients born in English speaking countries (3.5 hearings per ESB client).

Characteristics of Tribunal hearings: 45 per cent of Tribunal hearings were ‘live’ hearings, while 29 per cent were conducted by phone (i.e. teleconference) and 26 per cent were conducted by audio-visual link (AVL).

Client attendance/participation in substantive hearings varied with the nature of the matter before the Tribunal, ranging from 66 per cent of client ‘attendance’ at CTO hearing to 92 per cent clients ‘attendance’ for hearings regarding Temporary Patient orders. Four in every five ECT hearings were attended by the client.

A legal representative was more likely to be in attendance for certain types of matters, with significantly higher levels of legal representation noted in relation to Tribunal hearings that involved Temporary Patient orders (79%; also known as In-patient orders) and applications for Protected Estates Orders (79%). It was very uncommon (1%) for a legal representative to appear at a CTO hearing. It was only slightly more common (7%) for a lawyer to represent a client at an ECT hearing. The client’s legal representative was almost always a Legal Aid NSW solicitor from the Mental Health Advocacy Service (MHAS).⁵

Professional reports (e.g. psychiatric assessments and treatment plans) submitted to the Tribunal were found on file for 85 per cent of all hearings generated by our cohort. Where a report was submitted and on file, at least one report author was in attendance at 80 per cent of substantive hearings (adjournments and other ‘on paper’ hearings not included). The authors of assessment reports and treatment plans were more commonly psychiatrists, hospital registrars, doctors, case managers and social workers.

It was not a frequent occurrence for Tribunal hearings to be attended by a ‘support’ person — a client’s family member (e.g. spouse, parent, sibling, or offspring) or carer. ECT hearings were slightly more likely to be attended by the client’s support persons than CTO hearings (33% and 20%, respectively), as were applications for Temporary Patient orders (33%) and Protected Estates Orders (36%).

⁵ Information on Legal Aid NSW and the MHAS is available at <<http://www.legalaid.nsw.gov.au/asp/index.asp?pgid=514&cid=710&id=435>>.

The conventional view is that family members, spouses and other ‘support’ persons are allied with and supportive of the client’s personal opinions on their need for treatment and care. Many such individuals are also the client’s primary carer. However, the term ‘support’ person has broad connotations and such persons may have appeared before the Tribunal with views contrary to those of the client on the need for treatment and/or the type of determination they would like to see the Tribunal make. Protected Estate Orders, in particular, are matters dealt with by the Tribunal that may involve the views of family members or a spouse being in conflict with those of the client. Also, while the family is generally best placed to know the client well, many family members are estranged and do not associate with the client, often as a consequence of the client’s mental illness. The low level of attendance of clients’ support persons at Tribunal hearings may be explained by these factors as well as the client’s right to privacy to not have their family notified of their Tribunal hearing.

Medication: Medication regimes play an important role in mental health therapy. However, the Tribunal does not generally make specific orders involving medication. The exception is with CTOs, where the client’s current medication is always specified in the treatment plan at the time the order is made. This medication is subject to change by the treating team throughout the term of the CTO. Clients subject to a MHRT determination for a CTO can be breached if they don’t comply with a prescribed course of medication.

Medication was on record for clients in approximately three-quarters of all MHRT hearings examined in this study. In terms of principal medication type, the majority (88%) of clients were prescribed an anti-psychotic agent — a typical course of treatment for schizophrenia and related conditions. The next most commonly prescribed type of medication was anti-convulsants (6%), followed by anti-depressants (4%).

CTOs and ECT orders: These two types of orders were examined more closely in this study given that they are frequently the subject of applications to the MHRT by treating teams in relation to the care and treatment of persons with a mental illness. CTOs represented nearly two-thirds of all Tribunal applications and 56 per cent of determinations. ECT applications and orders represented almost 15 per cent of first hearing applications and around seven per cent of Tribunal determinations overall.

Complex needs clients: Special attention was also given to Tribunal hearings involving members of the cohort deemed for the purpose of this research to be ‘complex’ in needs because of their combination of mental condition(s) requiring the prescription of anti-psychotic medication and co-morbid substance abuse problems. Approximately 18 per cent of Tribunal hearings examined in this study involved a ‘complex needs’ client. These clients tended to be in the MHRT system for slightly longer than other clients, with far more males (79%) and persons in their twenties (45%) or thirties (28%) than in the general cohort. Based on their residential postcode and using the 2006 Census index of socio-economic disadvantage for the whole NSW population, it was found that ‘complex needs’ clients had relatively high levels of socio-economic *disadvantage*, whereas the full cohort of MHRT clients was characterised by relatively high levels of socio-economic *advantage*.

Conclusions

The MHRT CMS database and the associated paper files provided the research team with a wealth of information on which to build a comprehensive quantitative study of the operations of the Tribunal and the characteristics of its clients.

The MHRT, like other mental health tribunals across Australia, performs a critical gate-keeping role in balancing the interests and rights of mentally ill patients in Australian society. This gate-keeping role is particularly important given that ‘people with mental disorders are, or can be, particularly vulnerable to abuse and violation of rights’⁶ and ‘tend to experience greater difficulties in accessing justice than other groups, and also experience greater discrimination and disadvantage’.⁷

The NSW MHRT is not without its critics. The primary legislated function of the MHRT — conducting mandatory external reviews of compulsory psychiatric care — has been viewed by some as being negative and mechanical.⁸ However, the Tribunal’s work to ensure that patients receive the best possible care in the least restrictive environment is consistent with both the overriding objectives of mental health legislation and the principles of therapeutic jurisprudence.

The type of determination made by the MHRT is almost always in direct response to an application made by a psychiatrist or mental health facility for the authorisation of treatment of an involuntary patient in hospital or in the community.⁹ Sometimes this involves an application for something as specific as an ECT, which may be a ‘one-off’ therapeutic intervention. The role played by the MHRT is therefore indispensable. This is reflected in its mandate to assess the merits of applications for the initial or continued detention and care of involuntary patients and for the treatment of involuntary patients in the community by way of a CTO. Central to the MHRT’s legislated gate-keeping role is due process with a high premium placed on the individual liberty of each client.

This study identified that most applications to the MHRT for all types of orders are approved. In particular, very high approval rates occur in relation to applications to administer ECT to involuntary patients, the majority of whom were not capable of providing informed consent. This is not proffered as a criticism of the MHRT. Tribunals are in place to safeguard against the application of unnecessary and excessive treatment. Their vigilance extends especially to treatment that is ordered without a patient’s consent or in circumstances where the patient is incapable of providing consent because of their mental illness. In fact, clients are afforded extra legislative protections through the MHRT that apply specifically to the review of applications to administer ECT.

According to the United Kingdom’s ECT Review Group, the most common therapeutic use of ECT is in treating severe depression, particularly when accompanied by detachment from reality, a desire to commit suicide or refusal to eat and take medication.¹⁰ Many mental health patients in need of treatment by ECT are very ill and generally have a reduced capacity to consider their treatment needs, let alone attend or participate meaningfully in a tribunal hearing. In such circumstances, the Tribunals may find it necessary to defer to the expert medical opinion of the treating team and support the application for ECT in order to alleviate the patient’s symptoms and suffering. Supporting medical research shows that treatment by ECT results in a rapid improvement in the symptoms of severe depression, with high remission rates noted for acutely depressed patients who completed a short course of ECT.¹¹

The MHRT also must deal with the considerable needs of the many mental health clients who appear repeatedly before it. Fifteen per cent of the cohort in this study was in the system for the full period from their initial contact with the MHRT in 2003. These individuals also accounted

⁶ World Health Organization 2005, p. 1.

⁷ Mind (2001) cited in McLeod, Philpin, Sweeting, Joyce & Evans 2010.

⁸ It has been noted that compulsory treatment for a person classified as mentally ill cannot be averted unless the relevant statutory criteria are met (Carney, Tait & Beaupert 2008).

⁹ The exception being a small number of MHRT reviews of long-term *voluntary* patients.

¹⁰ UK ECT Review Group 2003.

¹¹ Lisanby 2007 and Husain, Rush, Fink et al 2004.

for one-third of all Tribunal hearings examined. This indicates not only the severe and intractable nature of the mental conditions of some individuals (many of whom were identified in this report as having ‘complex needs’); it also shows the high workload created for the MHRT by such a modest proportion of clients. The Tribunal’s role in the mental health system is critical to ensuring that involuntary patients who are in the system for prolonged periods are not subject to unnecessary or excessive treatment or unwarranted deprivation of their liberty.

A recent UK study¹² of the court/tribunal experiences of adults with mental health conditions, learning disabilities and limited mental capacity highlighted two findings in particular. The first, that contact with and support from a legal representative had positive impacts on a client’s court/tribunal experiences including acceptance and satisfaction with the eventual outcome. The second, that access to basic practical and moral support alleviated stress and increased a client’s understanding of their court/tribunal hearing. This was found to be especially important for clients who were symptomatic, whose mental condition was unstable or who were less capable of managing their condition. The moral and practical support could take a variety of forms including client access to their mental health care professional before, during and after hearings or having their carer and/or allied support persons (e.g. spouse, parent, carer) attend and participate in hearings with them.

This study found rather low levels of attendance by ‘support persons’ and legal representatives at Tribunal hearings (and here we are including teleconferenced and video-conferenced hearings together with live hearings). While explanations may be offered for these findings, they also suggest that strategies to improve the attendance and participation rate of clients’ legal representatives, carers and allied family members at hearings — particularly *first* hearings — may lead to improved therapeutic outcomes for clients, perhaps even in the event that the Tribunal’s determinations remained the same.

The MHRT generously provided access to the wealth of data contained in its electronic database of hearings and associated paper files. Needless to say, the MHRT’s information management system was not designed or intended as a research tool. This is not unusual among public agencies and it called for additional auditing and re-processing of the administrative data to a stage that would facilitate our analyses. Empirical research tends to closely scrutinise data and this research was no different. Stringent quality control necessitated by our analytical models meant that the data needed high integrity and robustness. With the benefit of hindsight, this has suggested a number of ways in which the MHRT could enhance its collection of data for the purpose of research and, ultimately, service delivery and feedback. For the present, however, tracking a sampled cohort of mentally ill people and their contacts with the Tribunal over a number of years would not have been possible without the MHRT having kept accurate and organised records of its hearings and clients.

It is hoped that this study and its findings adds to the overall body of knowledge on the role and operation of the Mental Health Review Tribunal in NSW.

¹² McLeod, Philpin, Sweeting, Joyce & Evans 2010.

Introduction

The Mental Health Review Tribunal

The New South Wales Mental Health Review Tribunal (MHRT) is a specialist body constituted under the *NSW Mental Health Act 2007* with a wide range of quasi-judicial powers to deal with the care, treatment and detention of people with a mental illness.¹³

This study describes and analyses the outcome of a sample of applications for mental health matters heard by the MHRT in its civil jurisdiction for a cohort of clients who first entered the Tribunal's system of hearings in 2003. These individuals were tracked in terms of their first and subsequent Tribunal hearings for a period of almost five years using the MHRT's electronic records and paper files.

The MHRT currently hears and makes determinations on applications for the care and treatment of people with a mental illness under the provisions of the *NSW Mental Health Act 2007*. The 2007 Act superseded the *NSW Mental Health Act 1990*. The MHRT operated under the legislative directions of the 1990 Act for the period examined in this study.

Special attention is given to the form, function and operation of the MHRT briefly summarised below. In addition, this is a study in the area of 'therapeutic jurisprudence'. The relevance of therapeutic jurisprudence to the operations of the MHRT is discussed in this report, as are other relevant findings relating to access to justice and to the law.

The role of the MHRT

The MHRT performs a crucial gate-keeping role in balancing the interests and rights of mentally ill patients in terms of their liberty with their safety and the safety of the community. This gate-keeping role is particularly important given that 'people with mental disorders are, or can be, particularly vulnerable to abuse and violation of rights'¹⁴ and 'tend to experience greater difficulties in accessing justice than other groups, and also experience greater discrimination and disadvantage'.¹⁵

The MHRT's current range of powers enables it to conduct mental health inquiries, to make and review mental health orders, and to hear appeals regarding the care, treatment and detention of people with a mental illness. While the MHRT deals with both civil and forensic patients,¹⁶ much of the Tribunal's work — and the basis of this report — involves its hearing of matters regarding applications for mental health orders for civil patients.

¹³ The NSW Mental Health Review Tribunal, <<http://www.mhrt.nsw.gov.au>>, first started operating in 1991 following the implementation of the *NSW Mental Health Act 1990*. By 1993, the MHRT 'was in full stride' (New South Wales Government Mental Health Review Tribunal 1998 Introduction (no page numbers)).

¹⁴ World Health Organization 2005, p. 1.

¹⁵ Mind (2001, p. 1) cited in McLeod et al 2010.

¹⁶ A forensic patient is a person who has:

- been found unfit to be tried for an offence and ordered to be detained in a correctional centre, mental health facility or other place or
- been found not guilty by reason of mental illness and ordered to be detained in a correctional centre, mental health facility or other place, or released into the community subject to conditions (<<http://www.mhrt.nsw.gov.au>>).

According to the *Mental Health Review Tribunal annual report 2008–09*, <<http://www.mhrt.nsw.gov.au/mhrt/pdf/annualreport200809.pdf>>, forensic matters comprised less than nine per cent of the total cases dealt with by the Tribunal in that financial year.

In dealing with mental health matters of a civil nature, the NSW MHRT has the power to:

- conduct mental health inquiries (since the 2007 Act but not during the period covered by this research)
- make orders authorising the involuntary detention or continued involuntary detention of a person in a mental health facility
- periodically review involuntary patients in mental health facilities
- hear appeals against an authorised medical officer's refusal to discharge an involuntary patient
- make, vary and revoke Community Treatment Orders (CTOs)
- hear appeals against a Magistrate's decision to make a CTO
- approve the use of Electro Convulsive Therapy (ECT) for involuntary patients
- determine if voluntary patients have the capacity to consent to ECT
- review voluntary patients in mental health facilities
- approve special medical treatment, including surgery, on an involuntary patient detained in a mental health facility
- make and revoke orders under the *NSW Trustee and Guardian Act 2009* for a person's financial affairs to be managed by the NSW Trustee.

The Tribunal's decisions are legally binding and often involve the consideration of complex issues. These decisions frequently impact directly on people's lives, health and liberty:

*Mental health laws mainly serve to delineate the circumstances in which a mentally ill patient may be required to become an in-patient or be subjected to the restrictions implicit in a community treatment order. In Australia involuntary committal, or the making of a treatment order, also carries the power to treat the person against their will in most jurisdictions.*¹⁷

In making its decisions, the MHRT seeks to balance several sets of often competing rights — the individual's right to liberty and safety and to freedom from unnecessary intervention, the individual's right to treatment, protection and care, and the right of the community to safety and protection. According to the World Health Organization:

*... a fundamental basis for mental health legislation is human rights. Key rights and principles include equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the rights to information and participation.*¹⁸

As articulated on its website and in its annual reports, the MHRT seeks to pursue the objects of the *Mental Health Act 2007*, including:

- the delivery of the best possible kind of care to each patient in the least restrictive environment
- the United Nations 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'
- to facilitate the involvement of mentally ill clients, and persons caring for them, in decisions involving appropriate care, treatment and protection.

¹⁷ Carney & Beaupert 2007, p. 1.

¹⁸ World Health Organization 2005, p. 3.

In summary, the MHRT is a quasi-judicial body operating within a legislative framework to facilitate the provision of *quality* mental health care¹⁹ to individuals in the least restrictive manner consistent with safe and effective treatment. The MHRT's legislative focus is on 'due process' with a high premium placed on 'individual liberty'.²⁰

MHRT civil orders and determinations

The type of civil order or determination made by the MHRT is almost always in direct response to an application made by a psychiatrist, hospital registrar or consulting doctor to treat a client's mental illness in a specific way.²¹ That is, the MHRT is only able to deal with the specific application or matter that is before it. The main types of applications considered by the MHRT are for involuntary detention in hospital and for involuntary care in the community by way of a community treatment order.

For example, electro convulsive therapy (ECT) is only considered by the MHRT once an application for ECT has been submitted. It is a specialised treatment appropriate for only a small number of mental health conditions. In considering an application for ECT, the Tribunal will take into consideration the type, severity and exigency of the client's mental condition, the efficacy of past treatments (if any), the likely success of the ECT, the implications for the patient's wellbeing, as well as the risk to the person if treatment is not given, community safety, and so on. Similarly, a Community Treatment Order (CTO) can only be made by the Tribunal once the treating team has made an application for a CTO and submitted an appropriate treatment plan.

As do all Australian MHTs, the NSW MHRT operates in a fundamentally different way to the criminal courts, which, in principle, have the discretion to impose any of the available orders/penalties (e.g. prison term, community service order, probation, fine, etc.) when determining the outcome (i.e. sentencing) for an individual's offence(s).²² That is, the MHRT is only able to deal with the specific application or matter before it. This basic difference should be kept in mind in considering the findings presented in this report.

Therapeutic jurisprudence

As a pioneering records-based study of clients involved in the MHRT hearing system, some new light may be shed on the concept of therapeutic jurisprudence (often referred to simply as TJ). An extremely vulnerable segment of the socially and economically disadvantaged population, such as those experiencing certifiable mental health issues, may be expected to provide fertile ground for a study of how therapeutic jurisprudence impacts on this population's ability to access the law. Therefore, the concept is of central importance to the research and warrants closer attention with regard to the MHRT's operations. This is reflected in the recent academic literature briefly outlined below.

¹⁹ As Sartorius (1999, p. 96) argued:

The quality of mental health care can be judged by a number of criteria. From the point of view of the patients, care is of good quality if access to it is unrestricted, if they are treated with respect, if they receive unbiased, well-documented and comprehensible information about treatment options likely to prove useful in their case and if they can express their preference for any of them, if treatment is provided with the necessary expertise avoiding any possible harm and maximizing its benefits, if the information about them and their mental illness is kept confidential, if they can afford the cost of the care that they receive without severe restrictions of other needs, and if their human rights are respected during the treatment process.

²⁰ For a succinct overview of the MHRT's 'modus operandi', see Carney et al (2011, pp. 63–64).

²¹ The exception being a small number of MHRT reviews of long-term *voluntary* patients.

²² However, Carney et al (2011, p. 94) have stated that:

in practice if not in design, Australian MHTs presently operate more in the way of a bail hearing: due to resource and other constraints, they mainly address the 'liberty' question, or serve as an external check on what we term the 'legal rectitude' of the inpatient treatment order (ITO) or community based treatment (CTO) order.

Therapeutic jurisprudence is a perspective that regards the law ‘in action’ as a social force that at times functions as a therapeutic agent and at other times functions as an anti-therapeutic agent. This effect is ‘highly relevant to mental health law’.²³ According to one commentator, it is ‘a respectful and proactive engagement with people involved in the court process to pay attention to their needs, rather than a neutral but mechanical and unsatisfying closing of files’.²⁴ A therapeutic jurisprudence approach emphasises the quality of the interaction between judicial officers and the individuals who appear before them, which is enhanced by direct engagement, empathy and communication.²⁵ Involvement in a legal process can act in much the same way as a clinical intervention, having positive repercussions for both clients and the broader community.²⁶

Furthermore, therapeutic jurisprudence questions whether the law can be applied in a more therapeutic manner whilst still observing other values, such as justice and due process.²⁷ According to the Australasian Institute of Judicial Administration (AIJA), therapeutic jurisprudence fills a gap in the general theory ‘concerning the impact of legal processes upon participant wellbeing and its implications for attaining justice system objectives’.²⁸

In reality, therapeutic jurisprudence is the lynchpin of many of the so-called specialist or problem-solving courts, tribunals and panels²⁹ now operating in the Australian legal landscape:

[Specialist courts] have an obvious, perhaps superficial, appeal in that they allow decision makers to deal with personal issues through an intersection with service frameworks outside the justice system to develop solutions. They are attractive as they create a mechanism to deal with otherwise intractable problems and, therefore, offer a possibility that such problems will dissolve or be ‘healed’.

The development of specialist courts challenges much of the traditional model of court practice. Court practice expands potentially towards a dialogue rather than the traditional monologue. The individual becomes involved in an ongoing relationship, one which is focused on identifying and resolving personal issues and individual problems. The relationship essentially ties the person to the court until the court determines otherwise. This can be contrasted to the criminal justice system, in which ends are more clearly defined, in essence the serving of the sentence or its equivalent.³⁰

The dynamics of the courtroom have been changed in many specialist courts seeking to deliver therapeutic jurisprudence. These range ‘from the traditional, adversarial process of assertion and denial to the sharing of information and plans to address the defendant’s behaviour’.³¹ The role of the judicial officer, too, tends to change from that of a passive adjudicator to one of more direct engagement and interest.³²

²³ Wexler 1999.

²⁴ Cannon 2007, p. 132.

²⁵ Anleu & Mack 2007.

²⁶ Freckelton 2007.

²⁷ Whilst therapeutic effects are obviously sought, such effects are not necessarily considered to be better than other effects or outcomes (Carson 2003).

²⁸ AIJA, <<http://www.aija.org.au/home.html>>, is a research and educational institute associated with Monash University in Victoria. The principal objectives of the Institute include research into judicial administration and the development and conduct of educational programs for judicial officers, court administrators and members of the legal profession in relation to court administration and judicial systems.

²⁹ Other examples of specialist and problem-solving courts in NSW include the NSW Drug Court, the NSW Youth Drug and Alcohol Court, and the Magistrates Early Referral Into Treatment (MERIT) Program. In addition, the Statewide Community and Court Liaison provides specialist mental health advice, including referral to treatment advice, to 19 local courts in NSW. See Karras, McCarron, Gray & Ardasinski 2006, pp. 158–161.

³⁰ Topp 2002, pp. 1, 4.

³¹ Popovic 2007.

³² Anleu & Mack 2007, pp. 174–175.

A 2010 UK study of the court experience of adults with mental health conditions, learning disabilities and limited mental capacity³³ found that the nature of interactions with the judiciary impacted on the experiences of the court user. When judicial officers made a point of addressing the client directly, avoided legal jargon and tailored their communication style to better accommodate the client's specific linguistic and comprehension needs, this elevated the level of client satisfaction with the experience. Court users reported that direct dialogue made them feel respected and involved in the court process and increased their ability to accept the court outcome.

It has also been observed that therapeutic jurisprudence generally involves judicial officers working more closely with non-legal agencies (such as health, community services, etc.), seeking their input to find solutions to problems and to aid in decision making. Often a 'team approach' is adopted to craft incentives and outcomes for participants, with the judicial officer, at times, adopting a brokering role between parties with different interests and goals.³⁴

Finally, in its recent study of the legal needs of people with a mental illness, the Law and Justice Foundation of NSW listed other distinguishing features of problem-solving courts including:

- collaboration with social services agencies, including assessment of offenders' (*patients'/clients'*) needs by caseworkers
- a less adversarial courtroom (*tribunal/panel*)
- increased interaction between decision makers and offenders (*patients/clients*).³⁵

All of these aspects — which aim at achieving a desired therapeutic outcome — are notable features of the NSW Mental Health Review Tribunal in its dealings with a select group of mentally ill persons.

Legal issues experienced by people with a mental illness — a vulnerable population

The purpose of the Law and Justice Foundation of NSW is to advance the fairness and equity of the justice system, and to improve access to justice and the law for socially and economically disadvantaged people. One of the Foundation's principal goals is to identify legal and access to justice needs through rigorous, evidence-based research and the analysis of relevant information from primary and secondary sources.

Reflecting the Foundation's priority for researching the legal needs of vulnerable populations, its 2006 study of the legal needs of people with a mental illness (representing almost one in every five Australians) showed that they are amongst the most disadvantaged in our society:

*As a result of their illness and related disadvantage ... people with a mental illness are vulnerable to particular legal issues, and come up against particular barriers that limit their ability to deal with these issues. The combination of poor financial circumstances, a perceived lack of credibility and cognitive and communication impairment pose major challenges for people with a mental illness seeking to participate in legal processes. People with a mental illness are likely to experience complex and multiple legal and other issues, which they are not always well placed to address, and which are deserving of particular attention from both research and service provision.*³⁶

³³ McLeod et al 2010.

³⁴ Fulton Hora 2007.

³⁵ Karras et al 2006. Words in italics added to better reflect the nomenclature of the MHRT.

³⁶ Karras et al 2006, pp. iii–iv.

While the Foundation identified that many NSW individuals experienced legal issues relating to their mental illness, specifically such as those falling under the *Mental Health Act* and adult guardianship laws, other legal issues were common (such as discrimination, domestic violence and victims of crime issues, family law and care and protection issues, housing issues, social security issues and debt issues). These issues appeared to arise from incapacity caused by mental illness and/or by the general financial and social disadvantage that many mentally ill people suffer.³⁷

The Foundation's report also found that people with a mental illness face a large number of barriers to accessing legal assistance for their problems. Some of these barriers relate to the symptoms of having a mental illness whilst others relate to the circumstances experienced by people with a mental illness.³⁸

Systemic barriers also preclude people with a mental illness from equitable access to the law and to justice. The identified barriers included:

- *The limited availability of affordable legal services.* Given that people with a mental illness tend to have lower levels of income, they are likely to be reliant on increasingly stretched services such as Legal Aid NSW, community legal centres (CLCs), Aboriginal legal services and pro bono legal service provision.
- *Time constraints placed on legal service provision.* Stakeholders argued that while people with a mental illness often require longer appointment times with lawyers, the limited resourcing of Legal Aid NSW and CLCs make this extremely difficult.
- *Remote, rural and regional issues.* Stakeholders suggested that the lack of affordable legal services is even more pronounced in rural and regional areas. The organisation and cost required to travel long distances to access services create additional barriers.
- *Difficulties in identifying mental illness.* Legal service providers may not always be able to identify that a client has a mental illness, which may result in a person not receiving the time, assistance and understanding they need to resolve their legal issue. While mental illness is often considered by Legal Aid NSW and CLCs to determine whether a person is eligible for legal representation, this is impossible if the illness remains unidentified.
- *A perceived lack of credibility.* Stakeholders observed that some lawyers find people with a mental illness less credible, and are less inclined to believe what they say and more ready to dismiss their claims.
- *Physical environment.* It was noted that certain aspects of the physical environment and office procedures of a legal service may act as barrier to individuals with a mental illness using the service.³⁹

The Foundation also found that a number of barriers appeared to prevent people from accessing and participating in the legal system.⁴⁰ A number of identified barriers, particularly relevant to the operation of the MHRT, are:

³⁷ Karras et al 2006, p. xviii.

³⁸ Karras et al 2006, pp. xviii–xix.

³⁹ Karras et al 2006, pp. xix–xx.

⁴⁰ Karras et al (2006, p. xx) give a more encompassing definition of participation in the legal system:

For the purposes of this project, participation in the legal system includes participation in courts and tribunals, internal appeals processes of government departments (e.g. Centrelink), alternative dispute resolution, and other external complaints processes (e.g. NSW Ombudsman).

- *Communication problems associated with the symptoms of mental illness.* Such problems may be exacerbated when a person does not speak English as a first language and when complicated legal terminology is used.
- *Features of the courtroom environment,* such as the formality and structure of courtrooms, can intimidate people with a mental illness and at times even exacerbate their symptoms.
- *A lack of legal representation.* Stakeholders argued for the importance of legal representation in facilitating effective participation in the legal system.
- *An imbalance in power between parties.* Noted particularly in relation to alternative dispute resolution, where people with a mental illness were unrepresented in the dispute resolution process.⁴¹

All of the aforementioned make a strong case for examining the operations of the NSW Mental Health Review Tribunal and for the Foundation's involvement in this research study and the larger research project on Australian MHTs to which this study is linked.

⁴¹ Karras et al (2006, pp. xx–xxi) identified other barriers to participation in the legal system including: stress, cognitive impairment, problems with time management, a perceived lack of credibility, and the failure to identify or recognise a person's mental illness.

Aim of the research

The aim of this research is to provide a comprehensive description and analysis of the characteristics of a sample of mental health clients and mental health outcomes in matters that have come before the NSW MHRT.⁴² We seek fresh understandings about the management of people with a mental illness, especially at the point of entry to involuntary care regimes negotiated before a tribunal that has legislated, quasi-judicial powers.

This approach, with its focus on a cohort of clients experiencing the MHRT system for the first time, allows us to glimpse the bigger picture of trends in the many thousands of interactions between clients and the Tribunal, including the outcomes of their applications and factors affecting the Tribunal's decisions.

Underlying the analyses reported in this study are research questions arising from the literature on therapeutic jurisprudence and mental health service delivery. These include an examination of whether the Tribunal's determinations were affected by:

- the client attending the hearing
- the client being legally represented at the hearing
- the attendance of mental health service professionals at the hearing
- the tabling of particular types of reports (e.g. psychiatrists' reports) with the Tribunal
- the attendance of family and other patient 'support' figures at the hearing
- the mode of the hearing (i.e. live hearings compared with Tribunal hearings conducted by telephone or video conference).

For the first time, a study is undertaken using a combination of information captured by and generated from the MHRT's electronic Client Management System and integrating information accessed from matching paper case files. This process has created an entirely new database capable of yielding cross-sectional insights and dynamic impressions of the sampled cohort of mentally ill people whose contacts with the MHRT were tracked over a number of years.

⁴² Originally this research was part of a larger research project funded by a linkage grant from the Australian Research Council (ARC Linkage Project LP0560358) and with research partnership funding and support from the Law and Justice Foundation of NSW and the NSW Mental Health Review Tribunal. The chief investigators for the ARC linkage project were Professor Terry Carney (University of Sydney) and Professor David Tait (University of Western Sydney; formerly of the University of Canberra); the partner investigators were the NSW Law and Justice Foundation and the NSW Mental Health Review Tribunal; and the industry partners were the Mental Health Tribunal ACT, Mental Health Review Tribunal NSW and Mental Health Review Board of Victoria. Together the chief investigators and partner representatives formed the Mental Health Tribunal Project Team. In the course of the ARC linkage project, the project team decided that the analyses of information on the NSW Mental Health Review Tribunal were too important to form only part of the larger research study and that it should stand as a study in its own right.

Method

The MHRT data used in this study relates to a cohort of 299 clients sampled from all clients *first* registered with the MHRT in 2003.⁴³ For each of these clients, their complete history — hearings and other contacts (e.g. adjournments, applications to vary existing orders) — with the Tribunal was tracked up to 31 October 2007, the date that the current *NSW Mental Health Act 2007* commenced.⁴⁴

The source of the research data was the MHRT's electronic Client Management System (CMS) and the paper files linked with these CMS records. Access to these sources of administrative information was both approved and facilitated by staff of the MHRT. To ensure the privacy of the clients sampled, the MHRT provided a de-identified Excel file of the CMS data for these clients (i.e. client numbers were replaced with non-identifying numbers assigned by the MHRT, which maintained a master list linking the assigned numbers to the original client numbers). Furthermore, all members of the research team who accessed the MHRT's paper files were required to sign confidentiality agreements.

Two different types of data were available from the CMS and associated paper files — *person-based* and *hearings-based* data. These were extracted, merged and processed to construct unit record data. Each unit record represents a specific contact (event) with the MHRT for a particular client in the cohort.

A number of points should be made concerning this analysis. First, this is a study of available information present on the file. Because the file itself is not intended as a complete record of proceedings, certain pieces of information may not have found their way onto the file. Second, the data used in this study does not include the information contained in the Tribunal's audio recording of proceedings (or transcript of it should such a record exist). Third, while certain information may not be on the paper file, this does not mean that issues that remained essentially undocumented were not a point of consideration in a hearing. Many aspects of the Tribunal's deliberations are integral to the Tribunal's decisions but may not have been explicitly stated or recorded on file, such as the perceived risk of the client's mental state to community safety. In short, this study focused on the available documentary records and not the actual evidence and discussion put forward at the Tribunal hearings.

⁴³ As described by the Foundation's research team in its draft *Methods* document (25 March 2009, pp. 5–6):

A sample of 300 cases was selected from all new civil clients who entered the MHRT system in 2003. The total number of clients who were admitted to the MHRT for the first time during 2003 was 1456. In order to obtain the sample a client was randomly chosen from this list and then every 5th client was selected until we reached a total of 300 clients. All hearings for these clients up until the end of October 2007 (i.e. the commencement of the Mental Health Act 2007) were included. During the data collection and entry process one client's coding sheets were misplaced; as a result the final sample was of 299 clients rather than 300.

⁴⁴ Some, if not all, of the sampled clients may have had a history of prior engagement with the mental health system of NSW, or the mental health system of some other state/territory, before presenting to the NSW MHRT. However, records detailing any such involvement are not held by the NSW MHRT. This means that the circumstances of any individual coming before the Tribunal are not included in the scope of this study.

In addition, although the sample method was used to randomly select the cohort of MHRT clients, there remains a small chance that the sampled cohort of clients fails to replicate the complete diversity of the population of clients from which it is drawn — in terms of key descriptors such as age distribution and gender balance as well as the actual distribution of diagnoses and outcomes of hearings in the MHRT client population. This is a fundamental characteristic of all sample studies. We believe the probability of our sample not being representative of the full population of MHRT clients is very low. The selection process was strictly enforced to ensure the greater diversity of the MHRT client population was captured.

Despite these limitations and others,⁴⁵ especially small cell sizes for certain cross-tabulations, the study of this MHRT cohort and its event histories allows an examination of the distinguishing characteristics of those mental health patients coming into contact with the MHRT for the first time. It also allows research into a range of issues central to therapeutic jurisprudence and the legally-regulated side of mental health service delivery. Nevertheless, caution needs to be exercised in relation to some of the findings presented in this report. Where appropriate, the potential implications of any limitations are noted and discussed.

Structure of the report

This analysis of the MHRT data is provided in three parts.

Part I details the general characteristics of a random sample of a cohort of 299 clients first registered with MHRT in 2003. In terms of their contact with the MHRT system, these clients were tracked for a period of just less than five years, commencing on 1 January 2003 and ending on 31 October 2007. In this period, these clients generated over 1000 hearings before the MHRT.

The end date for the study period was selected because it represented the commencement of the current *NSW Mental Health Act 2007*. Prior to 31 October 2007, and for the full period examined in this study, the NSW Mental Health Review Tribunal operated under the *NSW Mental Health Act 1990*.⁴⁶ In addition to the characteristics of the clients, the general features of the file records of 1083 MHRT hearings involving these 299 individuals were analysed, as were the various types of determinations made by the Tribunal in relation to these hearings.

Part I also includes a statistical analysis of the characteristics of clients subject to the various MHRT determinations (i.e. outcomes or orders). This statistical treatment considers identified differences in the demographic characteristics of clients subject to the different determinations. While this statistical treatment of the different MHRT determinations is provided, the information needs to be viewed with some caution as identified differences between clients subject to one order or another will reflect, first and foremost, distinctions in the type and severity of the clients' mental illnesses as well as the Tribunal's consideration of the likely success of any proposed treatment plans.

Part II provides a more detailed and extensive analysis of the characteristics of clients subject to two different types of orders frequently sought by treating teams and made by the MHRT: Community Treatment Orders (CTOs) and determinations for Electro Convulsive Therapy (ECT).

Part III examines the characteristics of a subset of matters involving a group of MHRT clients who, at the time of the hearing, may have been considered 'complex needs' clients because they were identified as having a co-morbid substance abuse problem at the time of their being prescribed anti-psychotic medication for their mental condition(s).

⁴⁵ The Tribunal's paper files do not contain records that follow a common or systematic format. Each mental health care agency tends to use its own reporting protocols. Some use pre-printed reporting forms, others just discursive notes on Area Health Service letterhead, amounting to doctor's notes of interview or case managers' field reports. This meant that diverse person and related hearing information had to be assembled by the research team in two steps. The first step entailed a review of a subset of the sampled files to determine the extent of items common to all files. The second step was to develop appropriate coding frames and rules to capture information more systematically across the sampled documents. These coding forms will be available in the online PDF version of this report.

⁴⁶ Section 9 of the *Mental Health Act 1990* stated:

- (1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:
 - (a) for the person's own protection from serious harm, or
 - (b) for the protection of others from serious harm.
- (2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

Statistical analyses

Descriptive tabulations

Tabulations of coded item frequencies and percentages were compiled from the MHRT dataset to describe relevant features and to explore differences between MHRT clients based on their demographic characteristics, mental conditions and factors relating to the Tribunal hearings.

Non-parametric analyses

In addition to the descriptive analyses, some non-parametric tests were also conducted to check for statistically significant differences between groups of MHRT clients. For example, chi-square tests were applied to examine the simple bi-variate relationship between:

- mental condition and gender of client
- mental condition and age of client
- mental condition and medication type
- the determination (i.e. outcome or orders) and legal representation at hearing
- outcome and client attendance/participation in hearings
- outcome and gender of client.

The chi-square test examines whether there is a significant relationship between two or more categorical variables. The test is based on the cross-tabulation of the relevant variables and compares the observed frequencies in each cell of the cross-tabulation with the frequencies expected if there were no relationship between the variables.⁴⁷ The chi-square test reveals the straightforward relationship between the two variables, when no other variables are taken into account (i.e. the bi-variate relationship). The statistical significance of each chi-square test was examined at the 0.05 level.

Missing values

The number of missing values for each variable included in the descriptive or non-parametric analyses is provided in the table notes. The number of valid records for each analysis is also provided in the table. The analyses were based only on those records that had data on all the variables of interest used in each analysis.

⁴⁷ Siegel & Castellan 1988.

PART I

DESCRIPTION AND ANALYSIS OF THE MHRT SAMPLE

General characteristics of the sample

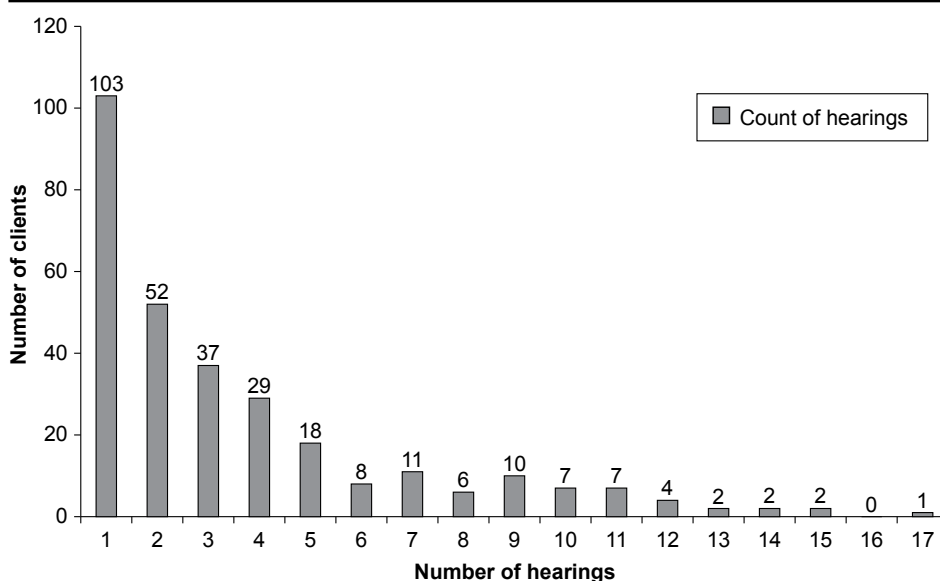
The study examined the outcome and file records of a total of 1083 MHRT hearings generated by a sample of 299 individual clients who entered the MHRT system for the first time in 2003. The study did not review the audio recordings or transcripts of these hearings.

The vast majority (99%) of hearings were preceded by a Tribunal or Magistrate's order. This included all involuntary matters, which, under section 56 of the previous *NSW Mental Health Act 1990*, were necessarily preceded by a Magistrate's order.⁴⁸

In just over half (52%) of the hearings, the person's residential status was recorded as 'in-patient', that is, the patient of a mental health facility. For the remaining hearings (48%), the person was recorded as residing in the community at the time of their hearing.

On average, each client belonging to the cohort was involved in 3.6 MHRT hearings for the period of almost five years between 2003 and 2007. The median number of tribunal hearings was two. The highest number of Tribunal hearings for an individual client in the cohort sampled for the period examined was 17 hearings (Figure 1).

Figure 1: Frequency distribution of MHRT hearings



Source: Foundation's NSW MHRT cohort study (2003–2007).

Figure 2 shows that 148 clients or almost half (49.5%) the sample of 299 clients who had been registered for the first time on the MHRT system in 2003 were no longer in the system one year later.⁴⁹

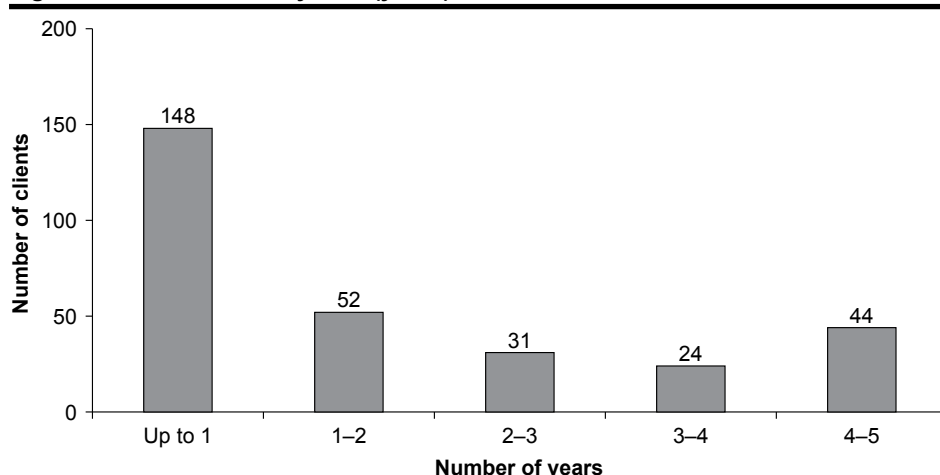
⁴⁸ Under the 1990 Act, the majority of involuntary patients came to the attention of the NSW MHRT through a magistrate's hearing (see Appendix B).

⁴⁹ A client may or may not have a history of involvement with the NSW or interstate mental health systems prior to the period examined and prior to being registered with the MHRT. The Tribunal does not routinely collect any such information.

Within the period examined (1 January 2003 to 31 October 2007), 'Time in the MHRT system' is the number of days between:

- (1) the date a file was first opened (representing the date that the client commenced being processed) by the MHRT, and
- (2) the order expiry date for the last hearing for that client.

The order expiry date was used even when it was after 31 October 2007, that is, the end date for the period studied. This yielded a small number of clients (5) with a time in the MHRT system that exceeded five years. These five clients appear in the 'four to five years' interval. Where an order expiry date was not recorded for the last hearing (e.g. hearings involving involuntary clients), the Tribunal listing date was used in the place of the order expiry date, unless this pre-dated the order expiry date for an earlier order, in which case that became the end date used. This calculation may not accurately reflect the actual time in the MHRT system for a very small number of MHRT clients. Furthermore, a client may or may not have continued their involvement with the MHRT system after the end of the period examined and it should be noted that some clients may have been discharged from the mental health facility prior to the expiry date of the Tribunal's order.

Figure 2: Time in MHRT system (years)

Source: Foundation's NSW MHRT cohort study (2003–2007).

While only 44 (or 15%) of the clients remained in the system for four years or longer, they generated a disproportionate share of the total number of Tribunal hearings in the period of almost five years. This group accounted for 369 hearings — just over one-third (34%) of all hearings for the study period — for an average of 8.4 hearings per client.

No client who was in the MHRT system for four years or longer generated fewer than three hearings, and 26 of the 44 clients (59%) who were in the MHRT system for four years or longer generated nine or more hearings.

The mental conditions of MHRT clients

Of the total 1083 hearings generated by the cohort, 781 hearings (72%) had on file a description of the client's mental condition(s) at the time.⁵⁰ It should be noted that one or more mental conditions could be recorded for a client at any particular hearing. Also, mental conditions are not necessarily mutually exclusive.

The distribution of types of mental conditions among those whose diagnosis was noted in supporting documentation on the file is as follows:⁵¹

- schizoaffective disorder in 76 hearings (or just under 10% of the 781 hearings)
- bipolar disorder in 68 hearings (9%)
- paranoid schizophrenia in 89 hearings (11%)
- schizophrenia in 350 hearings (45%)
- depression in 82 hearings (11%)
- borderline personality disorder in five hearings (0.6%)
- an intellectual disability in four hearings (0.5%).

⁵⁰ Information on a client's mental condition(s) often but not always appeared in supporting documentation, usually provided by the treating team. Furthermore, the MHRT commented that '[t]he client's mental condition is not routinely recorded because the Tribunal is not required to make a finding as to the specific condition.' (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 6 July 2009.)

⁵¹ The percentages total to more than 100 per cent because multiple mental conditions could be recorded for a client at any particular hearing.

In addition, clients were identified with:

- a co-morbid (secondary) drug abuse problem in 233 hearings (30%)
- a co-morbid (secondary) alcohol abuse problem in 118 hearings (15%)
- a co-morbid (secondary) problem with both drugs and alcohol in 101 hearings (13%).

Matters dealt with by the MHRT

As mentioned earlier, the type of order or determination made by the MHRT is always in direct response to an application made by a psychiatrist, hospital registrar or other health professional for an order to authorise the involuntary treatment of a person in hospital or in the community. Sometimes this involves an application for a specific therapeutic intervention, such as a course of ECT. Therefore, there is direct correspondence between the type of matter or application considered by the Tribunal and the determination made.

Table 1 lists the Tribunal determinations by the underlying matters considered at each hearing, in accordance with the *NSW Mental Health Act 1990* in force at the time. Notably:

- There were 695 hearings where the MHRT considered applications for a community treatment order (CTO), including 44 applications to vary an existing CTO. In total, 605 (or 87%) of these applications resulted in the MHRT ordering community treatment or the continuation of community treatment by a mental health facility. Only one per cent of applications for CTOs were declined by the MHRT. A further 12 per cent of CTO applications were subject to adjournment.
- The MHRT considered an application for Electro Convulsive Therapy (ECT) for involuntary patients in 70 hearings. In each of these hearings, the application for ECT resulted in an ECT order being made by the Tribunal.⁵² There were also no adjourned hearings involving applications for ECT for our cohort in the period examined.
- There were 250 matters before the MHRT that involved Temporary Patient orders (TPOs; also known as In-patient orders), including 183 matters to extend a Temporary Patient order previously made by a magistrate. In addition, there were 45 applications to review an existing TPO; 22 applications to review Continued Treatment; and nine Informal Patient reviews. The majority (73%) of these applications for Temporary Patient orders resulted in the MHRT classifying or continuing the client's classification as an in-patient of a mental health facility. One-quarter (26%) of hearings that involved in-patient matters were adjourned.
- The MHRT considered 46 matters concerning Protected Estates Orders (PEOs), including 28 applications. Eight of the 28 PEO applications were declined and 10 granted; the remaining 10 applications were adjourned. Of the 16 Protected Estates matters referred by a magistrate, two PEOs were made, eight applications declined and six hearings adjourned. There were two applications to revoke an existing PEO and, in each case, the Tribunal determined that the PEO would stand.

⁵² According to the *NSW Mental Health Review Tribunal 2007–8 annual report*, <<http://www.mhrt.nsw.gov.au/mhrt/pdf/annualreport2007.pdf>> Table 13, in the 2007 calendar year, ECT was categorised as 'determined to be necessary & desirable' (i.e. ECT application approved) in relation to 568 ECT applications; and categorised as 'determined to be NOT necessary & desirable' (i.e. ECT application declined) for 13 ECT applications (around two per cent of ECT applications for that year). In addition, 32 ECT applications were subject to an adjournment (around five per cent of ECT applications for 2007).

Table 1: Matters before the MHRT and Tribunal determinations for all hearings

<i>Matter/Application (NSW Mental Health Act 1990)</i>	<i>Determination</i>	<i>No. of hearings</i>
s. 131 Application for Community Treatment Order (CTO)	CTO made^a	560
	Order declined	7
	<i>Adjourned</i>	83
s. 148 Application for variation or revocation of CTO	CTO made/varied	44
s. 151(2) Appeal against Magistrate's CTO	CTO made/upheld	1
	Total CTOs made	605^b
s. 188 Application for Electro Convulsive Therapy (ECT) — Involuntary patient	ECT order made	70
	ECT declined	0
	<i>Adjourned</i>	0
	Total ECTs made	70
s. 56 Extend Magistrate's Temporary Patient order ^c (TPO)	TPO made	130
	Discharged	2
	<i>Adjourned</i>	51
s. 58 Review Tribunal's TPO	Continued TPO made	32
	Discharged	1
	<i>Adjourned</i>	12
s. 62 Review Continued TPO	Continued TPO made	21
	<i>Adjourned</i>	1
	Total TPOs made	183
s. 19 Application for Protected Estates Order (PEO)	PEO made	10
	Order declined	8
	<i>Adjourned</i>	10
s. 17 PEO referred by Magistrate	PEO made	2
	Order declined	8
	<i>Adjourned</i>	6
s. 36 Application for revocation of PEO	PEO made/upheld	2
	Total PEOs made	14
s. 69 Appeal against Refusal to Discharge	Appeal dismissed	18
	Discharged	1
	<i>Adjourned</i>	3
	Total appeals dismissed	18
GRAND TOTAL	ALL HEARINGS	1083

a 'Order made' includes where, in response to an application, the MHRT determined that an existing order be continued.

b Includes four orders made on s. 18 — Applications for Community Counselling Orders (CCO).

c Also known as In-patient orders. Includes nine voluntary treatment orders made under s. 63 — Review Informal Patient.

Note: Totals for each determination (e.g. 'Total CTOs made') is the sum of the bolded numbers for each set of relevant matters/applications.

Source: Foundation's NSW MHRT cohort study (2003–2007).

Demographic characteristics of MHRT clients

In analysing the demographic characteristics of the sampled cohort of MHRT clients, information recorded at *first* hearing is used to avoid counting the same individuals multiple times. This is because many clients in the cohort had more than one Tribunal hearing.

Gender

Over half (56% or 168) of the MHRT's clients in our sample were male and 44 per cent (131) were female.

Age

More than half the cohort (58%) was below 40 years of age at the time of their first hearing (Table 2a). The age distribution of mental health clients did not differ markedly from first hearing to all hearings (Table 2b), although some largely non-significant differences appear when gender was considered in combination with age.⁵³

Table 2a: Age of clients at first MHRT hearing (by gender)

Age — first hearing (10-year bands)	Female		Male		All persons	
	No.	%	No.	%	No.	%
Under 20	11	8.4	7	4.2	18	6.0
20 to 29	25	19.1	60	35.7	85	28.4
30 to 39	30	22.9	41	24.4	71	23.7
40 to 49	25	19.1	24	14.3	49	16.4
50 to 59	17	13.0	12	7.1	29	9.7
60 to 69	9	6.9	11	6.5	20	6.7
70 and over	14	10.7	13	7.7	27	9.0
Total	131	100.0	168	100.0	299	100.0

Source: Foundation's NSW MHRT cohort study (2003–2007).

Table 2b: Age of clients across all MHRT hearings (by gender)

Age — all hearings (10-year bands)	Female		Male		All persons	
	No.	%	No.	%	No.	%
Under 20	42	9.4	13	2.0	55	5.1
20 to 29	104	23.4	235	36.8	339	31.3
30 to 39	97	21.8	128	20.1	225	20.8
40 to 49	73	16.4	120	18.8	193	17.8
50 to 59	66	14.8	57	8.9	123	11.4
60 to 69	39	8.8	54	8.5	93	8.6
70 and over	24	5.4	31	4.9	55	5.1
Total	445	100.0	638	100.0	1083	100.0

Source: Foundation's NSW MHRT cohort study (2003–2007).

Place of residence

Place of residence was not recorded for only 19 of the 299 clients (or six per cent of all clients). Where recorded, it was found that the majority (75%) of clients lived in the Sydney, Hunter or Illawarra Statistical Divisions, which includes these cities *and* their surrounds (Table 3).

⁵³ At *first* hearing, the sole significant age difference was fewer than expected females in the 20 to 29 age group. However, across *all* hearings there were significantly:

- more female clients and fewer male clients in the under 20 age group
- more male clients and fewer female clients in the 20 to 29 age group
- more female clients than expected in the 50 to 59 age group.

Table 3: Client's place of residence at first hearing — Statistical Division (based on postcode)

<i>Place of residence — Statistical Division (based on postcode)</i>	<i>No.</i>	<i>%</i>
Sydney	170	60.7
Hunter	20	7.1
Illawarra	19	6.8
Richmond-Tweed	4	1.4
Mid-North Coast	17	6.1
Northern	9	3.2
North Western	8	2.9
Central West	8	2.9
South Eastern	14	5.0
Murrumbidgee	5	1.8
Murray	6	2.1
Far West	0	0.0
Total	280	100.0

Note: Where available, place of residence (postcode) for a subsequent hearing was used where a valid postcode was not on record for a client's first hearing. Postcode was not recorded at any hearing for 19 clients.

Source: Foundation's NSW MHRT cohort study (2003–2007).

There were 77 clients (or 28%) who resided in Local Government Areas outside the Sydney, Newcastle and Wollongong metropolitan areas. By comparison, around 32 per cent of the general population in NSW lived outside the *cities* of Sydney, Newcastle and Wollongong at the time of the Census in 2006.

Of the 77 clients who were recorded as living in country NSW, the majority lived in rural areas outside the larger country centres:

- one-third (27) resided in larger country centres (e.g. Dubbo, Orange, Taree)
- two-thirds (50) lived in rural areas outside the larger country centres.

According to the 2006 Census, approximately two-thirds of the population in country NSW lived in the larger country centres and only one-third lived in the more rural and remote areas (i.e. outside these country centres). This is the reverse of the pattern noted for MHRT clients.

Socio-economic status

Table 4 presents information on clients' place of residence in terms of the Australian Bureau of Statistics' Index of Relative Socio-Economic Advantage and Disadvantage, more commonly known as one of the four SEIFA Indexes.⁵⁴ This index is based on the postcode of each client's recorded place of residence at the first hearing and the SEIFA values have been banded in quartiles, ranging from areas that are characterised by high levels of socio-economic advantage to areas characterised by high levels of socio-economic disadvantage.⁵⁵

⁵⁴ For more information on the SEIFA Indexes, see <http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Seifa_entry_page>.

⁵⁵ Geographic areas, however, are not necessarily homogenous in their level of socio-economic disadvantage. In fact, a client living in a highly advantaged area may be one of the area's (or even the State's) most disadvantaged residents. Similarly, a client living in a highly disadvantaged area may be reasonably well-off, financially and socially (Kennedy & Firman 2004).

The majority (60%) of clients at the time of their first hearing lived in areas identified as being either mildly or highly advantaged as defined by SEIFA. This is 10 per cent higher than expected given the distribution of advantage across the state. Just over one-quarter (25%) of clients resided in areas marked by mild levels of socio-economic disadvantage and almost 15 per cent lived in areas marked by high levels of socio-economic disadvantage. Together, this is about 10 per cent lower than expected given the distribution of disadvantage across the state.⁵⁶

Table 4: Client's place of residence at first hearing — level of socio-economic disadvantage (SEIFA quartile by postcode)

<i>Level of socio-economic disadvantage (SEIFA quartile) of client's place of residence</i>	<i>No.</i>	<i>Actual %</i>	<i>Expected %</i>
Highly advantaged	77	27.4	25.0
Mildly advantaged	92	32.7	25.0
Total advantaged clients	169	60.1	50.0
Mildly disadvantaged	71	25.3	25.0
Highly disadvantaged	41	14.6	25.0
Total disadvantaged clients	112	39.9	50.0
Grand total	281	100.0	100.0

Note: Where available, place of residence (postcode) for a subsequent hearing was used where a valid postcode was not on record for a client's first hearing. Postcode was not recorded at any hearing for 19 clients.

Source: Foundation's NSW MHRT cohort study (2003–2007) and ABS (2008) *SEIFA: socio-economic indexes for areas*.

Country of birth

Records showed that the vast majority of clients sampled were born in English-speaking (ESB) countries — 92 per cent were born in Australia, and a further 1.3 per cent of clients were born in New Zealand, the UK or the USA (Table 5). Persons born in non English-speaking (NESB) countries made up six per cent of MHRT clients.

Clients born in NESB countries had a higher hearing rate than clients born in ESB countries, at 5.0 hearings per NESB client and 3.5 hearings per ESB client.

Language spoken and use of interpreter

The client spoke English at the vast majority (99%) of first hearings. In 15 hearings an interpreter was required for clients who spoke: Arabic/Lebanese (6 hearings), Greek (2), Cantonese (1), Mandarin (1), Japanese (1), Korean (1), Mongolian (1), Spanish (1) and Turkish (1).⁵⁷

⁵⁶ This pattern of 'advantage' rather than 'disadvantage' for people with a mental illness is contrary to observations of 'the actual poverty and stigma that is associated with mental illness' (Victorian Mental Health Review Board member and carer, cited in Carney et al 2011, p. 185).

⁵⁷ An interpreter is only used in hearings when the applicant/health agency makes a request to the MHRT for an interpreter.

Table 5: Country of birth of MHRT clients

<i>Country of birth (Region)</i>		<i>No. of clients</i>	<i>No. of hearings</i>	<i>Hearings per client</i>
ESB	Australia	276	955	3.5
	New Zealand	2	12	6.0
	UK	1	12	12.0
	USA	1	9	9.0
	Total ESB clients	280	988	3.5
NESB	Asia	8	36	4.5
	India ^a	3	18	6.0
	Europe	6	28	4.7
	South America	1	7	7.0
	Africa	1	6	6.0
	Total NESB clients	19	95	5.0
Grand total		299	1083	3.6

a Includes Pakistan and Bangladesh.

Source: Foundation's NSW MHRT cohort study (2003–2007).

Characteristics of MHRT hearings

Determinations made at Tribunal hearings

Table 6 shows the type of determination or order made at each of the 1083 MHRT hearings. Earlier in this report (Table 1) it was identified that community treatment orders were the most common application and matter before the MHRT — 695 of the 1083 hearings (64%) involved a CTO application. From Table 6 it can be seen that CTOs were also the most common order made by the Tribunal, representing 56 per cent of all Tribunal determinations.

Table 6: MHRT determinations for all hearings

<i>MHRT determinations — all hearings</i>	<i>No.</i>	<i>%</i>
Community Treatment Order (CTO) ^a	605	55.9
Temporary Patient order (TPO) ^b	183	16.9
Electro Convulsive Therapy (ECT)	70	6.5
Protected Estates Order (PEO)	14	1.3
Adjourned	166	15.3
Order application declined	23	2.1
Appeal dismissed	18	1.7
Discharged	4	0.4
Total	1083	100.0

a Includes four cases of Community Counselling Order. Also includes 44 applications to vary an existing CTO and one appeal against a CTO — all 45 applications resulted in the CTO being retained.

b Also known as In-patient orders. Includes nine cases of s. 63 — Review Informal Patient.

Source: Foundation's NSW MHRT cohort study (2003–2007).

Temporary Patient orders (17%) were a smaller but relatively common Tribunal outcome. In the main, Temporary Patient orders were made by the Tribunal in response to an application to review or continue a magistrate's classification of a person as mentally ill and order for their detention in a mental health facility as an in-patient.

ECT orders involving involuntary patients made up just over six per cent (6.5%) of all Tribunal determinations in the period examined, and all ECT determinations resulted from applications for electro convulsive therapy made to the Tribunal by a hospital or mental health facility.

Matters involving Protected Estates Orders (PEOs) made up just over one per cent (1.3%) of all matters dealt with by the Tribunal in this study.

Fifteen per cent of all matters before the Tribunal during the period examined were adjourned.⁵⁸

Mode of hearing

Table 7 shows that a small proportion of hearings involved an application for an adjournment of proceedings (7.5%) or an application to vary a Community Treatment Order (CTO) (3.9%). These adjournments and other hearings were generally conducted administratively without the need for a substantive hearing involving the parties.⁵⁹

Table 7: Mode of hearing

<i>Mode of hearing</i>	<i>No.</i>	<i>%</i>	<i>Valid %^a</i>
Live	430	39.7	44.8
Phone	282	26.0	29.4
Video	248	22.9	25.8
For adjournment	81	7.5	-
Application for variation of CTO	42	3.9	-
Total	1083	100.0	100.0

a Valid percentages are based on the 960 'live', 'phone' and 'video' substantive hearings (i.e. with adjournments and applications for CTO variations removed).

Source: Foundation's NSW MHRT cohort study (2003–2007).

It was more common for a substantive Tribunal hearing to be conducted live (40%) than by phone (26%) or video (23%). With adjournments and applications for CTO variations removed, live hearings represented 45 per cent of substantive hearings, while phone hearings and video hearings made up 29 and 26 per cent of substantive hearings, respectively.

⁵⁸ While brief reasons for Tribunal decisions are usually recorded in the notes kept on the Tribunal's determinations, the reasons for the adjournment of a hearing were not always clearly recorded on the MHRT file. Where available, this information was transcribed by the research team. Nonetheless, the research team could not be certain of the completeness or accuracy of the documented reasons for adjourned hearings.

Carney et al (2011, p. 279), in relating the findings of earlier research (Carney, Tait & Beaupert 2008), have commented on the NSW MHRT's reliance on 'the creative use of adjournments or other practical stratagems' that are sometimes used to ensure 'a positive right to mental health care'. The MHRT website <<http://www.mhrt.com.au>> provides the following information with regard to adjournments:

The Tribunal may from time to time adjourn its proceedings to such times, dates and places and for such reasons as it thinks fit. The purpose of adjourning proceedings is to ensure they are properly conducted. The Tribunal may adjourn proceedings if it is necessary to arrange for appropriate legal representation, or for an interpreter to assist the person or a primary carer or to allow for the production of important evidence.

Adjourning proceedings can have serious consequences. If the Tribunal adjourns proceedings in relation to a person who is detained in a mental health facility, that person is to continue to be detained in the facility unless discharged or allowed to be absent from the facility under another provision of the Act. As an adjournment may have significant consequences for an involuntary patient's liberty, the Tribunal does not regard administrative convenience as a sufficient justification for an adjournment.

The authorised medical officer should ensure that involuntary patients are brought before the Tribunal well before the expiry or review date and with sufficient information to allow the matter to be finalised without the need for an adjournment.

Although the Tribunal has power to adjourn proceedings, it does not have power to extend the operation of community treatment orders beyond their expiry date by granting an adjournment. Unless a new order is made before the expiry of the existing order, the client will no longer be subject to the order. Therefore, to ensure continuity of care mental health facilities should ensure that the Tribunal is provided with the necessary information in a timely manner to allow it to hold a hearing and make the necessary order within time. Any adjournment will only have effect during the term of the existing community treatment order.

⁵⁹ Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 20 November 2009.

Client attendance/participation in Tribunal hearings

In the first instance, without considering the type of matter before the Tribunal, two-thirds (66%) of clients were recorded as attending or otherwise participating (via phone or video hearings) in their hearing during the period examined. However, and as would be expected, more than one-third (36%) of hearings in which a client did not participate involved adjournments. Similarly, applications to vary a CTO, which are not substantive hearings, did not involve nor require the attendance of clients.

Clients attended almost three-quarters (74%) of substantive Tribunal hearings, but were significantly *more likely* to participate in Tribunal hearings involving an application to consider or review a Temporary Patient order. Over 92 per cent of clients attended these hearings for In-patient orders. In contrast, a *significantly lower* client attendance/participation rate was noted for CTO applications. Clients attended only 66 per cent of hearings involving applications to impose/extend/review a CTO.

Whilst not statistically significant:

- all 14 hearings involving an application for a Protected Estates Order or an application to revoke such an order were attended by the client
- 87 per cent of clients were in attendance/participated when an application for an order was declined by the Tribunal
- 83 per cent of hearings involving an application for ECT had the client in attendance or otherwise participating.

It is also important to note that a proportion of all clients, especially those hospitalised, may have been too unwell to attend their Tribunal hearing. The reasons why clients did not attend a hearing were not systematically recorded by the MHRT and thus not available for analysis.

Legal representation at Tribunal hearings

Without taking into consideration the type of matter, the client's legal representative was in attendance for 21 per cent of all Tribunal hearings within the period examined.⁶⁰

A legal representative was more likely to be in attendance for certain types of matters, with statistically high levels of legal representation occurring in relation to hearings that involved Temporary Patient matters (79%) and applications for Protected Estates Orders (79%). Statistically speaking, lawyers were also more likely to attend hearings that resulted in an order being declined (70% lawyer attendance), an appeal being dismissed (78% lawyer attendance), and a patient being discharged (100% lawyer attendance), although the numbers are relatively small.

It was very uncommon (1%) for a legal representative to appear at a hearing involving an application for a Community Treatment Order and only slightly more common (7%) for a lawyer to appear at a hearing for ECT.

Statistically, a legal representative was *more likely* to attend a hearing that was also attended by his/her client:

- 28 per cent of hearings attended by clients were also attended by their legal representative
- in contrast, only five per cent of hearings NOT attended by a client were attended by their legal representative.

⁶⁰ Cautionary note: Legal aid was available for all involuntary patient reviews in the first 12 months of detention. It was not available for CTO applications in the period covered by this research. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

Professional reports and attendance of report authors at Tribunal hearings

Professional reports (e.g. psychiatric assessments, etc) submitted to the Tribunal were found on file for 85 per cent of all hearings for our cohort of MHRT clients.

While no professional report was found on file for 15 per cent of hearings, this does not necessarily mean that a report was not provided, as a verbal report may have been given by a health or other professional on the day, or the Tribunal may have accessed reports on the mental health facility file but a copy of the report was not retained on the Tribunal's file.⁶¹ This is more likely to have been the case for matters heard at hospitals or other mental health facilities. In addition, certain matters, for example, adjournments, would not necessarily require the submission of a professional report.

Excluding adjourned hearings, there were 807 hearings that involved one or more reports on file submitted to the MHRT by a medical or other professional. This represents 88 per cent of all substantive hearings examined. The authors of professional reports were more commonly (and in descending order of frequency): psychiatrists, psychiatric registrars, doctors, case managers and social workers.

Where a report was submitted on file, at least one author was in attendance at 80 per cent of substantive Tribunal hearings examined in this study.

Tribunal hearings attended by 'support' persons

In 842 hearings (78%), the hearing was not attended by a spouse, family member or friend of the client.

For the remaining 241 hearings (22%) where such a person was in attendance, the person attending was more likely to be the client's mother (31% of 241 hearings), father (8%), spouse/partner (21%), offspring (11%) or sibling (9%). In 14 per cent of hearings, the client's support person was recorded as being either a more distant relative (e.g. niece, uncle, grandmother) or a non family member (e.g. friend, girlfriend, carer, worker). In the remaining seven per cent of 'supported' hearings, the attending person's relationship to the client was not specified.

Traditionally, a family member, spouse, partner or friend is viewed as a client's 'support person', that is, allied with and supportive of the client's personal views. Many such individuals also are the client's primary carer.⁶² However, the term 'support person' has broad connotations. It should be noted that such persons may have appeared before the Tribunal with views contrary to those of the client on the need for treatment and/or the type of determination they would like to see the Tribunal make. Protected Estate Orders, in particular, are matters dealt with by the Tribunal that may involve the views of a family member or spouse being in conflict with those of the client. Also, while the family are generally best placed to know the client well, many family members are estranged and do not associate with the client, often as a consequence of the client's mental illness.

⁶¹ Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 6 July 2009 and 20 November 2009.

⁶² The *NSW Mental Health Act 2007* (ss. 71–72, 75–78) gives effect to the rights of nominated primary carers to be notified of events affecting patients or detained persons receiving care and treatment. Primary carers are to be informed of a range of events, including admission to a mental health facility as an involuntary patient, discharge from a mental health facility, reclassification as a voluntary patient and applications made to the Tribunal for electro convulsive therapy. Perhaps surprisingly, there is no provision in the current Act to notify the primary carer of Tribunal hearings. The 1990 Act also did not have this provision.

Medication⁶³

Medication regimes have an important role to play in mental health therapy. However, the Tribunal does not generally make specific orders involving medication. The exception is with CTOs where the client's current medication is always specified in the treatment plan at the time the order is made. Nonetheless, medication is subject to change by the treating team throughout the term of a CTO. If a client who is subject to a MHRT determination for a CTO does not comply with a course of medication prescribed as part of their CTO they may be considered to be in breach of the order.

Medication was recorded for a client in around three-quarters (72%) of all MHRT hearings in the study. Medications, which may have been recorded by either their generic or proprietary names, were recoded and classified into six main genres according to the MIMS functional groupings. In terms of the principal type of medication recorded, the majority (88%) of clients were prescribed an anti-psychotic agent (Table 8). The next most commonly prescribed type of medication was anti-convulsants (6%) followed by anti-depressants (4%).

Table 8: Principal medication recorded for all hearings

<i>Medication (principal drug type)</i>	<i>No.</i>	<i>%</i>
Anti-psychotic agents	691	88.1
Anti-convulsants	49	6.3
Anti-depressants	33	4.2
Anti-anxiety agents	4	0.5
Sedatives/hypnotics	0	0.0
Other central nervous system agents	0	0.0
Other/unknown drugs	7	0.9
Total	784	100.0

Note: Medication was not applicable or not recorded (missing) for 299 hearings (27.6%).

Source: Foundation's NSW MHRT cohort study (2003–2007).

Medication and MHRT determination

Additional caution needs to be exercised in interpreting the following findings because the applied statistical test gave a validity warning.

Where medication was recorded it was found that over 90 per cent of clients given a CTO were prescribed anti-psychotic drugs. This correlation may not be surprising given that anti-psychotic agents are by far the most commonly prescribed drug and CTOs are the most common Tribunal determination.

The following findings were based on a test of the relationship between medication and determination, with no other variables taken into consideration:

- anti-psychotic medication was statistically *less likely* to be given to clients on ECT than clients receiving other orders
- CTO clients were statistically *less likely* to be prescribed an anti-depressant than other Tribunal clients

⁶³ The NSW MHRT provided the following cautionary note:

There is no requirement to record medication on the MHRT file. As such, recording of medication was found to be inconsistent and non-systematic in terms of both drug names and dosage levels. Also, it may be expected to be reasonably common that individual medications change by the time the Tribunal hears the matter. This information would not necessarily be recorded on file.

(Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 6 July 2009.)

Dosage levels for medications are not reported or analysed in this report.

- ECT clients were statistically *more likely* to be prescribed anti-depressants than other clients
- Temporary Patients were statistically *more likely* to be prescribed anti-convulsants than clients on other orders.

Mental condition and medication

The following *statistically significant* findings were identified from testing the relationship between medication and the clients' mental condition, with no other variables taken into consideration. Compared to other clients, clients diagnosed with:

- schizoaffective disorders were statistically *more likely* to receive anti-convulsant medications
- schizophrenia were statistically *less likely* to receive anti-convulsant medications⁶⁴
- clinical depression were statistically *more likely* to receive anti-depressant medications and *less likely* to be prescribed anti-psychotic drugs
- bipolar disorders were statistically *more likely* to receive anti-convulsant drugs.

No significant findings were identified in examining the medications prescribed for clients with the following mental conditions: borderline personality, paranoid schizophrenia,⁶⁵ drug abuse co-morbidity,⁶⁶ alcohol abuse co-morbidity and intellectual disability.

A comparison of clients experiencing different MHRT determinations

This section provides the reader with a general comparison of clients who received the various MHRT determinations. This involves consideration of any statistical differences identified in the characteristics of clients (e.g. age, gender, etc) subject to the different determinations. The identified statistical differences are summarised in Table 11.

This information needs to be considered with caution because identified differences between clients subject to one 'order' or another may reflect real distinctions in the type and severity of the mental illnesses of clients, as well as the Tribunal's consideration of the likely success of any treatment plan submitted to it by the clients' health professional.

Overview of MHRT determinations

There was a similar pattern to MHRT determinations whether the hearing was a first hearing or a subsequent hearing (Tables 9a, 9b and 9c). For mental health clients across all hearings, the most common application (64%) and thus determination (56%) was a Community Treatment Order (CTO) (Table 9a). However, the next tables (Table 9b: first hearings and Table 9c: subsequent hearings) show that a client was relatively less likely to receive a CTO at first hearing (42%) than at a subsequent hearing (61%).

Electro Convulsive Therapy (ECT) was a relatively common outcome for clients at their first hearing. ECT made up 15 per cent of first hearing applications and determinations. This is statistically different to the proportion of ECT determinations given at subsequent hearings (3%). It also suggests the likelihood of a course of ECT being used as a 'one-off' intervention.

⁶⁴ Clients with schizophrenia also appeared somewhat more likely to be prescribed anti-depressant drugs than other clients, although it should be noted that this finding approached but did not reach significance at the 0.05 level.

⁶⁵ Clients with paranoid schizophrenia appeared somewhat less likely to receive anti-depressant medications (not significant).

⁶⁶ Clients with a drug abuse co-morbidity problem also appeared somewhat more likely to be prescribed anti-convulsant medication than other clients (not significant).

Table 9a: MHRT determinations for all hearings

MHRT determinations — all hearings	No.	%
Community Treatment Order (CTO) ^a	605	55.9
Temporary Patient order (TPO) ^b	183	16.9
Electro Convulsive Therapy (ECT)	70	6.5
Protected Estates Order (PEO)	14	1.3
Adjourned	166	15.3
Order application declined	23	2.1
Appeal dismissed	18	1.7
Discharged	4	0.4
Total	1083	100.0

a Includes four cases of Community Counselling Order. Also includes 44 applications to vary an existing CTO and one appeal against a CTO — all 45 applications resulted in the CTO being retained.

b Also known as In-patient orders. Includes nine cases of s. 63 — Review Informal Patient.

Source: Foundation's NSW MHRT cohort study (2003–2007).

Adjournments also seemed more likely to occur at first hearing (19%) than at subsequent hearings (14%). Similarly, clients appeared more likely to have a matter discharged at first hearing (1%) than at a subsequent Tribunal hearing (0.1%). However, it should be noted that both these differences were small in size and did not reach statistical significance at the 0.05 level.

Table 9b: MHRT determinations for first hearings

MHRT determinations — first hearing	No.	%
Community Treatment Order (CTO)	126	42.1
Temporary Patient order (TPO) ^a	53	17.7
Electro Convulsive Therapy (ECT)	45	15.1
Protected Estates Order (PEO)	5	1.7
Adjourned	56	18.7
Order application declined	4	1.3
Appeal dismissed	7	2.3
Discharged	3	1.0
Total	299	100.0

a Also known as In-patient orders.

Source: Foundation's NSW MHRT cohort study (2003–2007).

Table 9c: MHRT determinations for subsequent hearings

MHRT determinations — subsequent hearings	No.	%
Community Treatment Order (CTO)	479	61.1
Temporary Patient order (TPO) ^a	130	16.6
Electro Convulsive Therapy (ECT)	25	3.2
Protected Estates Order (PEO)	9	1.1
Adjourned	110	14.0
Order application declined	19	2.4
Appeal dismissed	11	1.4
Discharged	1	0.1
Total	784	100.0

a Also known as In-patient orders.

Source: Foundation's NSW MHRT cohort study (2003–2007).

Determination and mental condition of clients

The findings discussed below are derived from our assessment of the likelihood of there being a significant relationship between the clients' diagnosed mental illness at the time of the hearing and the determination made by the Tribunal. This was done by way of applied statistical testing, which provides a basis for ruling out the likelihood that any relationships observed are due merely to chance. From this analysis, we are able to determine whether a client with a specific type of mental illness is more or less likely to have experienced a particular type of determination at a hearing. A limitation, however, is that the study is an observational one and is confined to only a very small set of collectible information that existed for all clients in the MHRT's paper case files. Therefore, no attempt could be made to relate the client's diagnosed mental illness to potential explanatory variables in the search for apparent relationships between a person's type of mental illness and the Tribunal's determination. Thus, an explanation of why any relationship exists will remain elusive until further research can identify a broader range of factors contributing to this relationship.

Indeed, any association identified in this study between the clients' mental conditions and the determination made by the MHRT may be a proxy for, or obscure, other factors behind the relationship. It should be remembered that this observational study is strictly limited to data that describes the circumstances of clients coming before the Tribunal at a particular time in relation to a specific application. In reporting results of the investigation, neither the Foundation's research team nor the MHRT were in a position to explore further the circumstances of individual clients beyond the written record of their hearings by the Tribunal. Any written records in the paper files had to be systematically recorded and needed to be available for, at least, most clients for a statistical analysis to be feasible. This requirement limited both the nature and extent of the data available for statistical analysis.

Remembering that the MHRT can only deal with the application for an order before it, and compared with other clients in the cohort:

- Clients with a bipolar disorder were statistically:
 - *more likely* to be classified as a Temporary Patient
 - *less likely* to receive a CTO.
- Clients with schizophrenia (including paranoid schizophrenia) were statistically:
 - *more likely* to receive a CTO
 - *less likely* to receive a determination for ECT.
- Clients with depression were statistically:
 - *more likely* to receive a determination for ECT
 - *more likely* to be classified as a Temporary Patient
 - *less likely* to receive a CTO.
- Clients identified with a drug abuse co-morbidity problem were:
 - *more likely* to receive a CTO
 - *less likely* to receive a determination for ECT.
- Clients identified with an alcohol abuse co-morbidity problem were:
 - *more likely* to receive a PEO
 - *less likely* to receive a determination for ECT.

No statistical differences were found in Tribunal determinations made for clients with a schizo-affective disorder, borderline personality disorder or an intellectual disability.

Determination and gender of clients

A comparison of MHRT determinations for male and female clients (Table 10) revealed a number of interesting differences. First, female clients (51%) received proportionally *fewer* CTOs than male clients (61%). Secondly, across all hearings females (10%) received significantly *more* ECT determinations than males (4%).

Table 10: MHRT determinations by gender of client for all hearings

MHRT determinations	Male %	Female %	All %
Community Treatment Order (CTO)	61.0	50.6	56.7
Temporary Patient order (TPO) ^a	14.4	18.4	16.1
Electro Convulsive Therapy (ECT)	3.8	10.3	6.5
Protected Estates Order (PEO)	0.9	1.8	1.3
Adjourned	15.5	15.1	15.3
Order application declined	2.4	1.8	2.1
Appeal dismissed	1.7	1.6	1.7
Discharged	0.3	0.4	0.4
Total	100.0	100.0	100.0

^a Also known as In-patient orders.

Source: Foundation's NSW MHRT cohort study (2003–2007).

In addition, an even higher number of female clients (21%) received an ECT determination at *first* hearing compared with men (10%).

Female clients were significantly *more likely* than male clients to receive an ECT determination regardless of whether the hearing was a first hearing or a subsequent hearing. This gender difference was statistically stronger with regard to subsequent hearings.

Determination and age of clients

An analysis of MHRT determinations by age (when grouped in 10-year age bands) revealed the following statistical differences. Compared with all other age groups:

- Clients up to and including 20 years of age were statistically:
 - *less likely* to have a Community Treatment Order made
 - *more likely* to be classified as a Temporary Patient.
- Clients aged 20 to 29 were *less likely* to receive a determination for ECT.
- Clients aged 50 to 59 were *more likely* to receive a determination for ECT.
- Clients aged 70 years and older were *more likely* to receive a determination for ECT.

There were no significant findings in relation to determinations for clients in the 30 to 39, 40 to 49 and 60 to 69 age groups.

Determination and place of residence of clients

No statistically significant difference between clients who resided in regional, rural and remote (RRR) areas of NSW and those who resided in the Sydney/Newcastle/Wollongong metropolitan areas was identified in relation to the types of orders made by the MHRT. In addition, a client's socio-economic status, as measured by SEIFA index for the area in which they lived, appeared to have no bearing on the determination made by the Tribunal. So while we previously noted that a higher than expected proportion of clients in the cohort lived in RRR areas of NSW, place of residence was not found to have a bearing on the Tribunal's determinations.

Client participation in hearings

As mentioned, two-thirds (66%) of clients were in attendance or otherwise participated in their hearing. The client was statistically *more likely* to be in attendance for matters involving an application for a Temporary Patient order (92 per cent attended by the client). ECT applications (83%) and Protected Estates Orders (100%) were also well attended by the client. Two-thirds of clients attended the hearing where it involved a CTO application.

MHRT hearings that were attended by the client were *less likely* to be adjourned, which is not surprising given that the MHRT is reluctant to deal with a matter if the client is absent.

Legal representation at hearings

It should be noted that legal aid, including legal representation by a solicitor from the Mental Health Advocacy Service (MHAS) of Legal Aid NSW, is only provided for specific Tribunal matters based on criteria determined by the NSW Legal Aid Commission. Other clients may be represented by a private solicitor at their Tribunal hearings.

The client's legal representative was in attendance in just over 21 per cent of all Tribunal hearings within the period examined. While this indicates that 79 per cent of Tribunal hearings did not involve a legal representative for the client, some clients may not have requested a lawyer, or not considered the matter important enough to engage a lawyer, perhaps because they were not unhappy with the course of action recommended in the application.

Other matters, applications for ECT for example, may have been made with a high degree of urgency by a medical professional in the interests of the client's mental wellbeing. In some such cases, it may not have been possible to have a legal representative attend the Tribunal hearing, which may have taken place at the treating hospital.

In general, clients' legal representatives attended:

- the majority (79%) of hearings involving applications for Protected Estates Orders
- the majority (79%) of applications for classification of a client as a Temporary Patient (i.e. an in-patient).

By contrast:

- only seven per cent of hearings regarding applications for ECT determinations for involuntary patients were attended by the client's lawyer
- in only six of the 605 hearings dealing with CTO applications was a client's legal representative in attendance.

The presence of a client's legal representative appeared to have had a major bearing on the determination of the hearing. Compared with hearings without a lawyer in attendance, Tribunal hearings attended by a legal representative for the client were *more likely*:

- to have an appeal dismissed (78 per cent of dismissed appeal hearings involved an attending legal representative)
- to be discharged (all four discharged cases involved a lawyer attending the hearing)
- to have an order application declined (70 per cent of declined orders involved a legal representative at the hearing).

In addition, hearings that were not attended by the client's lawyer were statistically *less likely* to have an appeal dismissed (only 22 per cent of appeals were dismissed without a lawyer being present).

Attendance of professionals at hearings

Certain matters before the Tribunal were regularly attended by the client's health (or other) professional. Typically, these professionals had prepared an assessment report on the client's mental condition for the Tribunal's consideration.

Almost 90 per cent of hearings involving an application for ECT or a TPO were attended by the health professional who prepared the client's assessment report. By contrast, and perhaps reflecting the somewhat less acute nature of the client's mental condition, only 76 per cent of applications for CTO involved the health (or other) professional being in attendance at the Tribunal hearing. It could also mean that another health professional, aside from the one who prepared the assessment report, appeared before the Tribunal.⁶⁷

Statistically, hearings were *less likely* to be adjourned when the client's professional worker was in attendance at the hearing.

Attendance of 'support' persons⁶⁸ at hearings

The MHRT hearing was attended by a member of the client's family or by a partner or friend of the client in 22 per cent of all hearings examined in this study. Higher levels of attendance by a client's 'support' persons was noted for ECT applications (33%), applications for TPOs (33%) and applications for Protected Estates Orders (36%).

Adjournments were statistically *less likely* to occur when the Tribunal hearing was attended by a client's 'support' person(s). Similarly and although the numbers are small, three of four discharged hearings were attended by the client's family member, partner, friend or other 'support' person.

Table 11 and the section that immediately follows summarises the set of identified statistical associations for the sampled cohort of MHRT clients and hearings.

⁶⁷ *The applicant of a matter before the Tribunal, who is usually a case manager or doctor, is always in attendance when the Tribunal actually hears the matter. The hearing would not go ahead without the health (or other) professional who made the application to the Tribunal attending the hearing. The only hearings where a health professional was not in attendance would be those matters listed for adjournment or variation of CTOs.*
(Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 15 February 2009.)

⁶⁸ The term 'support' person has broad connotations. It should be noted that the relative of a client, or their spouse or partner, or a friend of the client may have appeared at the Tribunal hearing with views contrary to those of the client on the need for treatment and/or the type of determination they would like to see the Tribunal make. Family members may have been estranged as a consequence of the client's mental illness.

Table 11: Table of statistical associations (MHRT cohort sample — 299 clients and their 1083 MHRT hearings, 1 January 2003 to 31 October 2007)

Determination	Variable							
	Mental condition ^{b, c}	Gender	Age group ^d	Medication (principal drug) ^{e, f}	Client	Lawyer	Professional author	Support person
Community Treatment Order (CTO)	↑ S ↑ C-DA ↓ B ↓ D		↓ Up to 20	↓ Anti-depressants		↑ Absent		
Electro Convulsive Therapy (ECT)	↑ D ↓ S ↓ C-DA ↓ C-AA	↑ Females ↓ Males	↑ 50 to 59 ↑ 70 plus ↓ 20 to 29	↑ Anti-depressants ↑ Anti-anxiety drugs ↓ Anti-psychotics	↓ Absent	↓ Present	↓ Absent	
Protected Estates Order (PEO)	↑ C-AA				↓ Absent	↑ Present ↓ Absent		
Temporary Patient order^a (TPO)	↑ B ↑ D		↑ Up to 20	↑ Anti-convulsants	↑ Present ↓ Absent	↑ Present ↓ Absent	↑ Present ↓ Absent	↑ Present

Key: ↑ = statistically more likely; ↓ = statistically less likely

- a Also known as in-patient orders.
- b B = Bipolar disorder; S = Schizophrenia (incl. paranoid schizophrenia); D = Depression; C-DA = Co-morbid drug abuse problem; C-AA = Co-morbid alcohol abuse problem.
- c No significant findings in relation to determinations for clients with schizoaffective disorders, borderline personality disorders or intellectual disability.
- d No significant findings in relation to determinations for clients in the 30 to 39, 40 to 49 and 60 to 69 age groups.
- e Caution needs to be exercised in interpreting the findings for determination by medication as the chi-squared test applied gave a validity warning.
- f Compared to other clients, clients with:
 - schizoaffective disorders or bipolar disorders were *more likely* to receive anti-convulsant medications
 - schizophrenia were *less likely* to receive anti-convulsant medications
 - depression were *more likely* to receive anti-depressant medications and *less likely* to receive anti-psychotic medications.

Note: Only factors found to be statistically associated with MHRT determinations (simple bi-variate relationship; significant at the p<0.05 level) are reported in this table.

Source: Foundation's NSW MHRT cohort study (2003–2007).

Summary of statistical associations

From Table 11, the Table of Statistical Associations, the following findings have been summarised. It should be noted that each finding is based on a simple bi-variate comparison — for example, the likelihood of an application for ECT being approved based on the client's gender — with *no other factors* taken into account.

- **Community Treatment Orders** were *more likely* made in relation to clients:
 - with schizophrenia (including paranoid schizophrenia; compared with other mental conditions)
 - with a drug abuse co-morbidity problem
 - whose legal representative did not attend the hearing.

Clients on CTOs were *less likely* to be prescribed anti-depressants.

Factors associated with a *reduced likelihood* of a Community Treatment Order being made include:

- being young (aged 20 years or less; compared with other age groups)
 - depression or a bipolar disorder (compared with other mental conditions).
- **Electro Convulsive Therapy:**
 - women were *more likely* than men to be ordered ECT
 - compared with other age groups, persons aged 50 to 59 or 70 and over were *more likely* to be ordered ECT
 - clients with clinical depression were *more likely* to be ordered ECT (compared with other mental conditions).

Hearings for ECT applications were *less likely* than other hearings:

- to have the client's legal representative attend the hearing
- to have the author of a client's professional report attend the hearing⁶⁹
- to have the client attend the hearing (in all likelihood because they were too ill).⁷⁰

ECT clients were *more likely* to be prescribed anti-depressants and/or anti-anxiety drugs, and were *less likely* to be prescribed anti-psychotic medications.

⁶⁹ It should, however, be noted that at least one health professional attended each of the 70 ECT hearings examined in our study. This person was not always the author of the client's professional report. For example, where the treating psychiatrist was unable to attend, the hospital may have sent the Registrar to the Tribunal hearing.

⁷⁰ This may largely reflect the seriousness of the client's mental condition and the urgent need for treatment:

The attendance of patients at ECT hearings can be either in person or by way of participation via video or teleconference. In a limited number of cases patient attendance may not be possible due to the acuity of their illness. If the Tribunal is in attendance at the hospital it is the usual practice of the psychiatrist member to visit the patient and to report his or her findings to the Tribunal panel. This will be recorded as the patient not attending the hearing although the Tribunal's file would note that the psychiatrist member visited the patient.

Where an urgent ECT application is made because the condition of a patient is such that the matter has to be determined expeditiously a video or telephone conference hearing may be held. Again, a small number of patients may be too unwell to attend and the Tribunal may proceed to determine the application in the patient's absence. In some of these cases the patient actually refuses to attend the hearing.

The Tribunal has recently been pro-active in having video conferencing facilities installed at all major hospital venues and this has had the effect of greatly reducing the number of ECT telephone hearings.

(Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 4 August 2009.)

- **Protected Estates Orders** were more common for clients with an alcohol abuse co-morbidity problem. PEOs were *more likely* to be made if the client's legal representative attended the hearing.

The *likelihood* of a PEO was *lower* if the client was absent from the hearing and/or the client's legal representative did *not* attend the hearing.

- **Temporary Patient orders (In-patient orders)** were *more likely* to involve clients with bipolar disorders or clinical depression.

The *likelihood* of a TPO being made was *higher*:

- where the client attended or otherwise participated in the hearing
- where the client was young (less than 21 years of age)
- where the client's legal representative attended the hearing
- where the author of a client's professional report was present at the hearing
- where the client's support person(s) attended the hearing.

The *likelihood* of a TPO being made was *lower* in hearings not attended by clients, their legal representatives or health professionals.

PART II

CTO AND ECT DETERMINATIONS

An analysis of CTO and ECT determinations

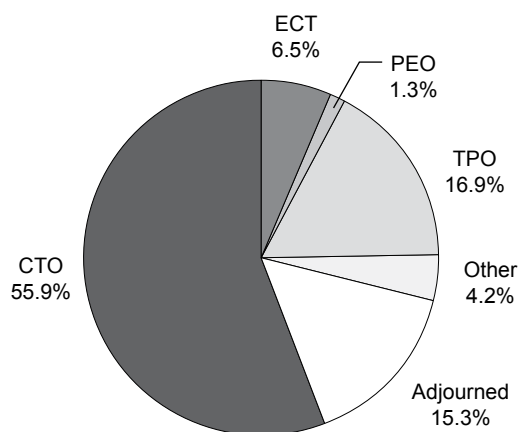
This section provides a separate examination of two common but different types of MHRT determinations — Community Treatment Orders (CTOs) and orders for Electro Convulsive Therapy (ECT).⁷¹ These two types of orders are frequently the subject of applications by treating teams to the Tribunal in relation to the care, management and treatment of persons with a mental illness.

CTO applications made up the largest number of matters before the MHRT in the period examined (see Table 1) and almost 90 per cent of applications for community treatment resulted in the Tribunal making a CTO. Therefore, it is not surprising that CTOs made up the most common (56%) Tribunal determination (Figure 3). A total of 605 of the 1083 MHRT hearings in the period examined resulted in the Tribunal making (560) or continuing (45) a CTO.

There were 70 hearings involving an application for ECT. An application for ECT can only be made to the Tribunal by an Authorised Medical Officer. Each of the 70 applications resulted in a determination for ECT. ECT orders represent 6.5 per cent of Tribunal determinations for the cohort in the period examined.⁷²

Together CTOs and ECT orders made up just under two-thirds (62%) of all Tribunal determinations for the period from 1 January 2003 to 31 October 2007.

Figure 3: MHRT outcomes



Note: 'Other' includes declined orders and dismissed appeals (see Table 1 for more detail). Temporary Patient orders (TPOs) are also known as In-patient orders.

Source: Foundation's NSW MHRT cohort study (2003–2007).

⁷¹ For detailed information on the MHRT and CTOs refer to <<http://www.mhrt.nsw.gov.au/tribunal/orders/cto.htm>> and for detailed information on the MHRT and ECT refer to <<http://www.mhrt.nsw.gov.au/tribunal/orders/ect.htm>>.

⁷² According to the NSW *Mental Health Review Tribunal 2007–8 annual report*, in the 2007 calendar year, ECT was categorised as 'determined to be necessary & desirable' (i.e. ECT application approved) in relation to 568 ECT applications and categorised as 'determined to be NOT necessary & desirable' (i.e. ECT application declined) for 13 ECT applications (around 2% of all ECT applications for that year). In 2007, there were 32 ECT applications subject to an adjournment (around 5% of all ECT applications for that year).

CTO determinations

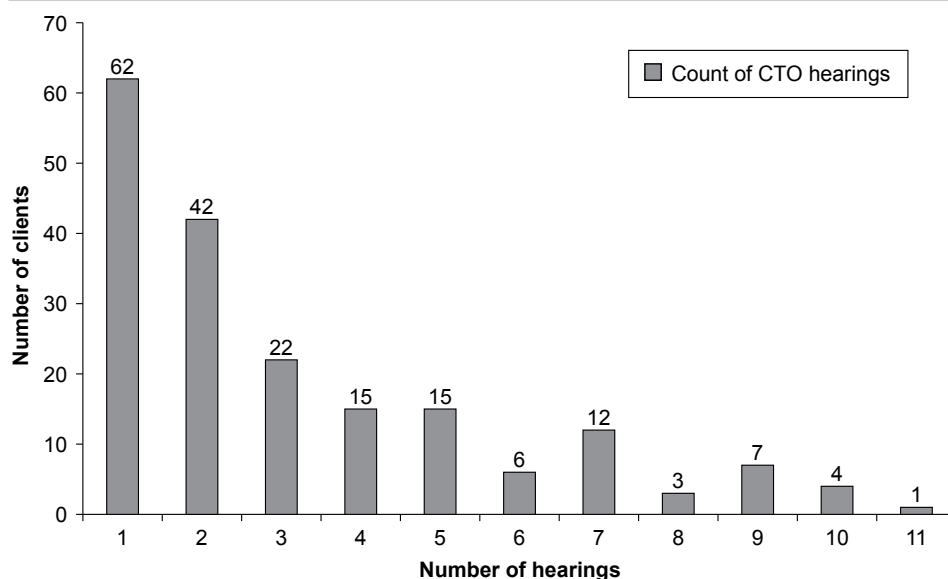
General

While there were 695 Tribunal hearings that involved applications for CTOs (including variations and appeals) during the period examined, only 605 hearings resulted in Community Treatment Orders (CTOs) being made.⁷³ This set of hearings will be referred to as CTO hearings.

CTO hearings represent 56 per cent of the 1083 MHRT hearings examined in the present study. The 605 CTO hearings involved 189 individual clients. On average, each of these clients received 3.2 CTOs during the period of almost five years.

From Figure 4, it may be seen that the largest number of individual CTOs for a single client was 11, although it was far more common for a client to receive just one CTO (62 clients or 33%) or two CTOs (42 clients or 22%).

Figure 4: Frequency distribution of CTO hearings



Source: Foundation's NSW MHRT cohort study (2003 to 2007).

A CTO was the first order made by the Tribunal for 126 of the 189 clients (67%) who received community treatment during the period examined. For the remaining 63 clients (33%), a different Tribunal proceeding or treatment order preceded the CTO.⁷⁴

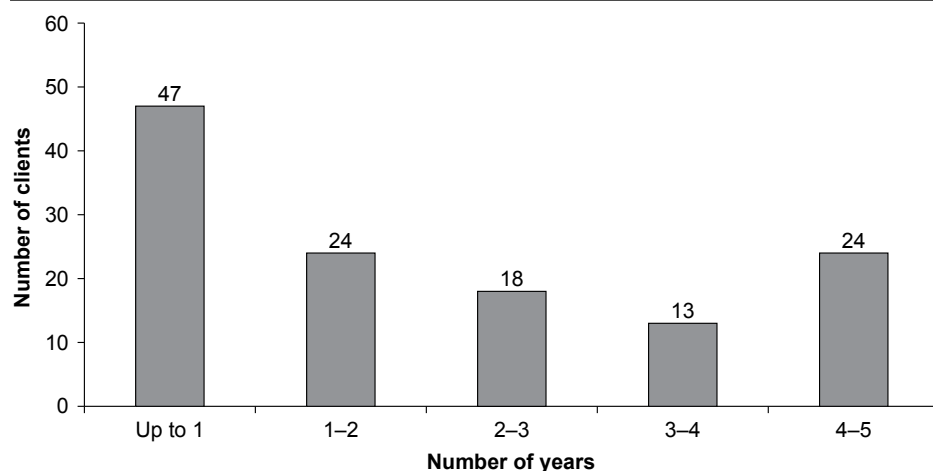
⁷³ Four hearings involving orders for Community Counselling are included with the 601 CTOs.

⁷⁴ In general, the first CTO for these 63 clients was often preceded by an adjournment (32) or Temporary Patient order (20) including a combination of both in six cases. For three clients, the CTO was preceded by a dismissed appeal, and for two clients the CTO was preceded by an earlier CTO application that was declined. ECT preceded the CTO for four clients, with one such client having four separate ECT determinations before the community treatment was ordered. For one client the CTO followed the combination of an earlier discharge, Temporary Patient order and adjournment; while for another the CTO followed a Protected Estates Order.

In over one-quarter (29%) of all CTO hearings the client was recorded as being an in-patient at the time the CTO was made. In other words, at the time of the hearing for the majority (71%) of CTO matters, the client was living in the community (and, for some, already on a CTO).⁷⁵

Figure 5 shows that 47 (or 37%) of the 126 clients who first received a CTO during the period examined were in the MHRT system for less than one year. Around 20 per cent of clients for whom a CTO was made remained in the MHRT system for four years or longer.

Figure 5: CTO clients — time in MHRT system (years)



Source: Foundation's NSW MHRT cohort study (2003–2007).

Mental condition of clients in CTO hearings

The clients' mental condition(s) were recorded on the MHRT file for 487 (or 81%) of the 605 CTO hearings.⁷⁶

It should be noted that one or more mental conditions could be recorded for a client at any hearing. Also, mental conditions are not necessarily mutually exclusive.

Clients in CTO hearings were recorded as having the following mental conditions:⁷⁷

- schizoaffective disorder in 51 hearings (11% of the 487 CTO hearings where a mental condition was recorded)
- bipolar disorder in 21 hearings (4%)
- paranoid schizophrenia in 70 hearings (14%)
- schizophrenia in 234 hearings (48%)
- depression in 16 hearings (3%)
- borderline personality disorder in two hearings (0.4%)
- a co-morbid (secondary) drug abuse problem in 161 hearings (33%)
- a co-morbid (secondary) alcohol abuse problem in 79 hearings (16%).

⁷⁵ See footnote 44, page 11. Some clients in the cohort may have had a history of engagement with the NSW MHRT prior to the period examined. This may include some CTO clients who were already on a CTO and thus living in the community (and not a mental health facility) when their current CTO was made. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

⁷⁶ 'The client's mental condition is not routinely recorded because the Tribunal is not required to make a finding as to the specific condition.' (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 6 July 2009.)

⁷⁷ The percentages total to more than 100 per cent because multiple mental conditions could be recorded for a client at any particular hearing. No CTO client in the sampled cohort was recorded as having an intellectual disability.

Demographic characteristics of CTO clients

In analysing the demographic characteristics of MHRT clients, the first hearing is used to avoid counting the same individuals multiple times as all clients in the sampled cohort had at least one Tribunal hearing but many in the cohort had more than one hearing.

Gender

There were 77 males (61%) and 49 females (39%) who first received a CTO. While there were around five per cent more men in the CTO group, this is not overly different to the gender breakdown for MHRT hearings generally (see Part I: Description and analysis of the MHRT sample, Demographic characteristics of MHRT clients, Gender).

Age

The largest proportion (34%) of clients was aged in their twenties at the time of the hearing in which the first CTO was made (Table 12). Clients in their thirties made up almost a further 25 per cent of all clients for who first received a CTO. Together these two age groups make up more than half of all clients ordered to undertake community treatment by the Tribunal.

Table 12: Age of clients at first CTO hearing

<i>Age (10-year bands)</i>	<i>No.</i>	<i>%</i>	<i>Cum. %</i>
Under 20	5	4.0	4.0
20 to 29	43	34.1	38.1
30 to 39	31	24.6	62.7
40 to 49	28	22.2	84.9
50 to 59	7	5.6	90.5
60 to 69	7	5.6	96.0
70 and over	5	4.0	100.0
Total	126	100.0	

Source: Foundation's NSW MHRT cohort study (2003–2007).

The age profile of clients who first received CTOs is substantially different to the age breakdown of all MHRT clients more generally (see Part I: Description and analysis of the MHRT sample, Demographic characteristics of MHRT clients, Age, Table 2a). Only 15 per cent of clients who first received a CTO were 50 years or older at the time at their first hearing compared with 25 per cent for the full MHRT cohort.

No particular combination of age and gender (e.g. 20 to 29 year old males) stood out for CTO clients in our sample of MHRT clients.

Place of residence at first hearing

Place of residence was found to be recorded on the MHRT file for all 126 CTO clients.

At the time of their first CTO hearing, approximately two-thirds (65%) of CTO clients lived in the Sydney, Hunter or Illawarra Statistical Divisions, which includes these cities *and* their surrounds (Table 13). This is lower than the corresponding percentage (i.e. 75%) for all MHRT first hearing clients and indicates a higher proportion (35%) of CTOs for clients in country areas.

Table 13: CTO clients' place of residence at first hearing — Statistical Division (based on postcode)

<i>Place of residence — Statistical Division (based on postcode)</i>	<i>No.</i>	<i>%</i>
Sydney	70	55.6
Hunter	5	4.0
Illawarra	7	5.6
Richmond-Tweed	1	0.8
Mid-North Coast	12	9.5
Northern	6	4.8
North Western	2	1.6
Central West	5	4.0
South Eastern	10	7.9
Murrumbidgee	5	4.0
Murray	3	2.4
Far West	0	0.0
Total	126	100.0

Source: Foundation's NSW MHRT cohort study (2003–2007).

There were 50 clients (38%) who lived outside the *cities* of Sydney, Newcastle and Wollongong at the time of their first CTO hearing. By comparison, around 32 per cent of the State's general population lived in regional, rural or remote (RRR) areas of NSW at the time of the 2006 Census.

For those 50 CTO clients who resided in Local Government Areas outside the cities of Sydney, Newcastle and Wollongong:

- 21 (or 42% of the 50) lived in larger country centres (e.g. Albury, Coffs Harbour, Orange, Wagga Wagga), and
- 29 (or 58%) lived in rural areas outside the larger country centres (e.g. Bega Valley, Goulburn Mulwaree, Hastings, and Tamworth Regional).

Socio-economic status

Just over half (56%) of the CTO clients, at the time of their first hearing, lived in areas identified as being either mildly or highly advantaged as categorised by the ABS Index of Relative Advantage and Disadvantage (Table 14). This is six per cent higher than expected given the distribution of advantage across the state.

There were 23 CTO clients (18%) identified at the time of their first hearing as residing in areas marked by high levels of socio-economic disadvantage. This is around seven percentage points lower than expected based on the distribution of disadvantage across NSW.

Country of birth

The MHRT files show that the vast majority of CTO clients in the sampled cohort were born in English-speaking (ESB) countries — 120 CTO clients (94%) were born in Australia, and a further 1.5 per cent of clients were born in New Zealand or the UK (Table 15). Persons born in non English-speaking (NESB) countries made up fewer than five per cent of clients.

Clients born in NESB countries had a higher rate of CTO hearings than clients born in ESB countries, at 5.5 CTO hearings per NESB client and 4.5 CTO hearings per ESB client.

Table 14: CTO clients' place of residence at first hearing — level of socio-economic disadvantage (SEIFA quartile by postcode)

<i>Level of socio-economic disadvantage (SEIFA quartile) of client's place of residence</i>	<i>No.</i>	<i>Actual %</i>	<i>Expected %</i>
Highly advantaged	29	23.0	25.0
Mildly advantaged	42	33.3	25.0
Total advantaged clients	71	56.3	50.0
Mildly disadvantaged	32	25.4	25.0
Highly disadvantaged	23	18.3	25.0
Total disadvantaged clients	55	43.7	50.0
Grand total	126	100.0	100.0

Source: Foundation's NSW MHRT cohort study (2003–2007) and ABS (2008) SEIFA: socio-economic indexes for areas.

Table 15: Country of birth of clients who first received a CTO

<i>Country of birth (Region)</i>	<i>No. of CTO clients</i>	<i>No. of hearings</i>	<i>Hearings per client</i>
ESB Australia	118	531	4.5
New Zealand	1	4	4.0
UK	1	9	9.0
Total ESB clients	120	544	4.5
NESB Asia	3	17	5.7
India ^a	1	1	1.0
Europe	2	15	7.5
South America	0	0	0.0
Africa	0	0	0.0
Total NESB clients	6	33	5.5
Grand total	126	577^b	4.6

a Includes Pakistan and Bangladesh.

b A further 28 CTO hearings were preceded by another Tribunal procedure or order. These 28 CTO hearings involved one client born in South Africa (3 hearings), Bangladesh (5 hearings), Vietnam (2 hearings), Chile (5 hearings), Greece (7 hearings), India (4 hearings) and Japan (2 hearings). The adjusted hearing rate for CTO clients, including these seven additional clients and their 28 CTO hearings would be a NESB CTO rate of 4.5 (i.e. 63 divided by 14) and a total rate of 4.4 (i.e. 605 divided by 138).

Source: Foundation's NSW MHRT cohort study (2003–2007).

Language spoken and use of interpreter

Clients spoke English at the vast majority (99%) of CTO hearings. In eight hearings an interpreter was requested for clients who spoke: Arabic/Lebanese (3 hearings), Cantonese (1), Mandarin (1), Japanese (1), Spanish (1) and Turkish (1).

Characteristics of the CTO hearing

Mode of hearing

The largest number of CTO hearings was conducted by phone (35%), while live hearings made up 30 per cent of CTO hearings. Video hearings comprised more than one-quarter (28%) of CTO hearings (Table 16).

There were 42 matters that did not involve a substantive Tribunal hearing involving any parties. With these hearings removed, the percentage breakdown becomes: live, 33 per cent; phone, 38 per cent; and video, 30 per cent.

Table 16: Mode of CTO hearings

Mode of CTO hearing	No.	%	Valid %^b
Live	184	30.4	32.7
Phone	212	35.0	37.7
Video	167	27.6	29.6
Application for variation of CTO ^a	42	6.9	-
Total	605	100.0	100.0

^a Includes one adjourned CTO application.

^b Based on the 563 'live', 'phone' and 'video' substantive hearings (i.e. adjournments and applications for CTO variations removed).

Source: Foundation's NSW MHRT cohort study (2003–2007).

The proportion of CTO hearings conducted in person (33%) appears low given that, for the full set of Tribunal hearings examined, 'live' hearings were more common (45%). On the other hand, hearings involving a phone link were higher for CTO hearings (38%) than for all Tribunal hearings (29%).⁷⁸ Hearings involving a video link appear slightly higher for CTO hearings (30%) than for all Tribunal hearings examined (26%).

Client attendance/participation in CTO hearings

Leaving aside the CTO matters that did not involve a substantive hearing, 71 per cent of clients were in attendance or otherwise participated in their CTO hearing, including by phone or video link.

Legal representation at CTO hearings

In only six (1%) of the 605 CTO hearings was a legal representative for the client in attendance. In all six cases, the legal representative was a Mental Health Advocacy Service (MHAS) solicitor (that is, no CTO client was represented by a private lawyer).

It is important to note that legal aid was not available to clients for CTO applications in the period covered by this research.⁷⁹

Professional reports and attendance of report authors at CTO hearings

Of the 605 CTO hearings, there were 538 hearings (89%) that involved one or more written reports being tabled with the MHRT by a health or other professional.⁸⁰ The authors of the professional reports submitted to the Tribunal were more commonly case managers (48%), psychiatric registrars (12%), psychiatrists (7%), doctors including visiting or resident medical officers (7%) and social workers (6%).

For those CTO hearings where a written report was submitted to the Tribunal, the majority (409 of the 538 CTO hearings, or 76%) were attended by the report's author.

⁷⁸ *At the time of many CTO hearings the client is already living in the community subject to a CTO. Many clients choose to participate in hearings by way of telephone as this is more convenient for them and does not interfere with their daily routines. This is quite different to a hearing for a client who is a patient in a mental health facility and therefore more likely to participate in the hearing at that facility in person or by video.*

(Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 20 November 2009.)

⁷⁹ Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.

⁸⁰ During file analysis, the research team noted that a professional report was not found on file for 67 CTO hearings (10.9% of CTO hearings). However, this does not discount the possibility of an oral report being presented to the Tribunal by a health or other professional attending the hearing.

CTO hearings attended by 'support' persons

In almost four out of every five (79.5%) CTO hearings, a client's spouse, relative or friend (or other 'support' person) did not attend the hearing.

For the 124 CTO hearings attended by a 'support' person, the person present was more likely to be the client's parent (39%), spouse/partner (22%), son/daughter (9%) or sibling (7%). In 14 per cent of hearings, the client's support person was recorded as being either a more distant relative (e.g. cousin, uncle, grandmother) or a non family member (e.g. friend, girlfriend, carer, worker). In the remaining nine per cent of 'supported' hearings, the attending person's relationship to the client was not specified.

Medication

Medication was recorded for the clients involved in the vast majority (577 of 605, or 95%) of CTO hearings.⁸¹ In total, 1074 medications were recorded on file for 577 CTO hearings in relation to 126 individual clients. As mentioned earlier, these medications were classified into six main drug types.

In terms of the principal drug recorded, an anti-psychotic drug was prescribed for clients involved in just over nine out of every ten (92%) CTO hearings. Considering together the primary and any secondary/additional medications recorded, anti-psychotic drugs comprised three-quarters (77%) of all drugs recorded for CTO hearings/clients (Table 17).

Anti-convulsants made up around 14 per cent of all medications for CTO clients, but were more likely to be recorded as a supplementary/additional drug (23%) than a primary drug (5%) for CTO clients. Anti-anxiety drugs and anti-depressant drugs were similarly more likely to show up as supplementary/additional medications for CTO clients.

Table 17: Medications recorded for clients for all CTO hearings

<i>Medication</i>	<i>Principal drug</i>		<i>Supplementary/ additional drugs</i>		<i>All medications</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
Anti-anxiety agents	2	0.3	27	5.4	29	2.7
Anti-psychotic agents	528	91.5	298	60.0	826	76.9
Anti-depressants	14	2.4	28	5.6	42	3.9
Anti-convulsants	29	5.0	116	23.3	145	13.5
Sedatives/hypnotics	0	0.0	1	0.2	1	0.0
Other central nervous system agents	0	0.0	0	0.0	0	0.0
Other/unknown drugs	4	0.7	27	5.4	31	2.9
Total	577	100.0	497	100.0	1074	100.0

Note: Medication was not applicable or not recorded (missing) for 30 CTO hearings (4.9%).

Source: Foundation's NSW MHRT cohort study (2003–2007).

⁸¹ See the cautionary note on the inconsistent and unsystematic recording of medication in footnote 63, page 28.

ECT determinations

General

There were 70 MHRT hearings that resulted in determinations for Electro Convulsive Therapy (ECT). These will be referred to as ECT hearings. All 70 ECT hearings resulted from an application from a mental health facility (or other medical professional) to administer electro convulsive therapy.

The 70 ECT hearings represent 6.5 per cent of the 1083 MHRT hearings examined in the present study and involved 45 of the 299 individual clients in the study cohort.

Within the time frame examined, ECT was the first determination made by the Tribunal for 40 of the 45 clients (89%) who received ECT. For the remaining five clients (11%), a different treatment order preceded the ECT.⁸²

All 70 ECT hearings involved involuntary clients.⁸³ In only six (or 9%) of the 70 ECT hearings was the client capable of giving informed consent and/or gave consent in writing for the electro convulsive therapy to proceed.

Table 18 shows that the largest number of individual ECT determinations for a single client was ten, although it was far more common for a client to receive just one ECT determination (36 clients) or two ECT determinations (six clients).⁸⁴

Table 18: Frequency distribution of ECT determinations

No. of ECT determinations	No. of clients	%	Cum. %
1	36	80.0	80.0
2	6	13.3	93.3
3	2	4.4	97.7
10	1	2.2	100.0
Total	45	100.0	

Source: Foundation's NSW MHRT cohort study (2003–2007).

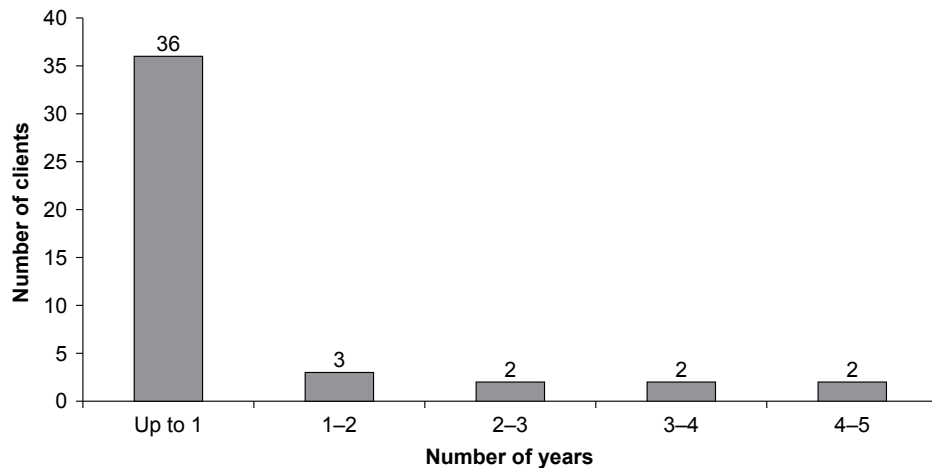
ECT clients within the cohort were generally in contact with the MHRT system for less than one year (Figure 6). While 36 ECT clients (80%) were in the system for less than 12 months, in fact 25 of these clients (69%) were recorded as being in the MHRT system for one week or less.⁸⁵

⁸² In general, ECT determinations for these five clients were preceded by a Temporary Patient order, sometimes with or without a preceding or intervening adjournment (two clients). For one client, a Temporary Patient order and nine separate orders for Community Treatment preceded the ECT order.

⁸³ The MHRT points out that most ECT administered to *voluntary* clients 'is performed in private facilities ... without any involvement by the Tribunal'. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

⁸⁴ It is also possible that some clients consented to further ECT sessions after the initial treatment improved their mental condition and they were made 'voluntary' patients. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

⁸⁵ *Most applications for ECT determinations are made to the Tribunal on an urgent basis and hearings are generally held within 2–3 days of the application being received. This allows the ECT treatment to be administered, where appropriate, as soon as is clinically required.*
(Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 20 November 2009.)

Figure 6: ECT clients — time in MHRT system (years)

Source: Foundation's NSW MHRT cohort study (2003 to 2007).

Mental condition of clients in ECT hearings

The client's mental condition(s) was recorded on file in 51 (or 73%) of the 70 ECT hearings.

It should be noted that one or more mental conditions could be recorded for a client at any particular hearing involving an ECT order. Also mental conditions are not necessarily mutually exclusive.

ECT clients were recorded as having the following mental conditions:⁸⁶

- depression in 31 ECT hearings (59% of the 51 ECT hearings)
- schizophrenia in 12 ECT hearings (24%)
- schizoaffective disorder in six ECT hearings (12%)
- bipolar disorder in six ECT hearings (12%)
- paranoid schizophrenia in just one ECT hearing (2%).

ECT clients were recorded as having a co-morbid drug abuse problem in four ECT hearings (8%) and a co-morbid alcohol abuse problem in two ECT hearings (4%).

Demographic characteristics of ECT clients

In analysing the demographic characteristics of MHRT clients, the first hearing is used to avoid counting the same individuals multiple times as all clients in the sampled cohort had at least one Tribunal hearing but many in the cohort had more than one hearing.

Gender

Seventeen ECT clients were male (38%) and 28 were female (62%). This is substantially different to the 44 per cent of females noted in the full set of MHRT clients studied (see Part I: Description and analysis of the MHRT sample, Demographic characteristics of MHRT clients, Gender).

⁸⁶ The percentages total more than 100 per cent because multiple mental conditions could be recorded for a client at any particular hearing. No ECT client was recorded as having a borderline personality disorder or an intellectual disability.

Age

More than half the clients (53%) were aged 50 years and older at the time of the hearing in which the ECT determination was made (Table 19). In addition, 20 per cent of all ECT clients were in the oldest age group — 70 and over — at the time of the ECT hearing.

Table 19: Age of clients for all ECT hearings

Age (10-year bands)	No.	%	Cum. %
Under 20	1	1.4	1.4
20 to 29	9	12.9	14.3
30 to 39	12	17.1	31.4
40 to 49	11	15.7	47.1
50 to 59	17	24.3	71.4
60 to 69	6	8.6	80.0
70 and over	14	20.0	100.0
Total	70	100.0	

Source: Foundation's NSW MHRT cohort study (2003–2007).

This profile is also very different to the age distribution of clients of MHRT hearings in general (see Part I: Description and analysis of the MHRT sample, Demographic characteristics of MHRT clients, Age, Table 2b). For all MHRT hearings, persons aged 50 years and older comprised only 25 per cent of clients, while persons aged 70 years and over made up just five per cent of clients.

From an analysis of the interaction of age and gender, two additional points are noteworthy for ECT clients:

- in the two oldest age groups, '60 to 69' and '70 and over', there were roughly equal numbers of men and women involved in ECT hearings
- women outnumbered men by more than four (82%) to one (18%) in the '50 to 59' age group involved in ECT hearings.

Place of residence at first hearing

Thirty-seven of 43 ECT clients (86%) lived in the Sydney, Hunter or Illawarra Statistical Divisions (which includes these cities *and* their surrounds) at time of their first hearing (Table 20). Place of residence was not recorded for two ECT clients. Only 14 per cent of ECT clients lived in regional, rural or remote (RRR) areas of NSW at the time of their first Tribunal hearing.

Seven of the 43 ECT clients (16%) resided in Local Government Areas outside the *cities* of Sydney, Newcastle and Wollongong at the time of their first hearing, with:

- four living in larger country centres (Coffs Harbour, Taree, Maitland and Shoalhaven), and
- three living in rural areas outside larger country centres (Bathurst Regional, Greater Hume Shire and Warrumbungle Shire).

By comparison, around 32 per cent of the State's population lives outside the cities of Sydney, Newcastle and Wollongong, that is, in regional, rural or remote areas of NSW.

Table 20: ECT clients' place of residence at first hearing — Statistical Division (based on postcode)

<i>Place of residence — Statistical Division (based on postcode)</i>	<i>No.</i>	<i>%</i>
Sydney	28	65.1
Hunter	4	9.3
Illawarra	5	11.6
Richmond-Tweed	0	0
Mid-North Coast	2	4.7
Northern	0	0
North Western	1	2.3
Central West	1	2.3
South Eastern	0	0
Murrumbidgee	0	0
Murray	2	4.7
Far West	0	0.0
Total	43	100.0

Note: Where available, place of residence (postcode) for a subsequent hearing was used where postcode was not on record for a client's first hearing. Postcode was not recorded at any hearing for two ECT clients.

Source: Foundation's NSW MHRT cohort study (2003–2007).

Socio-economic status

At the time of their first hearing, the majority (79%) of ECT clients lived in areas identified as being either mildly or highly advantaged as defined by the SEIFA Index (Table 21). This is some 30 per cent higher than expected given the distribution of advantage across NSW.

Only three ECT clients (7%) were identified as residing in areas marked by high levels of socio-economic disadvantage. That is, the number of ECT clients coming from highly disadvantaged areas of NSW is 18 per cent lower than expected given the level of extreme disadvantage across NSW.

Table 21: ECT clients' place of residence at first hearing — level of socio-economic disadvantage (SEIFA quartile by postcode)

<i>Level of socio-economic disadvantage (SEIFA quartile) of client's place of residence</i>	<i>No.</i>	<i>Actual %</i>	<i>Expected %</i>
Highly advantaged	17	39.5	25.0
Mildly advantaged	17	39.5	25.0
Total advantaged clients	34	79.1	50.0
Mildly disadvantaged	6	14.0	25.0
Highly disadvantaged	3	7.0	25.0
Total disadvantaged clients	9	20.9	50.0
Grand total	43	100.0	100.0

Note: Where available, place of residence (postcode) for a subsequent hearing was used where postcode was not on record for a client's first hearing. Postcode was not recorded at any hearing for two ECT clients.

Source: Foundation's NSW MHRT cohort study (2003–2007) and ABS (2008) *SEIFA: socio-economic indexes for areas*.

Country of birth, language spoken and use of interpreter

All ECT clients in our cohort were born in Australia except for one person whose country of birth was Germany. Also, all ECT clients spoke English at their hearing. No interpreter was requested at any ECT hearing during the period examined.

Characteristics of the ECT hearing

Mode of hearing

Table 22 shows that the largest number of ECT hearings (44%) was conducted by phone. Live or ‘in-person’ hearings made up 30 per cent of ECT hearings, while video hearings made up around one-quarter (26%) of ECT hearings.⁸⁷

Table 22: Mode of ECT hearings

<i>Mode of ECT hearing</i>	<i>No.</i>	<i>%</i>
Live	21	30.0
Phone	31	44.3
Video	18	25.7
Total	70	100.0

Source: Foundation's NSW MHRT cohort study (2003–2007).

The high proportion of ECT hearings conducted over the phone stands in contrast to the much lower proportion of phone hearings (29%) for all Tribunal hearings examined in this study.

Client attendance/participation in ECT hearings

Eighty-three per cent of clients were in attendance or otherwise participated at their ECT hearing. In only 12 of the 70 ECT hearings (17%) was the client absent or otherwise did not participate.⁸⁸

Legal representation at ECT hearings

In only five of the 70 ECT hearings (7%) was a legal representative for the client in attendance. In all five cases, the legal representative was a MHAS solicitor (with no ECT client represented by a private lawyer). However, during the period examined there was no automatic right to legal aid for clients subject to applications for ECT.⁸⁹

Professional reports and attendance of report authors at ECT hearings

One or more reports were submitted to the MHRT by a health (or other) professional for 57 of the 70 ECT hearings (81%).⁹⁰

The authors of professional reports were commonly psychiatric registrars (57%), psychiatrists (16%) or doctors including visiting or resident medical officers (14%). Where a report was submitted for

⁸⁷ *The attendance of patients at ECT hearings can be either in person or by way of participation via video or teleconference. In a limited number of cases patient attendance may not be possible due to the acuity of their illness. If the Tribunal is in attendance at the hospital it is the usual practice of the psychiatrist member to visit the patient and to report his or her findings to the Tribunal panel. This will be recorded as the patient not attending the hearing although the Tribunal's file would note that the psychiatrist member visited the patient.*

Where an urgent ECT application is made because the condition of a patient is such that the matter has to be determined expeditiously, a video or telephone conference hearing may be held. Again, a small number of patients may be too unwell to attend and the Tribunal may proceed to determine the application in the patient's absence. In some of these cases the patient actually refuses to attend the hearing.

The Tribunal has recently been pro-active in having video conferencing facilities installed at all major hospital venues and this has had the effect of greatly reducing the number of ECT telephone hearings.

(Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 4 August 2009.)

⁸⁸ The MHRT has advised that the only reason the Tribunal would accept for a client not attending their ECT hearing was if he/she were too ill to participate. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

⁸⁹ Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.

⁹⁰ During file analysis, the research team noted that a professional report was not found on file for 13 ECT hearings (18.6% of ECT hearings). However, this does not discount the possibility of an oral report being presented to the Tribunal by an attending health professional. The Tribunal advised that, where there is no written report, a doctor would always have attended the hearing and given oral evidence. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

an ECT hearing, the majority (51 of 57, or 90%) of these hearings were attended by the author of the report. For all 70 ECT hearings examined in this study, we found that at least one professional attended the hearing, but this person was not necessarily the author of the professional report.

ECT hearings attended by 'support' persons

In two-thirds (67%) of ECT hearings, the hearing was not attended by a client's spouse, relative or friend. For the remaining ECT hearings, the 'support' person who attended the Tribunal hearing was likely to be the client's parent (35%), spouse/partner (22%), son/daughter (22%) or sibling (9%). In the remaining 'supported' hearings, the attending person's relationship to the client was not specified.

Medication

In only 26 of the 70 ECT hearings (37%) was medication on record for the client.⁹¹

In total, 67 medications were recorded on file for the 26 ECT clients. In terms of the principal drug recorded, half (50%) of the 26 clients were prescribed an anti-psychotic drug (Table 23). The next most commonly prescribed type of primary medication for ECT clients was anti-depressants (35%).

Table 23: Medications recorded for ECT clients for all hearings

<i>Medication</i>	<i>Principal drug</i>		<i>Supplementary/ additional drugs</i>		<i>All medications</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
Anti-anxiety agents	1	3.8	5	12.2	6	9.0
Anti-psychotic agents	13	50.0	14	34.1	27	40.3
Anti-depressants	9	34.6	6	14.6	15	22.4
Anti-convulsants	1	3.8	10	24.4	11	16.4
Other/unknown drugs	2	7.7	6	14.6	8	11.9
Total	26	100.0	41	100.0	67	100.0

Note: Medication was not applicable or not recorded (missing) for 44 ECT hearings (62.9%).

Source: Foundation's NSW MHRT cohort study (2003–2007).

Anti-psychotic agents also showed up as a supplementary/additional medication for ECT clients. More than one-third (34%) of medications prescribed in addition to the principal drug were anti-psychotics.

Anti-convulsants tended to show up more as a supplementary/additional medication for ECT clients and not as their primary medication (24% compared to 4%). This was also the case for anti-anxiety medications prescribed for ECT clients (12% compared to 4%).

⁹¹ See the cautionary note on the inconsistent and unsystematic recording of medication in footnote 63, page 28.

PART III

A 'COMPLEX NEEDS' CLIENT GROUP — THE CO-MORBIDITY CLUSTER

General

This section examines the characteristics of a particular group of complex needs MHRT clients. This group comprises Tribunal clients identified as having a mental condition for which an anti-psychotic drug was prescribed and who were also recorded as having a co-morbid substance abuse problem — that being a co-morbid drug abuse problem, a co-morbid alcohol abuse problem, or a co-morbidity problem with both alcohol and drugs. This group will be referred to as the 'co-morbidity cluster'⁹² or as 'complex needs' clients.

As a client could have this composite of 'complex needs' factors at one hearing but not the next, the set of hearings where these co-morbidity cluster factors were present will be referred to as 'complex needs' hearings.

There were 192 MHRT hearings that involved clients that fall within the co-morbidity cluster.⁹³ Thus, hearings involving people with 'complex needs' represent approximately 18 per cent of the 1083 MHRT hearings examined in the present study.

The 192 'complex needs' hearings involved 92 individual clients. On average, during the period of almost five years, each 'complex needs' client had two hearings in which they displayed the co-morbidity cluster of factors, that is, the combination of anti-psychotic medication and substance abuse problems.

The highest count of hearings for which a client displayed the 'complex needs' factors was seven. It was far more common (48 clients or 52%) for a client to have just one 'complex needs' hearing in the period examined (Figure 7).

There were 47 persons who, at the time of their *first* MHRT hearing (within the period examined), were identified with the co-morbidity cluster of factors.

Nearly 43 per cent of clients displaying the 'complex needs' characteristics at first hearing were in the MHRT system for less than one year (Figure 8). Another 13 per cent were in the system for between one and two years. Around 15 per cent of 'complex needs' clients remained in the system for four years or longer.

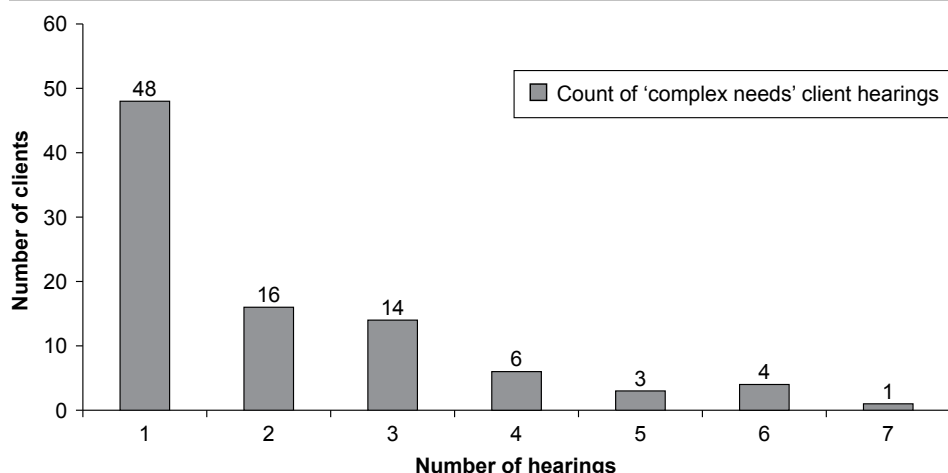
While clients identified with 'complex needs' at first hearing were in the MHRT system slightly longer than all other clients (631 days vs 573 days or 2.3 years vs 2.2 years, respectively), this difference was not statistically significant.

⁹² The Suicide and Mental Health Association International provides the following definition of co-morbidity:

The simultaneous appearance of two or more illnesses, such as the co-occurrence of schizophrenia and substance abuse or of alcohol dependence and depression. The association may reflect a causal relationship between one disorder and another or an underlying vulnerability to both disorders. Also, the appearance of the illnesses may be unrelated to any common etiology or vulnerability.

⁹³ Of the 1083 hearings, 691 hearings involved treatment plans specifying that the client was prescribed an anti-psychotic medication. Of these 691 hearings, 499 hearing (or 72%) did not record a co-morbid substance abuse problem for the client. Of the remaining 192 hearings, 97 hearings indicated that the client had an identified drug abuse problem, 12 hearings indicated that the client had an alcohol abuse problem, and 83 hearings recorded that the client had a substance abuse problem that involved both drugs and alcohol.

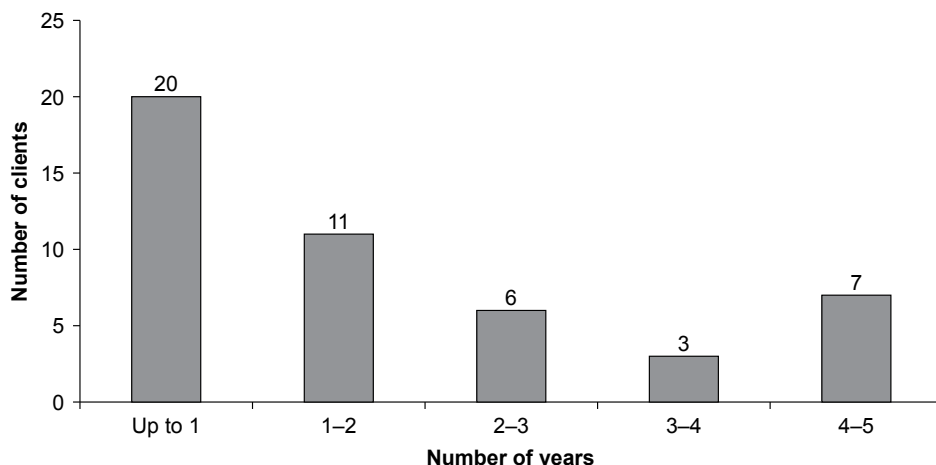
Figure 7: Frequency distribution of ‘complex needs’ client hearings



Note: A ‘complex needs’ client is identified as having been prescribed an anti-psychotic drug for their mental condition and having a co-morbid substance abuse problem.

Source: Foundation’s NSW MHRT cohort study (2003–2007).

Figure 8: ‘Complex needs’ clients — time in MHRT system (years)



Note: A ‘complex needs’ client is identified as having been prescribed an anti-psychotic drug for their mental condition and having a co-morbid substance abuse problem.

Source: Foundation’s NSW MHRT cohort study (2003–2007).

Determinations for ‘complex needs’ clients

For mental health patients deemed for the purpose of this research to be complex in needs because of their combination of anti-psychotic medication and substance abuse problems, the outcome of their hearings was more likely (77%) to be a CTO (Table 24). The next most common Tribunal determination for clients in this ‘complex needs’ group was classification as a Temporary Patient (in-patient) (17%).

Table 24: MHRT determinations for 'complex needs' clients

MHRT determinations — all 'complex needs' hearings	No.	%
Community Treatment Order (CTO)	147	76.6
Temporary Patient order (TPO) ^a	32	16.7
Electro Convulsive Therapy (ECT)	1	0.5
Protected Estates Order (PEO)	0	0.0
Adjourned	7	3.6
Order application declined	3	1.6
Appeal dismissed	1	0.5
Discharged	1	0.5
Total	192	100.0

a Also known as In-patient orders.

Source: Foundation's NSW MHRT cohort study (2003–2007).

The Tribunal determination for the *first* 'complex needs' hearing within the study period for 'complex needs' clients also tended to be a CTO (66%) or classification as a Temporary Patient (in-patient) (17%).

Mental condition of 'complex needs' clients

The clients' mental condition(s) were on file in all 192 hearings involving clients characterised by the co-morbidity cluster of factors.

It should be noted that one or more mental conditions could be recorded for a client at any particular hearing; and also that mental conditions are not necessarily mutually exclusive.

Clients with 'complex needs' were recorded as having the following mental conditions at their hearings:⁹⁴

- schizoaffective disorder in 22 hearings (or 12% of the 192 hearings)
- bipolar disorder in 12 hearings (6%)
- paranoid schizophrenia in 26 hearings (14%)
- schizophrenia in 86 hearings (45%)
- depression in six hearings (3%)
- borderline personality disorder in one hearing (0.5%)
- a co-morbid (secondary) drug abuse problem in 180 hearings (94%)
- a co-morbid (secondary) alcohol abuse problem in 95 hearings (50%).

In over 40 per cent (41%) of 'complex needs' hearings, the client was recorded as being an in-patient at the time of the hearing.

Clients with complex needs characteristics were statistically *more likely* than other MHRT clients to have schizophrenia (including paranoid schizophrenia). 'Complex needs' clients were, however, statistically *less likely* to be diagnosed with depression than other MHRT clients.

⁹⁴ The percentages total more than 100 per cent because multiple mental conditions could be recorded for a client at any particular hearing. No 'complex needs' client was recorded on file as having an intellectual disability.

Due to the way in which ‘complex needs’ clients were defined (i.e. having, *inter alia*, a co-morbid substance abuse problem), they were also statistically *more likely* than other MHRT clients to be recorded as having an identified drug abuse or alcohol abuse problem.

Demographic characteristics of ‘complex needs’ clients

In analysing the demographic characteristics of MHRT clients, the first hearing is used to avoid counting the same individuals multiple times because all clients in the sampled cohort had at least one Tribunal hearing but many in the cohort had more than one hearing.

Gender

There were 37 males (79%) in the group characterised as ‘complex needs’ clients. This is statistically different to the gender breakdown for MHRT clients in general, as males comprised just over half (56%) of all MHRT clients in the full cohort at first hearing. Ten ‘complex needs’ clients were female (21%).

Age

By far the largest proportion (45%) of ‘complex needs’ clients was aged in their twenties at the time of their first hearing (Table 25). Thirty-year-olds made up a further 28 per cent of ‘complex needs’ clients. Persons under 40 years of age made up almost 80 per cent of clients with identified ‘complex needs’ characteristics at the time of their first hearing.

Table 25: Age of ‘complex needs’ clients at first ‘complex needs’ hearing

Age (10-year bands)	No.	%	Cum. %
Under 20	3	6.4	6.4
20 to 29	21	44.7	51.1
30 to 39	13	27.7	78.8
40 to 49	8	17.0	95.8
50 to 59	1	2.1	97.9
60 to 69	0	0.0	97.9
70 and over	1	2.1	100.0
Total	47	100.0	

Source: Foundation’s NSW MHRT cohort study (2003–2007).

This age profile is markedly different to the age profile of clients of MHRT hearings generally (see Part I: Description and analysis of the MHRT sample, Demographic characteristics of MHRT clients, Age, Table 2a), where we find a higher proportion of clients aged 50 years and older (25%) and a lower proportion of clients aged 40 years and less (58%) in the full cohort at first hearing.

No particular combination of age and gender (e.g. 20 to 29 year old *males*) stood out for ‘complex needs’ clients in our sample of MHRT clients.

Place of residence

Place of residence was found to be on file for all except three ‘complex needs’ clients. At time of their first hearing, three-quarters (75%) of ‘complex needs’ clients lived in the Sydney, Hunter or Illawarra Statistical Divisions, which includes these cities *and* their surrounds (Table 26). This is no different to the corresponding percentage for all MHRT clients.

Table 26: 'Complex needs' clients' place of residence at first hearing — Statistical Division (based on postcode)

<i>Place of residence — Statistical Division (based on postcode)</i>	<i>No.</i>	<i>%</i>
Sydney	28	63.6
Hunter	1	2.3
Illawarra	4	9.1
Richmond-Tweed	0	0.0
Mid-North Coast	6	13.6
Northern	2	4.5
North Western	0	0.0
Central West	2	4.5
South Eastern	1	2.3
Murrumbidgee	0	0.0
Murray	0	0.0
Far West	0	0.0
Total	44	100.0

Note: Where available, place of residence (postcode) for a subsequent hearing was used where postcode was not on record for a client's first hearing. Postcode was not recorded at any hearing for three 'complex needs' clients.

Source: Foundation's NSW MHRT cohort study (2003–2007).

There were 12 'complex needs' clients (27%) who lived in RRR NSW — outside the *cities* of Sydney, Newcastle and Wollongong — at the time of their first hearing. By comparison, according to the 2006 Census, around 32 per cent of the State's population lived in regional, rural or remote areas of NSW.

For the 12 'complex needs' clients who resided in Local Government Areas outside the *cities* of Sydney, Newcastle and Wollongong:

- one-third (4) lived in the larger country centres of Coffs Harbour, Taree, Maitland and Orange
- two-thirds (8) lived in rural areas outside these larger country centres (e.g. Bellingen, Goulburn Mulwaree, Parkes, Tamworth Regional, etc).

Socio-economic status

At the time of their first hearing, more than half (53%) of the 'complex needs' clients, lived in areas identified as being either mildly or highly *disadvantaged* as defined by the ABS Index of Relative Advantage and Disadvantage. This is three percentage points higher than expected given the distribution of disadvantage across NSW. However, this difference is not statistically significant.

Compared to clients in the lower risk category, there was almost double the proportion of 'complex needs' clients living in areas marked by high levels of socio-economic disadvantage (12 and 21 per cent, respectively). However, this difference is also not statistically significant.

Nonetheless, the level of high socio-economic *disadvantage* associated with 'complex needs' clients is very different to the level of socio-economic *advantage* that characterised the full cohort of MHRT clients. In addition, the level of socio-economic *disadvantage* associated with 'complex needs' clients is more reflective of the level of disadvantage found in the general population of NSW.

Country of birth, language spoken and use of interpreter

There were only two 'complex needs' clients born in non English-speaking countries — Japan and the Philippines. The rest (45) were born in Australia. All 'complex needs' clients spoke English and

an interpreter was not used at any of their hearings (including the hearings of the clients born in Japan and the Philippines).

Characteristics of the 'complex needs' hearing

Mode of 'complex needs' hearings

The largest proportion (40%) of 'complex needs' hearings was conducted in person (Table 27). Hearings involving a teleconference call made up 35 per cent of 'complex needs' hearings. Video hearings comprised one-quarter (25%) of 'complex needs' hearings. These percentages reflect matters that actually went before the Tribunal and not adjournments or applications to vary existing orders, which are dealt with by the Tribunal without the need for a substantive hearing involving the parties.

In-person (live) hearings were slightly less common (40%) for 'complex needs' hearings than for the full set of Tribunal hearings (45%). On the other hand, there were somewhat more 'complex needs' hearings conducted by phone (35%) compared with all Tribunal hearings examined (29%).

Table 27: Mode of 'complex needs' hearings

<i>Mode of 'complex needs' hearing</i>	<i>No.</i>	<i>%</i>	<i>Valid %^a</i>
Live	76	39.6	40.2
Phone	66	34.4	34.9
Video	47	24.5	24.9
Adjournment or application for variation of order	3	1.5	-
Total	192	100.0	100.0

^a Valid percentages are based on the 189 'live', 'phone' and 'video' substantive hearings (i.e. adjournments and applications for variation of orders removed).

Source: Foundation's NSW MHRT cohort study (2003–2007).

Client attendance/participation in 'complex needs' hearings

Leaving aside those matters where the Tribunal did not conduct a substantive hearing, 70 per cent of 'complex needs' clients were in attendance or otherwise participated in their hearing. This is not statistically different to the percentage of clients who attended their MHRT hearing, more generally.

Legal representation at 'complex needs' hearings

In 34 (or 18%) of the 192 'complex needs' hearings, a legal representative for the client was in attendance. This was not statistically different to the level of legal representation for hearings that did not involve a 'complex needs' client.

In 33 'complex needs' hearings, the legal representative was a MHAS solicitor. In one hearing, the client was represented by a private solicitor.

Statistically, a legal representative was *more likely* to attend a 'complex needs' hearing if the client also attended the hearing. Nonetheless, it should be noted that the majority (78%) of 'complex needs' hearings attended by the client, in fact, did not have a legal representative present.

Professional reports and attendance of report authors at 'complex needs' hearings

Of the 192 'complex needs' hearings, the vast majority (189 hearings or 98%) involved one or more written reports being submitted to the Tribunal by a health or other professional.⁹⁵ It was statistically *more likely* for a professional report to be submitted at hearings involving a 'complex needs' client (98%) than for hearings involving clients that did not exhibit the co-morbidity cluster of factors (82%).

The authors of professional reports for 'complex needs' clients were commonly case managers (44%), psychiatric registrars (14%), psychiatrists (6%), social workers (8%), or doctors including visiting or resident medical officers (6%).

Where a written report was submitted to the Tribunal at a hearing for a 'complex needs' client, the majority (154 of 189, or 82%) of these hearings were attended by the report author. Authors of professional reports were only present in 58 per cent of hearings not involving 'complex needs' clients. This difference is statistically significant.

'Complex needs' hearings attended by 'support' persons

In only 33 (or 18%) of the 189 'complex needs' hearings was a client's spouse, relative or friend (or other 'support' person) in attendance at the Tribunal hearing.

Hearings involving clients in the co-morbidity cluster were statistically *less likely* to have a client's spouse, relative or friend (or other 'support' person) in attendance compared with hearings involving other MHRT clients.

For the 33 'complex needs' hearings attended by a 'support' person, the person in attendance was likely to be the client's mother (45%), father (15%), spouse/partner (9%) or sibling (6%). In 18 per cent of hearings, the client's support person was recorded as being either a more distant relative (e.g. uncle, grandmother) or a non family member (e.g. friend, girlfriend). In the remaining 'supported' 'complex needs' hearings, the attending person's relationship to the client was not specified.

Notably, sons and daughters did not appear as 'support persons' in the hearings of 'complex needs' clients. In general terms, this is likely to be indicative of the comparatively younger age of 'complex needs' clients (i.e. 51 per cent were below the age of 30 and 79 per cent were below the age of 40), as well as the younger age of their offspring (if indeed they had children).

Medication

At least one medication was found on file for all 192 hearings involving 'complex needs' clients.⁹⁶ This is an artefact of the definition of 'complex needs' clients (i.e. clients identified as having a mental condition for which *an anti-psychotic drug was prescribed* and who also had a co-morbid

⁹⁵ During file analysis, the research team noted that a professional report was not found on file for three 'complex needs' hearings. These three hearings do not correspond to the three 'complex needs' hearings not actually heard by the Tribunal (i.e. adjournments or applications). For one phone hearing and two video hearings, a professional report was not found on file. However, this does not discount the possibility of an oral report being presented to the Tribunal by an attending health or other professional at the time of the hearing.

⁹⁶ See the cautionary note on the inconsistent and unsystematic recording of medication in footnote 63, page 28.

substance abuse problem).⁹⁷ Therefore, at least one medication was on file for all ‘complex needs’ hearings and, if a solitary drug was recorded, that drug was always an anti-psychotic agent.

There were 198 instances in which one or more *additional* medications was found on file for the 192 ‘complex needs’ hearings (Table 28). As noted earlier these ‘complex needs’ hearings relate to 47 individual ‘complex needs’ clients.

Table 28: Medications recorded for ‘complex needs’ clients for all ‘complex needs’ hearings

Medication	Principal drug^a		Supplementary/ additional drugs		All medications	
	No.	%	No.	%	No.	%
Anti-anxiety agents	0	0	13	6.6	13	3.3
Anti-psychotic agents	192	100.0	101	51.0	293	75.1
Anti-depressants	0	0	11	5.6	11	2.8
Anti-convulsants	0	0	45	22.7	45	11.5
Other/unknown drugs	0	0	28	14.1	28	7.2
Total	192	100.0	198	100.0	390	100.0

^a By definition, the principal drug type for all ‘complex needs’ clients was an anti-psychotic drug.

Source: Foundation’s NSW MHRT cohort study (2003–2007).

Expressed another way, including the anti-psychotic drug listed as the principal drug, there were a total of 390 instances of prescribed drugs recorded in the treatment plans for the 47 ‘complex needs’ clients and their 192 ‘complex needs’ hearings.

Sometimes an additional (i.e. second, third, etc.) anti-psychotic drug was prescribed as part of the treatment plan for a ‘complex needs’ client. On average, each ‘complex needs’ client was recorded as being prescribed two medications; with at least one of these on the treatment plan being an anti-psychotic agent.

⁹⁷ The research team recorded up to eight medications listed on a treatment plan for any particular hearing. Due to the selection criteria applied to the ‘complex needs’ group, an anti-psychotic drug was always listed as the principal drug (Medication 1). Anti-psychotic drugs represented 63 of the 109 drugs (57.8%) recorded in Medication 2; 21 of the 52 drugs (40.4%) recorded in Medication 3; 8 of the 22 drugs (36.4%) recorded in Medication 4; and 9 of the 15 drugs (60.0%) recorded in Medication 5 (note: no drugs recorded in Medication 6–8). Furthermore:

- an anti-psychotic drug was listed as an additional/supplementary medication in 101 of 198 ‘complex needs’ hearings (51.0%)
- an anti-convulsant drug was listed as an additional/supplementary medication in 45 of 198 ‘complex needs’ hearings (22.7%)
- an anti-anxiety drug was listed as an additional/supplementary medication in 13 out of 198 ‘complex needs’ hearings (6.6%)
- an anti-depressant drug was listed as an additional/supplementary medication in 11 out of 198 ‘complex needs’ hearings (5.6%).

Discussion

This study has examined the characteristics and trends in hearings conducted by the NSW Mental Health Tribunal based on a cohort of clients who first presented before the Tribunal in 2003. These clients were tracked in terms of their interactions with the MHRT for a period of almost five years. By focusing on this sample of applications considered by the Tribunal and the decisions made by the Tribunal, unique insights into its operations have been gained regarding the experiences of its clients. While essentially a descriptive study, there was also some scope for exploring associations between some key variables defining the hearings and the participants involved in these hearings. The report now discusses these findings.

The quasi-judicial, inquisitorial functions of the MHRT are manifold:

- to determine whether a person has a serious mental illness, is able to function independently in the community, and can take responsibility for their own treatment
- to determine whether the person is a danger to themselves or the community
- to determine whether the person needs to be detained for the purposes of treatment
- to determine whether the person requires specialised treatment, such as electro convulsive therapy.

While the focus of this study was its civil hearings, the Tribunal has a broader jurisdiction and also conducts forensic hearings. Forensic hearings, however, were not examined in this study.

It should also be noted that the study examined matters dealt with by the Tribunal under the previous *NSW Mental Health Act 1990* and not the current *NSW Mental Health Act 2007*, which replaced it. Nonetheless, we believe that most — if not all — of the findings of this study continue to have relevance to the operation of the MHRT under the current Act.

Significantly, the *NSW Mental Health Act 2007* introduced a number of additional objectives (under s. 68) to be applied in the provision of care and treatment of individuals with a mental condition, including that:

- care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community
- every effort that is reasonably practicable should be made to involve patients in the development of treatment plans and plans for ongoing care
- the role of carers for people with a mental illness or disorder and their rights to be kept informed should be given effect.⁹⁸

While it would be imprudent to claim that such objectives were not considered or applied in the provision of mental health care and treatment by the MHRT (and mental health professionals) under the 1990 Act, enshrining these principles in the latest mental health legislation does demonstrate an increased commitment to the protection of the rights of persons with a mental illness.

⁹⁸ NSW Health (2007), see Appendix A.

In the following discussion, we draw together a number of observations based on our detailed statistical study of the sampled cohort of MHRT clients. It should be remembered these were, by definition, only persons who were new entrants to the MHRT system in 2003 and that their history of hearings was tracked for a finite period of almost five years from their individual points of entry in 2003.

Matters and Tribunal determinations

In general, the MHRT approved most of the applications before it. In the period reviewed and for the cohort studied, it was found that almost 90 per cent of applications for community treatment resulted in the Tribunal making a Community Treatment Order (CTO). Even higher levels of correspondence between applications and determinations were observed for in-patient orders and Electro Convulsive Therapy (ECT) determinations. Overall, only a small number of applications to the Tribunal were dismissed and, in fact, only for matters involving Protected Estates were a substantial number of applications declined by the MHRT.

The concordance between applications made to the Tribunal and the determinations made is perhaps not surprising given the MHRT's legislated role in considering *applications* for treatment orders made by health professionals and in *reviewing* existing mental health classification and treatment orders including those made by magistrates. After all, the MHRT can only deal with the application before it and the treating health professional and magistrate must show good reasons for the course of action being recommended. However, it could be argued that:

If the mental health system is operating optimally, then in theory the tribunal would always find in favour of the treating team's view that the consumer should be detained, discharged onto a CTO or the CTO renewed, since the treating team has the power to terminate an involuntary order without going through the tribunal and may be expected to have done so. However the role of the tribunal is to safeguard the consumers' rights in cases of incorrect decisions of the treating team.

In the real world, the consumer's case against continued involuntary status may either be valid or may reflect a lack of insight into the illness, or often a mix of the two.⁹⁹

Earlier research also found that the advice of medical officers was almost always followed by the Mental Health Review Tribunal in the United Kingdom:

*The research findings showed that tribunal decisions on restricted patients were cautious. Patients were almost never discharged unless this was recommended by the RMO [Responsible Medical Officer]; and, overall, the advice of RMOs (which was mainly that the patient should remain detained) was followed in more than 80% of the hearings. On the rare occasions when the tribunal decisions conflicted with the RMOs recommendation, this was usually because the tribunal viewed the case **more** cautiously than the RMO, favouring detention for longer than the consultant considered necessary.¹⁰⁰*

Notably, the *NSW Mental Health Act 2007* (and the 1990 Act that it replaced) mandates that ECT cannot be administered to clients who are unable to provide consent or refuse this treatment unless the MHRT first gives approval. Thus, MHRT approval affords the client (and the system) with an

⁹⁹ Carney et al 2011, p. 227.

¹⁰⁰ Grounds (1989, p. 299), original emphasis maintained.

extra protection that applies specifically to applications to administer ECT.¹⁰¹ The point of interest is that not one of the 70 ECT applications involving an involuntary patient in our study was refused by the Tribunal.¹⁰²

*For involuntary clients ... the Tribunal can approve ECT if ‘the patient is incapable of giving informed consent or is capable of giving informed consent to the electro convulsive therapy but has refused, or has neither consented nor refused, to have the treatment’. Thus capacity does not provide rights to decide whether to undergo the treatment.*¹⁰³

It could be argued that mental health tribunals were established to add to the expertise of mental health professionals in determining a client’s capacity to make considered decisions on their mental illness and the need for care and treatment. Tribunals also safeguard against the application of unnecessary and excessive treatment, especially treatment that is ordered without a patient’s consent or in circumstances where the patient is incapable of providing consent because of their mental illness.

The most common therapeutic use of ECT is in treating severe depression, particularly when accompanied by detachment from reality (psychosis), a desire to commit suicide or refusal to eat.¹⁰⁴ Mental health patients, who are very ill, such as many of those in need of treatment by ECT, generally have a reduced capacity to consider their treatment needs, let alone attend or participate meaningfully in Tribunal hearings. In such circumstances, the Tribunals may find it necessary to defer to the expert medical opinion of the treating team and support the application for ECT in order to alleviate the patient’s symptoms and suffering.

Perhaps supporting this approach is medical research on the effectiveness of ECT, which shows that ECT results in a rapid improvement in symptoms of depression in the majority of patients;¹⁰⁵ with remission rates as high as 75 per cent for acutely depressed patients who completed a short course of ECT.¹⁰⁶

ECT determinations are a select but very important area of the Tribunal’s work. They do, however, represent less than seven per cent of all MHRT determinations. CTOs are a far more common determination made by the MHRT — around 57 per cent of Tribunal hearings result in a CTO being made or continued. Temporary Patient classifications (i.e. in-patient orders) were the next most common determination (16%), while matters resulting in PEOs were relatively uncommon, representing a little over one per cent of the matters considered by the Tribunal in this study. The following sections consider how these different mental health matters and client characteristics are reflected in the MHRT’s ‘workload’.

¹⁰¹ Carney et al 2008. Also note that the relevant statutes are ss. 87 to 97 of the *NSW Mental Health Act 2007* and ss. 188 to 194 of the repealed *NSW Mental Health Act 1990*. A new feature of the 2007 Act was its direction (s. 96) to the Mental Health Review Tribunal that approvals of electro convulsive therapy for involuntary patients are not to exceed 12 treatments, unless there are special circumstances (including the success of any previous ECT) to justify a higher number of treatments (NSW Health 2007, p. 1; see Appendix A).

The MHRT points out that most ECT administered to *voluntary* clients ‘is performed in private facilities ... without any involvement by the Tribunal’. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

¹⁰² We do note, however, that in the 2007 calendar year, ECT was categorised as ‘determined to be necessary & desirable’ in relation to 568 ECT applications; and categorised as ‘determined to be NOT necessary & desirable’ (i.e. ECT application declined) for 13 ECT applications (around two per cent of all ECT applications for that year). There were 32 ECT applications subject to an adjournment (around five per cent of all ECT applications for 2007). (New South Wales Government Mental Health Review Tribunal 2008, Table 13.)

¹⁰³ Carney et al 2011, p. 71. The quoted text refers to s. 96 of the *NSW Mental Health Act 2007*.

¹⁰⁴ UK ECT Review Group 2003.

¹⁰⁵ Lisanby 2007.

¹⁰⁶ Husain, Rush, Fink et al 2004.

Time in the MHRT system

The present study covered the five-year period preceding the introduction of the *NSW Mental Health Act 2007*. Around half the cohort examined in this study was in the MHRT system for one year or less, a further 17 per cent were in the system for one to two years, and almost 15 per cent of clients were in the system for four years or longer. Therefore, it may be observed that time in the MHRT system does not display a typical right-skewed distribution¹⁰⁷ but rather a right-skewed distribution with a prominent ‘bump’ in its tail (see Figure 2), which probably reflects a substantial proportion of mental health clients who are ‘repeat players (with chronic, relapsing conditions)’.¹⁰⁸

Generally, Tribunal clients had either one (34%) or two (17%) hearings in the period and were in the system for one year or less. However, 15 per cent of clients continued to appear before the Tribunal for almost five years after their first hearing, and this group had an average of eight hearings. Most were CTO clients and many were characterised as having ‘complex needs’. By contrast, the majority of ECT clients (80%) had just one Tribunal hearing in the study period and presumably this led to a single, short course of ECT.¹⁰⁹

It is interesting to note that the *15 per cent* of MHRT clients who were in ‘the system’ for the full period of almost five years, generated *one-third of all hearings* in the period examined. This finding raises two points. The first is the enduring nature of the mental condition(s) of some clients as evidenced by their recurring appearances before the Tribunal. The second is the workload created for the Tribunal by such a modest proportion of clients.¹¹⁰ In many respects, this is a direct consequence of the high premium that NSW mental health statutes place on individual liberty and due process:

*[In NSW] relatively frequent intervention by [the MHRT] is mandated in order to initiate and continue compulsory treatment for a prolonged period.*¹¹¹

Other plausible reasons for repeated appearances before the Tribunal are the severe and intractable nature of certain mental conditions, clients failing to respond to (or comply with) treatment and medication, and the treatment plan being constructed and constantly adapted to minimise and manage the sometimes harmful impacts of mental illness on a client’s life.

Demographic characteristics of Tribunal clients

Not every individual in the general population who has a mental health issue comes to the attention of the mental health system, let alone the MHRT. Thus, any identified differences in the demographic characteristics of Tribunal clients are likely to reflect the fact that the MHRT deals with mental health issues at the higher end of the scale of severity and urgency. Conversely, clients with matters heard by the Tribunal represent a very small proportion of the population seeking mental health care.

¹⁰⁷ The distribution is said to be right-skewed or skewed to the right when the right tail is longer; the mass of the distribution is concentrated on the left of the figure and the distribution has relatively few high values (von Hippel 2005).

¹⁰⁸ Carney et al 2011, p. 310.

¹⁰⁹ It is also possible that some clients consented to further ECT sessions after the initial treatment improved their mental condition and they were made ‘voluntary’ patients. The MHRT points out that most ECT administered to *voluntary* clients is performed in private facilities without any involvement by the Tribunal. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

¹¹⁰ Studies of recidivism in the criminal justice system have identified similar patterns. That is, relatively small numbers of offenders are responsible for disproportionately large number of court appearances (Coumarelos 1994; Cain 1996; Hua & Fitzgerald 2006).

¹¹¹ Carney, Tait & Beaupert 2008, p. 341.

Gender: There were more males (56%) than females (44%) in the cohort. This differs markedly from the profile of mental health issues for males and females in the general population, where women are found to experience higher rates of mental disorders than men.¹¹²

The gender difference found for the general cohort was not necessarily consistent across different groups of Tribunal clients. Persons subject to CTO determinations were even more likely to be male (62%), whereas the pattern was reversed for ECT determinations, with 62 per cent of ECT clients being female.

The proportion of males in the ‘complex needs’ group (i.e. clients on anti-psychotic medication with a co-morbid substance abuse problem), at almost 78 per cent, is higher than for the general cohort and even higher than for CTO clients. Given that gender differences in the prevalence of psychoses are not found for the general population,¹¹³ this is more likely to be a function of alcohol and drug dependence being considerably more prevalent in men.¹¹⁴

Age: Around 58 per cent of Tribunal clients were aged below 40 years at first hearing date. This in itself is not exceptional. However, there were identified differences in the age–gender profile of Tribunal clients subject to various determinations. In particular, clients receiving ECT were more likely to be older women. Women outnumbered men by more than two-to-one for ECT clients aged 50 years and older and by more than four-to-one in the 50 to 59 age group. Given that 78 per cent of women ECT clients in the 50 to 59 age group were diagnosed with depression, menopause appears to be a possible link. One study found that, after taking into account other risk factors for depression, ‘transition to menopause and its changing hormonal milieu are strongly associated with new onset of depressed mood (even) among women with no history of depression’.¹¹⁵ Fifty years is the average age for onset of menopause in Australian women.¹¹⁶ Systematic reviews of ECT trials have found that ECT was more effective than combination pharmacotherapy in treating severe depression¹¹⁷ particularly among the elderly.¹¹⁸

‘Complex needs’ tribunal clients, on the other hand, were comparatively youthful. Almost 80 per cent of ‘complex needs’ clients were below 40 years of age at their first hearing, with more than 50 per cent below 30 years of age. The majority (75%) of these clients were male. This fits the profile of alcohol and drug dependence being considerably more prevalent in younger men, with males aged 16 to 24 years and males aged 25 to 34 years showing the highest levels of substance use disorders (16 and 11 per cent, respectively) in the general population of Australia.¹¹⁹

Ethnicity: Persons born in non English-speaking countries made up just over six per cent of persons before the Tribunal in the study period. While the small numbers in the sampled cohort prevented any more detailed analysis, it was interesting to note that persons from non English-speaking backgrounds had a higher average hearing rate (5.0 hearings per client) than persons born in English-speaking countries (3.5 hearings per client).

¹¹² The National Survey of Mental Health and Wellbeing (ABS 2007) identified that, in general, women experienced higher rates of 12-month mental disorders than men (22% compared with 18%); <[http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/\\$File/43260_2007.pdf](http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf)>.

¹¹³ Jenkins, Lewis, Bebbington, Brugha, Farrell, Gill & Meltzer 2003.

¹¹⁴ The National Survey of Mental Health and Wellbeing (ABS 2007) found that men had twice the rate of substance use disorders (7.0% compared with 3.3% for women); <[http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/\\$File/43260_2007.pdf](http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf)>.

¹¹⁵ Freeman, Samuel, Lin & Nelson 2006.

¹¹⁶ Menopause Centre of Australia, <http://www.menopausecentre.com.au/online/index.php?option=com_content&task=view&id=41&Itemid=36>.

¹¹⁷ UK ECT Review Group 2003.

¹¹⁸ O’Connor, Knapp, Husain et al 2001.

¹¹⁹ Australian Bureau of Statistics 2007, Table 3, p. 29.

For clients whose first language was not English, comprehension of English did not appear to be a factor in Tribunal hearings. In only 15 of the 95 hearings for the 19 culturally and linguistically diverse (CALD) clients in the sample were the services of an interpreter used.¹²⁰ While the small total number of CALD clients prevented a more thorough analysis of the issues, the preliminary findings support the recommendation of other mental health studies that more research is needed ‘to understand the different experiences of accessing justice for adults with mental health problems, for different demographic groups particularly by ethnicity’.¹²¹

Socio-economic disadvantage, remoteness and RRR clients: If there is a link between mental illness and socio-economic disadvantage, the MHRT data did not reveal a clear association. Certainly, the socio-economic status of the full cohort was somewhat more advantaged than the general NSW population. This was also the case for CTO clients and particularly so for ECT clients. Only for the ‘complex needs’ clients in our cohort was the profile of socio-economic disadvantage reflective of that found for the NSW general population.

The majority of MHRT clients in the study sample came from the metropolitan and large urban areas of NSW. The Tribunal conducts face-to-face hearings in hospitals and community health facilities throughout the Sydney, Wollongong, and Newcastle metropolitan regions. Face-to-face hearings also take place in the large country urban centres of Goulburn and Orange. Beyond these centres, the Tribunal conducts hearings either by videoconference or by telephone.¹²²

The MHRT, whilst providing a service for the mentally ill, is unlike other service providers in that it does not have a mission to proactively secure new clients. Rather, it exists to meet demand for statutory management of persons deemed by appropriate medical and legal authorities to be incapable of self-management and who are referred by health service providers. The geographic demand for hearings, therefore, dictates a centralised approach focused on Sydney. In this sense, the MHRT has a reactive role to perform; and centralisation means it can reach out to country mental health centres by way of appropriate and available modes of communication as already noted.

When compared with the population distribution of the State, the geographic spread of the Tribunal’s clients is a little biased towards the densely populated large metropolitan areas and away from thinly populated rural areas. For instance, 28 per cent of Tribunal clients came from areas outside the cities of Sydney, Wollongong and Newcastle, whereas the corresponding percentage of the State’s population that resided in rural and remote NSW is 32 per cent. We do note, however, that two-thirds of the Tribunal’s *country* clients resided in areas outside the larger country centres. In the general NSW population, the share of *country* residents who lived outside the larger country centres is half that. So the proportion of Tribunal clients coming from the rural and remote areas of NSW is larger than expected and contrary to what may be anticipated from a centralised or ‘city centric’ approach.

However, this finding does not apply to ECT clients in our study sample. Once again, on the basis of the geographic distribution of the general population, only half the expected number of ECT clients

¹²⁰ These figures could well underestimate the need for an interpreter at MHRT hearings given that the services of an interpreter are utilised only when the health agency or treating team has made a request for an interpreter to attend the hearing. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

¹²¹ KM Research and Consultancy Ltd 2009, p. 48. The heavy reliance on medical ‘lingo’ in Tribunal hearings and the need for a degree of proficiency in the English language also were identified as key problem areas for mental health tribunals in Australia. Clients of tribunals and their carers and support persons ‘found the use of technical medical terms difficult throughout the mental health system. This was exacerbated in some cases by poor education and lack of English language proficiency’ (Carney et al 2011, p. 178). People with a mental illness may also be prevented from accessing and participating in the legal system ‘when a person does not speak English as a first language and when complicated legal terminology is used’ (Karras et al 2010, p. xx).

¹²² MHRT website <<http://www.mhrt.com.au>>.

resided in RRR areas of NSW. The fact that there are relatively few applications for ECT coming before the MHRT from country and remote areas of NSW itself may not be a problem for the MHRT. It may, nonetheless, be of interest to community mental health care in NSW, especially given the relevance of associated factors, such as:

- the long running social and economic plight of farmers and other country residents in Australia¹²³
- the reported incidence of mental illness, depression and suicide in rural communities¹²⁴
- the lower rate at which country people with mental health problems access professional help for mental health disorders.¹²⁵

Characteristics of Tribunal hearings

Mode of hearing: Tribunal hearings were more likely conducted in person (45%) than by teleconference (29%) or video conference/audio-visual link (AVL) (26%). There are different reasons for this. Reflecting the fact that many clients subject to a CTO are not patients of a mental health facility and continue to live in the community, a higher proportion of Tribunal hearings that involved CTO clients were conducted over the phone (37%). This saves the client the time, effort and inconvenience of attending a Tribunal hearing in person. It also reduces the amount of disruption to daily activities such as work, education and caring for children.

Similarly, ECT hearings were often conducted over the phone (44%) or AVL (26%), but for different reasons. It is not uncommon for the Tribunal to consider urgent applications for ECT in relation to involuntary patients. In such cases, the patient's mental condition may necessitate urgent treatment and the hospital's psychiatrist may speak directly to the Tribunal over the phone (or by AVL where installed) from the hospital or other medical facility in order to arrange approval to administer ECT as quickly as possible.

In dealing with RRR clients, 70 per cent of Tribunal hearings were conducted by AVL and a further 21 per cent were teleconferenced. Therefore, it would seem that the Tribunal's current and expanding use of technology — teleconferences and AVLs — provides a workable substitute for live hearings involving RRR clients. Teleconferencing and AVLs also appeared to be used to meet the particular needs of CTO and ECT clients, at least in the cohort studied.

We will now consider participation in MHRT hearings by all parties — clients, lawyers, 'support' persons and health professionals. Some commentators have suggested that the level of such participation could be viewed as unreasonably low given that a person's freedom, right to natural justice, care, protection and treatment were at stake:

Attendance by proposed involuntary mental health consumers at MHT hearings in Australia has been found to be modest ... and legal representation rare overall ... and is concentrated on inpatient

¹²³ Human Rights and Equal Opportunity Commission 1999.

¹²⁴ For example, rural areas traditionally record higher suicide rates than urban areas (Australian Bureau of Statistics 2009). Hoogland and Pieterse (2000) noted that economic and social stresses can also precipitate anxiety, depression, family breakdown, grief, anger, alcoholism, suicide and other mental health problems.

¹²⁵ Caldwell, Jorm & Dear (2004) found that, although the proportion of young men reporting mental health disorders did not differ significantly between rural and remote areas compared with metropolitan areas, young men with a mental health disorder from non metropolitan areas were significantly less likely than those from metropolitan areas to receive professional help for a mental health disorder. For women, both mental health disorders and suicide rates were higher in rural and remote areas and these women were also somewhat less likely than those from metropolitan areas to receive professional help for a mental health disorder (result just failed to reach statistical significance).

orders.¹²⁶ Attendance at hearings by key clinicians may not be common, with junior staff interpreting clinical notes instead.

The following discussion explores the dimensions and likely reasons for the non-attendance or non-participation of clients and other parties at MHRT hearings, including those hearings conducted by telephone and audio-visual link.

Client participation in hearings: Across all hearings including adjournments, two-thirds (66%) of the cohort were recorded as attending or otherwise participating in their Tribunal hearings. Client participation rates were highest for substantive hearings involving applications for PEOs (100%), Temporary Patient classifications (92%) and ECT (83%). Substantive hearings involving CTO applications had a lower level of client participation (71%). ‘Complex needs’ clients had a level of participation in their hearings (70%), slightly above that for the full cohort.

In research examining the operation of MHTs across Australia, clients who were interviewed stated a number of reasons for not attending their Tribunal hearing. Some said that they were simply incapable of attending the hearing because they were symptomatic and very ill. Other clients expressed disillusionment with the Tribunal and felt that the Tribunal outcome was *fait accompli*, so there really was no point in attending the hearing.¹²⁷ Other clients felt that their views and preferences would not be listened to and that the Tribunal was there to ‘rubber stamp’ the recommendations of the psychiatrist. This perception was more likely to be the case for long-term clients on repeated Community Treatment Orders.¹²⁸ It has also been identified that attendance of legal advocates at Tribunal hearings also ‘made a difference to consumers’ willingness to attend’.¹²⁹ In this study, clients were statistically *more likely* to attend their Tribunal hearing when their legal representative attended the hearing.

Legal representation at hearings: People with mental illness are one of four priority client groups for Legal Aid NSW.¹³⁰ Legal aid to Tribunal clients is generally provided by the Mental Health Advocacy Service (MHAS), which is an arm of Legal Aid NSW that specialises in mental health issues. In NSW, legal aid is subject to means testing. An assessment of the person’s mental condition in terms of the merit of providing legal representation may also be applied.

For the period examined in this study, legal aid was available to MHRT clients subject to involuntary applications for their detention in a hospital or mental health facility. However, legal aid was not available to clients subject to CTO applications; nor was it an automatic entitlement for MHRT clients subject to ECT applications.

Overall, just over one in every five (21%) Tribunal hearings examined in this study were attended by a client’s lawyer, almost always a solicitor from Legal Aid NSW’s MHAS. Whether or not

¹²⁶ Refers to Chapter 4, p. 96, footnote 1 in Carney et al 2011, which reads:

Based on recent Annual Reports, similar rates (at 8.3%) are found in WA (Mental Health Review Board Western Australia, Annual Report 2005). Legal representation was higher in NSW in 2006 (16.2% in 2006), but mostly for inpatient rather than CTO reviews (Mental Health Review Tribunal of New South Wales, 2006 Annual Report). By 2009–10 the rate was reported to have risen to 33.4% (2010 Annual Report, p. 17).

¹²⁷ Carney et al 2011, p. 170.

¹²⁸ Carney et al 2011, p. 228.

¹²⁹ Carney et al 2011, p. 170.

¹³⁰ Legal Aid NSW identified people with a mental illness as some of their most disadvantaged clients. As one of four ‘priority client groups’ concerted efforts were being made to develop policies and programs to better meet their legal needs. As detailed in the Legal Aid NSW Annual report 2008–2009 (p. 14):

The Mental Health Advocacy Service (MHAS) provides duty representation before Magistrates and the Mental Health Review Tribunal in 20 psychiatric units in metropolitan and central Sydney for people who are subject to involuntary treatment or detention under the Mental Health Act 2007. The Service also coordinates assigned duty representation before the Mental Health Review Tribunal in 19 regional psychiatric units spread throughout NSW.

the Tribunal hearing was attended by a lawyer representing the client was found to have a strong relationship with the Tribunal's determination of a mental health matter. Clients were more likely represented by their lawyers in dismissed appeals (78 per cent of appeals that were dismissed were attended by the client's legal representative) and hearings where an application for an order was declined (70 per cent of declined order applications were attended by the client's lawyer). Similarly, lawyers were in attendance in 79 per cent of hearings for PEOs and 79 per cent of hearings for TPOs. By contrast, legal representation at CTO hearings, at just one per cent, was quite rare.

The low level and 'recency' of aid noted for CTO clients in NSW in the past has been the subject of criticism.¹³¹ However, Legal Aid NSW recently reviewed its policies allowing the provision of some grants of legal aid for CTO cases (see Mental Health Advocacy Service 2008).

In terms of legal representation, NSW stands out from other MHTs in Australia in terms of the provision of legal aid as a right for people facing involuntary patient reviews in the first 12 months. Persons appearing before the NSW MHRT are entitled to legal aid in relation to involuntary detention orders, their initial Tribunal hearing, and hearings dealing with regular reviews of continuing orders during the first year of a mental health order.¹³² Outside this period, legal representation by a solicitor from the MHAS is subject to both means testing and merit testing.¹³³ Legal Aid NSW also operates a *private* duty lawyer scheme to make up for any shortfall in MHRT cases earmarked for mandatory legal representation.

Local and international research on MHTs has also identified that the short timing of tribunal hearings — primarily to deliver urgent care and treatment — has a bearing on legal representation. If the client's condition necessitates hospitalisation then the client may be too ill (or too affected by administered medication) to arrange legal representation,¹³⁴ let alone meet with a lawyer and adequately prepare for the hearing.¹³⁵ Outside the operation of the duty lawyer scheme for in-patients, the merits test in NSW requires legal advocates to take into consideration the client's current mental state in assessing merit and in some cases there would be little point in the solicitor engaging with the client before the scheduled Tribunal hearing because the client is simply too unwell (i.e. symptomatic).¹³⁶

Far from being unique to Australian mental health law, such deficiencies have been noted for MHTs around the world. This has also led some commentators to believe that, in terms of access to justice and the law, individuals with a mental illness are 'systematically underrepresented in all matters related to their disability'.¹³⁷

¹³¹ Carney et al 2011, p. 242. In addition to calls for greater legal aid, a new position of consumer advocate was created to undertake a broader advocacy and support role.

¹³² Carney et al 2011, p. 246. By contrast, legal representation was found to be poor for Victorian MHT clients with severe mental illnesses, for clients who had been hospitalised for long periods and for symptomatic patients whose rationality and ability to function normally was compromised. Carney et al (2011, p. 246) reported that consumers who are clearly acutely ill are usually not legally represented before the Victorian Tribunal:

If someone is completely psychotic and there's going to be no benefit, we would not represent them. So if they were really, really, really quite ill, and there was obviously not benefit in the representation, they'd been in hospital many, many, many times before, and they were quite ill, we would not provide them with representation (Coordinator, Human Rights and Civil Law Service, Victoria Legal Aid).

¹³³ While the *NSW Mental Health Act* (previous and current) provides for legal representation at all hearings where Legal Aid NSW criteria are satisfied, a solicitor may not be able to engage with a patient because of the seriousness of their mental condition, for example when the client is completely psychotic. (Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010.)

¹³⁴ Apparently, there is no appointed person, advocacy group or service to arrange legal representation for in-patients and other mental health clients appearing before the NSW MHRT.

¹³⁵ Carney et al 2011, p. 246. This was particularly seen by one NSW advocate as an indictment on the current situation:

Just the expectation that people [who are already] suffering huge disadvantages and difficulties would be expected to appear before a legal body without the right to representation is really at its most basic level, incomprehensible.

¹³⁶ Carney et al 2011, p. 246.

¹³⁷ Perlin 1992, p. 42.

Other NSW research on the operation of the NSW MHRT commented on the lack of legal representation for Tribunal clients on CTOs.¹³⁸ We do, however, note the positive nature of the recent changes made by Legal Aid NSW in the provision of legal representation for some CTO clients. Aside from the lack of relevant policies prior to 2008, another possible explanation for the lack of legal representation of CTO clients at Tribunal hearings is that clients are likely to find a treatment plan that allows them to remain in the community agreeable.¹³⁹ Therefore, the client may have considered it unnecessary to engage a legal representative.

The relatively low level of attendance of lawyers at ECT hearings (7%) may reflect the lack of automatic entitlement to legal aid as well as the critical nature of an application to have electro convulsive therapy approved — the immediacy of which may have prevented the client from engaging a legal representative before the Tribunal considered the application. Both the previous and the current legislation direct that the MHRT considers applications for ECT for all involuntary patients.¹⁴⁰ This is intended to act as an additional procedural safeguard against unnecessary treatment using electro convulsive therapy. We find these safeguards all the more indispensable given the finding from our study that a legal representative was in attendance at only five of the 70 MHRT hearings dealing with ECT applications for involuntary patients.

Professional reports: Psychiatric assessments and other professional reports submitted for the consideration of the Tribunal were found on file for 88 per cent of substantive Tribunal hearings. Overall, the Tribunal was supported by an attending health or other professional in eight out of every 10 substantive hearings. While it was found that only 20 per cent of Tribunal hearings were not attended by a health or other professional, the majority (80%) of these unattended hearings involved applications for CTOs, some of which were ‘on paper’ hearings dealing with varying the conditions of existing CTOs.

It has been asserted in a UK study that ‘the tribunals invariably endorsed the recommendations made to them’ by clinicians.¹⁴¹ We found that the Tribunal was more likely to approve an application where a professional report was submitted and the psychiatrist or other member of the treating team was in attendance at the hearing.

‘Support’ persons at hearings: The MHRT hearing was attended by a member of the client’s family or by a partner or friend of the client in 25 per cent of all substantive hearings examined in this study. Higher levels of attendance by the client’s ‘support’ persons were noted among applications for PEOs (37%), ECTs (33%) and applications for Temporary Patient classifications (33%).

The fairly low level of attendance of family members, carers and other support persons at hearings may be considered a less than desirable feature of Tribunal operations, particularly given the positive role that carers and family members often play in providing useful evidence to the Tribunal and thereby achieving more attractive therapeutic outcomes for mental health clients.¹⁴² Not surprisingly, good procedural justice has been linked to positive effects on mental health outcomes.¹⁴³

¹³⁸ Carney et al 2011, p. 246. Lack of legal representation was also noted for long-term in-patients.

¹³⁹ However, as previously indicated, some clients, particularly those subject to repeated CTOs, may be disillusioned with the MHRT system and may have considered that the outcome of future hearings was ‘a done deal’, given their perception of the Tribunal’s general deference to clinical opinion over social and family considerations and the client’s own views.

¹⁴⁰ The NSW MHRT also deals with consent issues for voluntary patients (s. 185 of *NSW Mental Health Act 1990*; s. 90 of *NSW Mental Health Act 2007*).

¹⁴¹ Peay 1989, p. 209.

¹⁴² McLeod et al 2010.

¹⁴³ Boothroyd et al (2005) in KM Research and Consultancy Ltd 2009.

While the general view is that family members, spouses, partners and friends attend hearings to provide the client with support and encouragement (i.e. the traditional role of an ‘allied person’), it needs to be recognised that in some cases, such individuals may have appeared before the Tribunal offering views contrary to those of the client regarding the need for treatment and/or the type of determination they would like to see the Tribunal make. As the recent review of Australian Mental Health Tribunals pointed out:

*Evidence provided by the family and other carers is a very contentious issue. Generally the family are in a position to know the consumer well, unless they are estranged.*¹⁴⁴

In particular, orders to protect the financial assets of a person with a mental illness are matters that can involve the views of a family member or spouse being diametrically opposed to those of the client. In addition, the notion that such persons are inclined to always support the client’s claims is questionable. The research suggests that family, friends and carers of the mentally ill may facilitate involuntary admission to a mental health facility with or *without* the intervention of a legal body, such as the Tribunal,¹⁴⁵ and against the wishes of the client.

Furthermore, while there was no provision in the *NSW Mental Health Act 1990* to notify a patient’s family or even a primary carer of a Tribunal hearing (except in the case of applications for ECT),¹⁴⁶ this is consistent with the Act’s protections of the civil rights of people with a mental illness, in particular, safeguarding their confidentiality. Of course, clients do not always notify, or for that matter, want to notify family members of their hearing, especially if their mental illness is the cause of estrangement with family. Clients may simply prefer *not* to have family members or other ‘support’ persons attend their Tribunal hearings.

Therapeutic jurisprudence

While the primary function of the MHRT — conducting mandatory external reviews of compulsory psychiatric care — has been viewed by some as negative and mechanical,¹⁴⁷ the work of the Tribunal to ensure that patients receive the best possible care in the least restrictive environment is both consistent with the overriding objectives of mental health legislation and the principles of therapeutic jurisprudence.

In the vast majority of hearings considered in this study, the outcome determined by the MHRT was the ordering of compulsory treatment or the ordering of continued detention in a mental health facility. While on face value, such orders may appear antithetical to the principle of delivering therapeutic outcomes, this is not necessarily so; nor do such orders constitute a breach of rights or civil liberties; nor do they represent an outcome that is contrary to the patient’s self interests:

*The tribunal has to determine a legal question, but it is a legal question set in a health-care context and dependent for its interpretation on a clinical opinion. Thus, an examination of the statutory criteria can lead almost inexorably to a wider discussion of the patient’s care and future plans.*¹⁴⁸

¹⁴⁴ Carney et al 2011, p. 218.

¹⁴⁵ Carney, Tait & Beaupert 2008.

¹⁴⁶ The *NSW Mental Health Act 2007* introduced such provisions where the patient has nominated a primary carer. The 2007 Act requires the mandatory notification of primary carers of mental health events such as involuntary admissions, discharges and applications to the Tribunal to administer ECT.

¹⁴⁷ Compulsory treatment for a person classified as mentally ill cannot be averted unless the relevant statutory criteria are met (Carney, Tait & Beaupert 2008, p. 3).

¹⁴⁸ Richardson & Machin (2000) cited in Carney, Tait & Beaupert (2008).

In fact, the individual's rights to freedom from arbitrary detention and/or compulsory treatment are shielded by procedural safeguards applied by the Tribunal through the *Mental Health Act* (both current and previous), including:

- ensuring minimum objective criteria are met before an individual can be subject to compulsory treatment
- regular reviews of the compulsory treatment of individuals¹⁴⁹
- the 'least restrictive alternative principle' as a guiding principle for decision-making and final criterion for compulsory treatment.¹⁵⁰

There are clear resonances between therapeutic jurisprudence and the practices of the MHRT. Nonetheless, this report's companion study (Carney et al 2011), which compared the NSW Tribunal with those operating in other jurisdictions, suggested that the NSW MHRT and the Act under which it operates may yet find room for improvement.¹⁵¹

Of particular relevance to the operations of the MHRT in NSW are two sets of findings from the 2010 UK study of the court experiences of adults with mental health conditions, learning disabilities and limited mental capacity:¹⁵²

1. 'Across all court types (including tribunals), contact with legal representatives had a positive impact on court experiences' (p. *iv*). Court users stated that they were reassured by having someone on their side available to fully explain the court process and legal terms to them.¹⁵³ They also felt that they were more prepared for the hearing and for the eventual outcome by having a legal representative attend the hearing with them (p. 22).
2. 'Access to basic practical and moral support alleviated stress and increased a court user's understanding of their court case' (p. *iii*). While most court users with mental health conditions reported that they only required 'basic practical and moral support to help them to deal with the pressure of a court case', for clients who were symptomatic, whose conditions were less stable, or who were less capable of managing their condition, 'access to specialist support, for example from an intermediary, carer, community mental health worker, or Clinical Practice Nurse, was vital' (p. 21).

¹⁴⁹ *NSW Mental Health Act 2007*:

- s. 37 (1) The Tribunal must review the case of each involuntary patient:
- (a) at the end of the patient's initial period of detention as a result of a mental health inquiry,
 - (b) at least once every 3 months for the first 12 months the person is an involuntary patient,
 - (c) at least once every 6 months while the person is an involuntary patient after the first 12 months of detention.
- s. 62 (1) The Tribunal must review, at least once every 6 months, the case of each continued treatment patient in order to determine whether the patient is a mentally ill person who should continue to be detained.
- s. 63 (1) The Tribunal must review, at least once every 12 months, the case of each informal patient who has received care or treatment, or both, in a hospital for a continuous period in excess of 12 months.

¹⁵⁰ Carney, Tait & Beaupert 2008, p. 47.

¹⁵¹ See, in particular, Carney et al 2011, pp. 189–190. Broad concerns with the mental health legislation in NSW have been raised previously by peak organisations and advocacy groups. For example, People with Disability Australia (Inc.), in its submission on the draft Bill to the 2007 Act, raised a number of concerns about the fair and equitable treatment of people with a mental illness in NSW: *... the review of the Mental Health Act 1990 is a significant opportunity to develop progressive legislation that protects the human rights of people with mental illness and ensures adequate and appropriate care and treatment. We are extremely concerned that the Mental Health Bill 2006 does not capitalise on this opportunity. Instead, it appears to view people with mental illness in the context of 'control' rather than 'protection', and because of this allows for the rights of people with mental illness to be limited, comprised and in some cases ... to be violated.* (People with Disability Australia Incorporated 2006)

¹⁵² McLeod et al 2010.

¹⁵³ McLeod et al (2010, p. 15) also identified that 'in civil and family cases, if a carer or support worker was present during initial meetings with solicitors they were more likely to be aware of the court user's needs'.

In relation to the findings on the importance of a client having legal representation at Tribunal hearings, section 3 of Schedule 2 of the *Mental Health Act 2007* stipulates that because a person is suffering from a mental illness or developmental disability this is not an impediment to their legal representation in a mental health inquiry or before the Mental Health Review Tribunal (s. 152). Rather:

[t]his is accepted to be authority to act on the instructions of a person who may be mentally ill, as the purpose of most hearings under that Act is to make a determination as to the presence or otherwise of mental illness and the need for restrictive forms of care.¹⁵⁴

A possible implication for the MHRT is what increased role it could play in ensuring that Tribunal clients have a legal representative and that their lawyer attends substantive hearings. This would appear to be especially important when the hearing involves:

- an application for ECT (in this study, nearly 93 per cent of hearings for ECT involving involuntary patients were *not* attended by the client's legal representative)
- Protected Estates Order (over one-quarter of PEO hearings were *not* attended by the client's lawyer)
- in-patient status (more than 20 per cent of Temporary Patient hearings were *not* attended by the client's lawyer)
- any appeal (one in five appeals against a refusal to discharge (s. 69) were *not* attended by the client's lawyer).

Evidence from the recent broader research into Australian mental health tribunals (Carney et al 2011) suggest that there may be problems with lawyers representing Tribunal clients adopting a more formal, adversarial and legalistic approach that is counter to the spirit of Tribunals and their informal, inquisitorial, interventionist, problem-solving approach. Whether this is a consequence of lawyers' legal training and role in prosecutorial court cases (e.g. the need to cross-examine witnesses and disprove testimonies and other evidence), at times it may have anti-therapeutic consequences, including the possibility of discharging clients who are in need of continuing in-patient treatment for their mental illnesses.¹⁵⁵ Fortunately, the specialist legal services of the MHAS of Legal Aid NSW act to diminish the likelihood of these counter-productive outcomes eventuating.

The means by which lawyers could optimise their therapeutic effect in the context of a tribunal hearing were identified in the UK study of the court experiences of mentally ill adults and reinforced the findings of earlier work.¹⁵⁶ In order to maximise the positive effects of their advocacy work in tribunal settings, lawyers representing mental health patients were encouraged to:

- familiarise themselves fully with the facts of the case before the hearing
- interview the client, carers and other parties to determine the state of the client's mental condition and its impacts on functioning within social and familial settings

¹⁵⁴ Legal Aid NSW 2007.

¹⁵⁵ Carney et al 2011, pp. 252–257.

¹⁵⁶ Winick (2003, p. 35) cited in Carney et al 2011.

- explore the best available options for treatment, including alternatives to involuntary detention, where ‘harm’ was not an issue¹⁵⁷
- advise and counsel the client on likely outcomes (especially those that the client may perceive as unattractive or harsh)
- protect the client’s rights at the hearing, including ensuring that the client’s views were heard
- engage in advocacy at the hearing in accordance with the client’s expressed wishes and best interests.

These particular recommendations from the UK study will undoubtedly be of interest to Legal Aid NSW and especially its MHAS solicitors.

The second set of findings reported from the UK study mark the importance of the participation of family, carers and other support persons and the client’s mental health professional (or case worker) in Tribunal hearings. Participation of allied persons and health professionals in hearings is considered crucial to facilitate the client’s understanding of and satisfaction with the Tribunal’s process. It is also considered to lead to the best possible outcome for the client. Increasing the level of participation of support persons and allied health professionals in Tribunal-heard civil matters is likely to result in determinations and outcomes that are more attuned to the client’s mental health needs and preferences for treatment and care.

While the findings of this study indicate that MHRT hearings were very well attended by health professionals, the level of attendance by clients’ relatives and other support persons was very different. Across the board, a client’s relative or support person was in attendance in only one in every four Tribunal hearings, with the level only slightly higher for ECT, PEO and Temporary Patient hearings. While the *NSW Mental Health Act 2007* introduced provisions for the mandatory notification of primary carers of mental health events such as involuntary admissions, discharges and applications to administer ECT, there is no broad provision in the 2007 Act to inform carers, family members and other client allies of each and every substantive MHRT hearing concerning the person they care for and may wish to support. In this regard, the 2007 Act demonstrates due regard for the client’s right to privacy. Nonetheless, it also highlights the tension between the client’s right to privacy and the need to provide appropriate family and carer support to clients during Tribunal hearings.

Given the impact of mental illness on the family and the lay impression that Tribunal hearings are confrontational and legalistic in nature, finding ways to increase the participation of *allied* family members and friends to support clients at their Tribunal hearings may not be easy or prove overly effective. Nonetheless, ensuring that relatives, carers and friends know of the hearing well in advance and are aware of the importance of participating in the disclosure process is likely to result in overall better outcomes for clients. Whether this process of engagement would be best performed by a Tribunal member(s) or by the client’s mental health professional (or caseworker) needs to be decided and would need to take into consideration the substantial increase in workload for the affected parties.

¹⁵⁷ Carney (et al 2011, p. 202) have commented on the meaning of harm and the dangers posed by ‘interpretational slippage’ in eroding the human rights of people with a mental illness. They state that: ‘Harm to self can be taken narrowly, in reference to suicide or physical self harm, or more broadly in terms of unhealthy lifestyle, homelessness or reputational damage.’ They also quote one of their surveyed NSW health professionals:

And that harm can be, with the current reading of the Act, it’s open to interpretation almost anyway you like. Such as financial harm, harm to reputation, harm by virtue of a personal neglect, not eating and drinking, those sorts of things. Apart from more obvious ones such as deliberate sort of direct attempts to kill oneself or harm oneself or direct obvious attempts to physically harm someone else.

Given that the research has identified the importance of having the client's legal representative, health professional, carers and support persons attend the hearing, what then the value of the client attending the hearing? Is there likely to be a fair 'trial' or valid 'legal decision' when the client does not attend his or her own Tribunal hearing? Certainly, a number of commentators have observed that the rules of natural justice are more likely violated in the client's absence:

*Tribunals frequently reached decisions on the basis of extra-legal factors or by replacing legal prerequisites with simplified or inaccurate tests (or proxies); and procedural fairness was not afforded because this information was often raised **when clients were not present and remained unexplained.***¹⁵⁸

*[T]he rules of natural justice were frequently bypassed because the factors most pertinent to tribunal decision-making were often broached for the first time **when clients were not present, such as during the deliberation phase.***¹⁵⁹

Certainly, there is more inherent value in having clients attend hearings where the Tribunal is deliberating certain matters and outcomes. Without trivialising CTOs, the 'no show' of clients at their CTO hearings, particularly where the application before the Tribunal is to continue community treatment, may not be as crucial to due process and fair outcomes as, say, having a client attend their PEO hearing. Eliciting and considering the views, concerns and preferences of clients is a core principle of therapeutic jurisprudence and is fundamental to informed decision-making and the application of fair and even justice at mental health tribunals. Having the client in attendance at their Tribunal hearing or otherwise participating via phone or AVL is particularly important to fair and reasonable justice, especially in relation to determinations being made with regard to applications for ECT, Temporary Patient status and Protected Estate Orders. Of course, there may be pressing mental health reasons why the client is unable to attend or participate in a hearing, and an urgent start to treatment may be the very reason for the application to the MHRT.

However, in the absence of any pressing need to commence treatment, one may expect that the Tribunal would give strong consideration to adjourning a matter where the client is unable to attend and/or participate in proceedings. Evidence from this study supports this practice: 15 per cent of matters in our sample were adjourned and in approximately four of every five adjourned hearings, the client was not in attendance. Leaving aside adjourned hearings and CTO hearings (low client attendance levels already discussed), across all other MHRT hearings the level of non-attendance/participation of clients was just 10 per cent.¹⁶⁰

In cases where it is determined that a Tribunal hearing — especially the first hearing — should proceed in the client's absence, it may be considered in the best interests of natural justice for the client to be represented by strong advocates — by their legal representative and by an allied family member, carer or other support person. Of course, the treating doctor or consultant psychiatrist also needs to be in attendance at these Tribunal hearings.¹⁶¹

¹⁵⁸ Carney et al 2011, p. 88 (our emphasis).

¹⁵⁹ Peay (2005, pp. 217–218), as cited in Carney et al 2011, p. 86 (our emphasis).

¹⁶⁰ According to the MHRT,

*[c]lients attend involuntary reviews unless too sick to do so. Occasionally clients in CTO matters seek to avoid the hearing and sometimes involuntary clients on leave will do the same. The Tribunal will **not** proceed without the client unless it is satisfied that it is appropriate in the circumstances to do so.*

(Information provided by John Feneley, Deputy President of the NSW Mental Health Review Tribunal, 23 December 2010 (original emphasis maintained).)

¹⁶¹ It is our view that not everything relevant to the MHRT's consideration of a matter involving an absent client will be contained in a freshly opened file or detailed within the first professional assessment report. Also, Carney et al (2011, p. 211) noted that it was fairly rare for the consultant psychiatrist to attend the tribunal hearing.

Finally, the authors would like to acknowledge that this study would not have been possible had the NSW MHRT not maintained both its computerised Client Management System (CMS) *and* its system of paper case files — something that not all mental health tribunals in Australia do. This study also was not possible without the MHRT agreeing to provide the data needed to conduct this research. As with any information management system, and with the benefit of hindsight, there is scope for further enhancing the collection and recording of information within the MHRT and such improvements would benefit Tribunal decision-making as well as the conduct of evidence-based research.

Some suggestions that we believe would further enhance the MHRT's management and administrative systems include:

- more consistent recording of information for substantive Tribunal hearings *and* 'on paper' hearings (e.g. adjournments, etc.)
- standardised paper files/forms and recording protocols that could be shared across all locations at which the MHRT operates
- online resources such as links to Diagnostic and Statistical Manual of Mental Disorders (DSM) categories, the pharmaceutical and generic names of medications and mental health advocacy practising standards
- making available, through the MHRT website, published research on the legal issues of people with a mental illnesses.

It is hoped that this study will act as a springboard for the systematic collection of more complete and rigorous data, not only by the NSW MHRT but by mental health tribunals operating in other Australian jurisdictions. Only with better data can more thorough and comprehensive research on the legislatively-guided and therapeutically-motivated operations of mental health tribunals be undertaken.

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Appendix A: Information bulletin on the 2007 Mental Health Act

NSW Health 2007, *Information bulletin: Mental Health Act 2007*, Mental Health and Drug and Alcohol Office, Sydney, <http://www.health.nsw.gov.au/policies/ib/2007/pdf/IB2007_053.pdf>.

Information Bulletin



Department of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
<http://www.health.nsw.gov.au/policies/>

Mental Health Act 2007

Document Number IB2007_053
Publication date 07-Nov-2007
Functional Sub group Clinical/ Patient Services - Mental Health
Corporate Administration - Information and data
Clinical/ Patient Services - Medical Treatment
Summary Commencement of operation of the Mental Health Act 2007, information about key changes from the Mental Health Act 2007.
Author Branch Mental Health and Drug and Alcohol Office
Branch contact Dennis Bale 9424 5884
Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Community Health Centres, Divisions of General Practice, NSW Ambulance Service, NSW Dept of Health, Private Hospitals and Day Procedure Centres, Public Hospitals
Audience Administration, all clinical mental health staff, emergency departments
Distributed to Public Health System, Community Health Centres, Divisions of General Practice, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Hospitals, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes
Review date 07-Nov-2012
File No. 07/8433
Status Active

MENTAL HEALTH ACT 2007

The Mental Health Act 2007 (the Act) was passed by Parliament earlier in the year and is to come into effect on 16 November 2007. The Mental Health Act 1990 (the 1990 Act) will cease to have effect.

The Act maintains many of the principles of the 1990 Act. For example many key elements remain unchanged, including the definitions of mental illness and mentally ill person, the definition of mentally disordered person, the concept of treatment in the least restrictive environment in which treatment can be provided effectively, the timing of Magistrate and Mental Health Review Tribunal reviews of involuntary detention.

Notable new features of the 2007 Act include:

- Additional objectives to be applied in the provision of care and treatment (s68), including:
 - ◆ Care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community;
 - ◆ Every effort that is reasonably practicable should be made to involve patients in the development of treatment plans and plans for ongoing care;
 - ◆ The role of carers for people with mental illness or disorder and their rights to be kept informed should be given effect.
- Ambulance Officers who have appropriate authorisation are added to the range of persons (eg Police, medical practitioners, accredited persons) who may initiate transport to a mental health facility for assessment (s20);
- Community Treatment Orders (CTOs) will be able to be made for people living in the community without need for inpatient admission;
- The maximum possible duration of CTOs is extended to 12 months (ss51, 56);
- A definition of Primary Carer is provided with provision for patients to make nominations and to also nominate persons who are not to be provided with information about them (ss71, 72);
- Clear powers are provided to detain for transport, sedate and search (s81);
- Psychosurgery becomes prohibited (s83);
- Mental Health Review Tribunal approvals of electro convulsive therapy (ECT) are not to exceed 12 treatments, unless there are special circumstances (including the success of any previous ECT) to justify a higher number of treatments (s96);
- Gazetted "hospitals" and "health care agencies" under the 1990 Act will become "declared mental health facilities" (s109).
- Provisions in respect of forensic patients remain unchanged, other than being largely moved from the Mental Health Act to the Mental Health (Criminal Procedure) Act 1990.

Ambulance Officers

An authorised Ambulance Officer who is providing ambulance services to a person may take them to a mental health facility if the officer believes they may be mentally ill or mentally disturbed.

Information Bulletin



Title: Mental Health Act 2007

Ambulance officers must be specifically authorised to undertake this role. That is occurring progressively as they undergo training. It will be some time before all ambulance officers are authorised.

Primary Carers

The Act provides, through a prescribed hierarchy set out in section 71, for each patient of a mental health facility (both inpatient and community) to have a primary carer. At the top of the hierarchy is a guardian, if one is appointed. Next is a parent if the patient is under 18 years of age. If neither a guardian or a parent is appropriate, the patient is entitled to make a nomination. If no nomination is made, the primary carer is a spouse (if the relationship is close and continuing) or then any person who is primarily responsible for providing support or care to the patient (other than on a commercial basis).

Any nomination (or variation or revocation) of a primary carer made by a patient must be given effect to unless it is reasonably believed:

- that to do so may put the patient or nominated person or any other person at risk of harm; or
- that the patient who made the nomination (or variation or revocation) was, at the time incapable of making it.

The Regulation provides that nominations will remain in force for a period of twelve months.

Persons nominated as Primary Carers are to be provided a range of information. Particular note should be taken of the requirement in section 75 to notify the primary carer within 24 hours of a person being involuntarily detained in a mental health facility. Section 78 deals with some other situations where information is to be provided to primary carers.

Patients are also entitled to nominate persons to be excluded from receiving notices and information (s72(2)). A person under 18 may not exclude a parent (s72(3)).

Notices

There are a number of provisions of the Act that require persons (eg patients, primary carers) to be provided a notification or a document. Section 192 deals with how delivery may be effected, eg by personal delivery, by post or by fax.

Mental health facilities should endeavour to obtain other contact information, eg telephone and mobile numbers, particularly for primary carers, so that notifications can be supplemented as necessary to ensure timely provision of information. Notification to primary carers of a person's admission (s75), as mentioned under the heading above, is an example of a situation where notification by post alone would be insufficient.

Information Bulletin



Title: Mental Health Act 2007

Community treatment orders

Continue to be available to be made at Magistrates' inquiries in inpatient units. They may now also be made for people in the community. The criteria for making of such orders are similar to those in the 1990 Act. It is a requirement that persons to be the subject of an application for a CTO be provided with a notice to that effect and a copy of the proposed treatment plan.

Applications for CTOs for people living in the community are to be made to the Mental Health Review Tribunal. For people not detained in a mental health facility, the application must not be heard earlier than 14 days after the person is given notice of the application.

The persons who may apply for a community treatment order are:

- the authorised medical officer of a mental health facility where the person is a patient;
- a medical practitioner who is familiar with the clinical history of the person;
- the director of community treatment (director of a health care agency in the 1990 Act) who is familiar with the clinical history of the person; and
- the primary carer of the person.

Authorised medical officers

In the 1990 Act, the term "medical superintendent" had different meanings depending upon the section of the Act. For some functions (mainly those relating to actions and decisions about involuntary patients), the "medical superintendent" included a "medical officer, nominated by the medical superintendent, attached to the hospital".

The 2007 Act clarifies the situation by relying primarily on the term "authorised medical officer" in relation to issues and decisions about patient care. The term "medical superintendent" is used in relation to management and administrative decisions.

The medical superintendent is required to nominate the authorised medical officers who will perform functions under the Act for the mental health facility. Each mental health facility should maintain a current record of the persons nominated.

Mental health facility infrastructure

On the 16 November 2007, gazetted "hospitals" will automatically become "declared mental health facilities". Authorised (licensed, private) Hospitals will become "private mental health facilities". Appointments of medical superintendents and deputy medical superintendents of these facilities in place on that day will continue to be valid.

Services gazetted as health care agencies under the 1990 Act have also been gazetted as "mental health facilities".

Information Bulletin



Title: Mental Health Act 2007

Continuance of involuntary patient orders

Temporary Patients orders and Continued Treatment Patients orders will continue to be valid for the periods for which they were made. They will be known under the one name of Involuntary Patient orders.

Persons admitted involuntarily and awaiting an outcome from a Magistrate's inquiry will become known as "assessable persons".

Community Treatment Orders will continue to be valid for the periods for which they were originally made. Any existing Community Counselling Orders will lapse on 16 November 2007.

Provision of forms of documentation

A number of documents are used in the day-to-day operation of the Act. A listing of the documents is in attachment A. Hard copies of some of these documents are being provided directly to inpatient mental health facilities. The documents will also be available for downloading from the Department of Health website.

The document "Schedule 1 - Medical Certificate as to examination of observation of person" is a stock item (NH600900 PH202) obtainable from Salmat, the Government forms stockist (ph 02 9743 8777, fax 02 9743 8746).

Electro Convulsive Therapy Registers can be obtained from the Mental Health and Drug & Alcohol Office on 02 9391 9307.

The Mental Health Act 2007 and the Mental Health Regulation 2007 can also be purchased from Salmat (ph: 1300 656 986, fax: 02 9324 1901) or can be viewed at <http://www.legislation.nsw.gov.au/>.

Otherwise, there is no centralised stock of forms maintained and mental health services will have to make their own arrangements for supply.

Training

Is being organised through the NSW Institute of Psychiatry. Area health services will have received requests to nominate key staff for phase 1 training prior to the Act coming into operation. Further training will be carried out over the next twelve months.

Professor Debora Picone AM
Director-General

*Title: Mental Health Act 2007***Attachment A****MENTAL HEALTH ACT 2007****Index of Forms**

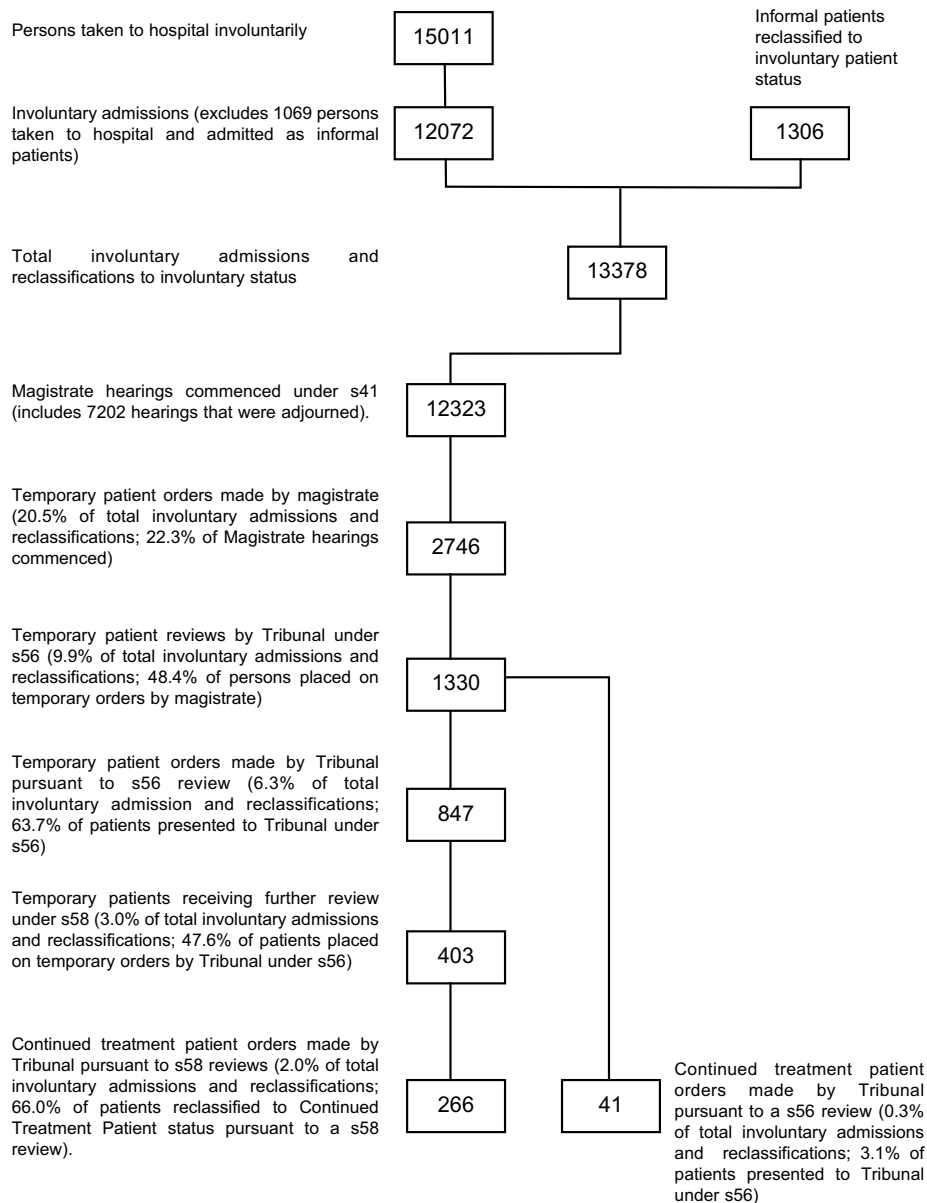
Description
Schedule 1 - Medical Certificate as to examination of observation of person
Schedule 3 - Statement of rights
Form 1 - Medical report as to mental state of detained person
Form 2 - Notice to proceedings before Magistrate
Form 3 - Magistrates' form of Summons
Form 4 - Appeal by patient to Tribunal against refusal to discharge
Form 5 - Appeal by person other than patient against refusal to discharge
Form 6 - Information and Consent to ECT
Form 7 - ECT Register
Form 8 - Summons - Mental Health Review Tribunal - NOT PROVIDED
Form 9 - Oath of Assessor - NOT PROVIDED
Form 10 - Weekly advice to Mental Health Review Tribunal of involuntary referrals
Form 11 - Weekly advice to Mental Health Review Tribunal of decisions at Magistrates' inquiries
Form 12 - Order or direction of Magistrate - mental health inquiry
Application by Guardian for voluntary admission of person to hospital
Application from primary carer for discharge of patient
Application to medical superintendent for review of decision of authorised medical officer
Decision of primary carer in respect of proposed special medical treatment
Decision of primary carer in respect of proposed surgery
Nomination of Primary Carer
Notice to Guardian of discharge of voluntary patient
Notice to patient of breach of community treatment order
Notice to primary carer of involuntary patient of application to Tribunal to consent to ECT
Notice to primary carer of voluntary patient of application to Tribunal to determine validity of consent for ECT
Notification to primary carer of proposed special medical treatment
Notification to primary carer of proposed surgery
Personal Application For Voluntary Admission To Hospital
Request by Ambulance Officer for assessment of a mentally ill or mentally disturbed person
Request by member of the NSW police force for assessment of a mentally ill or mentally disturbed person at a mental health facility
Transfer of involuntary patient between declared mental health facilities
Your rights after the magistrate's inquiry

Appendix B: Pathways of involuntary patients into NSW MHRT (under *Mental Health Act 1990*)

New South Wales Government Mental Health Review Tribunal 2007, *Mental Health Review Tribunal annual report 2006*, NSW MHRT, Sydney, <<http://www.mhrt.nsw.gov.au/mhrt/pdf/annualreport2006.pdf>>, Table 4.

Table 4

Flow chart showing progress of involuntary patients admitted during the period January to December 2006.



Note: Continued treatment patients are subject to six monthly periodic reviews by the Tribunal under s.62

