annual report 2018-19

10 September 2019

The Honourable Roger Cook MLA
Deputy Premier; Minister for Health; Mental Health
13th Floor
Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Deputy Premier

I am pleased to present the Mental Health Tribunal's Annual Report in accordance with section 488 of the *Mental Health Act 2014* for the period 1 July 2018 to 30 June 2019.

Yours faithfully

Karen Whitney
President
Mental Health Tribunal

Contents

Overview of the Mental Health Tribunal

The *Mental Health Act 2014* (WA) (the Act) permits psychiatrists in Western Australia to treat certain patients without their consent. The Act refers to these patients as 'involuntary patients'. A psychiatrist makes a patient 'involuntary' by making an 'involuntary treatment order'.

Without adequate safeguards, the power to make involuntary treatment orders could be abused. Parliament created the Mental Health Tribunal (the Tribunal) to protect patients from potential abuse of the powers under the Act. The Tribunal is an independent decision-making body established by the Act to safeguard the rights of involuntary patients in Western Australia.

What we do

The Tribunal's main job is to review every involuntary treatment order made by a psychiatrist in Western Australia within 35 days (10 days for children). The Tribunal reviews each order again every three months (every 28 days for children) whilst the order is place. The purpose of the Tribunal's review is to determine whether the patient still needs the involuntary treatment order. The Tribunal can also decide other questions under the Act. Patients or treating teams can ask the Tribunal to decide these questions by filling out a form (an application).

The Tribunal makes decisions based on information provided at a hearing. A hearing is a meeting where the Tribunal listens to participants' views and then makes a decision. The Tribunal usually holds its hearings at the hospital or health service treating the patient. This is for the convenience of participants only. The Tribunal is independent and is not part of the treating team or the health service.

The Tribunal expects the patient's psychiatrist and treating team to attend the hearing. The Tribunal also strongly encourages patients and their families to attend hearings. Patients may bring an advocate or a lawyer to speak for them if they choose.

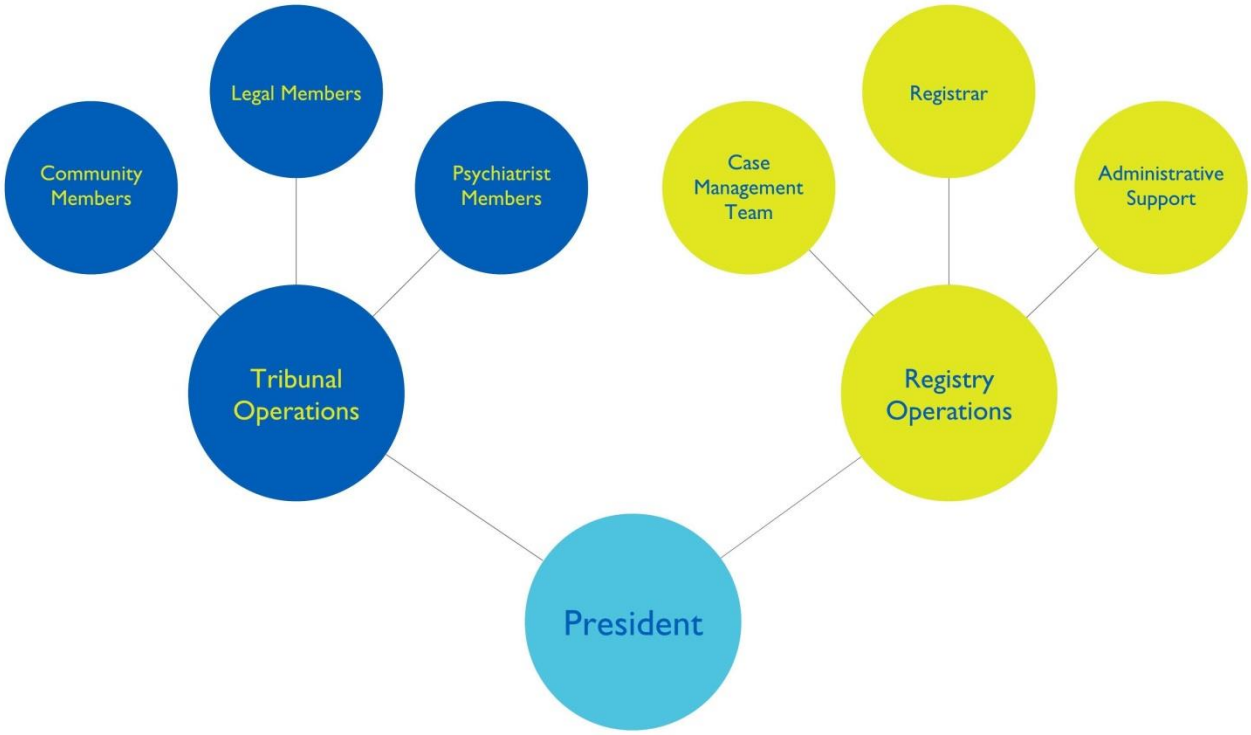
At the end of a hearing, the Tribunal decides the question in issue. The Tribunal tells the participants its decision, and the reasons for its decision.

Who we are

The Tribunal has a President and Tribunal members who make decisions under the Act. When the Tribunal holds hearings, it usually sits in panels of three. One member is a lawyer, one is a psychiatrist, and the third is a community member. Tribunal members are independent statutory officers appointed by the Governor on the recommendation of the Minister. They do not work for the hospital or health service treating the patient.

The current President of the Tribunal is Karen Whitney. She is a legal member, appointed as President on 30 December 2017 for five years. On 30 June 2019, the Tribunal also had 11 sessional legal members, 22 sessional psychiatrist members, and 17 sessional community members. A full list of Tribunal members is at Appendix One.

The Tribunal also has a Registry. The Registry is the office that supports the Tribunal members by scheduling hearings and processing hearing materials. It has a Registrar and six staff: a Senior Case Management Officer; three Case Management Officers; a Records Officer and an Executive Assistant. The Registrar is responsible under the Act for scheduling hearings on a timely basis. The Registrar is also responsible for notifying parties when and where hearings will take place.



Our strategic objectives

We have four primary strategic objectives:

- We will achieve high quality patient-centred outcomes in every matter.
- We will support stakeholder participation in the hearing process.
- We will improve how we work and maximise our use of technology.
- We will build our capacity and make best use of our resources.

The Tribunal's Strategic Plan (including its vision, mission and values) is at Appendix Two.

President's Report

The 2018-19 financial year was very exciting for the Mental Health Tribunal. We significantly advanced our reform program to ensure full compliance with our statutory requirements and achieve best practice in operations. I highlight below the Tribunal's key achievements, its most significant issues, and noteworthy events during the past financial year.

Key achievements

New home

On 29 January 2019, the Tribunal moved to new premises in the WA Government-owned Albert Facey House, 469 Wellington Street Perth. The new premises comply with the Government Office Accommodation Policy and provide a superior level of accommodation. The new premises meet the Tribunal's service delivery requirements at substantially better value-for-money. The WA Government Consolidated Account absorbed the fitout costs of the new premises.

The Tribunal's new premises include a compact, predominantly open-plan 164 sqm office suite. This currently houses the Registry and the President. The office includes a purpose-built records room to meet the Tribunal's on-site record storage needs. The premises also include a 25 sqm ground floor hearing room. The Tribunal currently conducts videoconference hearings from the hearing room. However, the location and layout of the hearing room provides the potential for future use for in-person hearings (with some modifications).

The relocation was the culmination of 12 months of negotiation and planning involving the Mental Health Commission, the Department of Finance, and the Tribunal. Alex Watt, the Mental Health Commission's Director of Corporate Services, provided significant on-going support from his team, particularly in the area of Information and Technology. The project could not have proceeded without this assistance. The Tribunal is also grateful for the efforts of the Department of Finance's Building Management and Works teams, which were responsible for the fitout and funding arrangements. The move itself required many hours of hands-on work by the Tribunal's enthusiastic and capable Registry staff. They all contributed to ensuring that everything was packed and ready for the removalists to collect over the Australia Day public holiday weekend. I offer my personal thanks to this fantastic team for their contribution to the move. I am also grateful to the Tribunal members who continued conducting hearings in the atmosphere of chaos leading up to the move, and who adjusted to the procedural changes arising from the move without complaint.

Registry staff and the President pack and stack crates in preparation for removalists.

Hearing venue safety protocols and audit

The Tribunal schedules more than 3,600 hearings per annum. In most years, about 85% of hearings are held off-site on hospital or health service premises. The Tribunal relies heavily on the security arrangements in place at hospital and health service premises. Although security incidents are rare, the Tribunal owes its members a duty of care to avoid exposing them to unnecessary risk of injury. This includes a duty to provide a safe system of work.

An incident at a hospital-based Tribunal hearing in late November 2018 raised concerns about hearing safety. I took advice from the Department of Justice's Court and Tribunal Services on design protocols for rooms used by quasi-judicial officers interacting with members of the public. It was evident that seating arrangements and room configurations at some hospital and health service premises would be unlikely to meet the Tribunal's duty to provide its members with a safe system of work. Accordingly, I took the extraordinary step of suspending in-person hearings at hospitals and health service premises until I was able to inspect all metropolitan area venues and consult with clinical directors about updated safety protocols. In the meanwhile, all hearings took place by videoconference.

Over the next two weeks, I met with clinical directors to inspect hearing rooms and discuss modifications necessary to improve Tribunal member safety at hearings. The response was extremely positive. Hospitals and health services overwhelmingly supported the modifications necessary to reduce risks and improve safety. In-person hearings resumed at each venue immediately following implementation of modifications. As a result, within two weeks in-person hearings had resumed at nearly every venue.

Only one hospital was unable to provide a safe venue for hearings without conducting further works. Hearings at this venue remained via videoconference for the rest of the financial year. Works will be completed in August 2019. In-person hearings will resume at this venue then.

Rollout of new Tribunal applications and standard orders

As reported last year, for a range of reasons the Tribunal's case management system, ICMS, was never updated to reflect the changes in the Tribunal's powers arising from the 2014 Act. Since the 2014 Act commenced in late 2015, the Tribunal's orders have reflected the Tribunal's powers arising from the 1996 Act rather than the 2014 Act.

During 2018, the Tribunal created a suite of new application forms and standard orders reflecting the Tribunal's powers under the current Act. Unfortunately, the Tribunal was unable to integrate the forms into our existing case management system during the first half of the 2018-19 financial year. Following consultation with the case management team, in February 2019 the Tribunal opted for a manual rollout of the new forms and orders whilst integration options are explored.

Accordingly, the Tribunal now provides consumers, treating teams, advocates, and lawyers with 13 different Tribunal application forms customised to reflect the Tribunal's decision-making powers under the 2014 Act. Furthermore, all Tribunal orders are now sealed and reflect the type of application made or statutory review undertaken. These improvements ensure that patients and treating teams receive orders which accurately reflect the Tribunal's decisions.

In conjunction with the rollout of the new application forms and orders, the Tribunal streamlined and simplified its hearing correspondence. Notices of Hearing and Notices of Cancellation are simple, clear, and easy to read and understand. The Tribunal now provides an information sheet to assist treating teams preparing for hearings. The Tribunal has updated its brochures for patients to provide them with clear, relevant information about the hearing process and rights of review.

Initial feedback from stakeholders has been very positive.

Registry staff restructure update

As reported last year, in 2018 the Tribunal restructured its Registry staffing to improve quality and achieve efficiencies. Registry roles were aligned to the model used in other Australian courts and tribunals. Permanent positions were advertised in mid-2018, and the successful candidates commenced employment in their new roles during October, November, and December 2018.

Tribunal member restructure

Since the commencement of the Mental Health Review Board (the Board) in 1996, the operating model for the Board (and then the Tribunal commencing in 2015) was a full or part-time President and a number of sessional members. This model works very well with a low volume or unpredictable caseload, because it does not commit the organisation to remuneration except where members are actually needed. Because members are appointed on a casual basis, remuneration tends to be at higher rates.

With higher volume and more stable caseloads, the exclusive use of sessional members becomes very expensive and less efficient. As Tribunals transition from low volume/unpredictable caseloads to higher volume/more stable caseloads, most also transition to a mix of full-time, part-time, and sessional members. This transition was contemplated by the Act, which provides in section 477(2) that members may be appointed on a full-time, part-time, or sessional basis.

Legislative changes commencing in November 2015 significantly increased the frequency of Tribunal hearings. The number of hearings scheduled annually by the Tribunal increased by 84%, from 1,962 in 2013-14 (the last full financial year before the commencement of the 2014 Act) to 3,618 in 2018-19. However, the recurrent funding allocated to the Tribunal has only increased by 39%, from $1,883,241 in 2013-14 to $2,623,000 in 2018-19.

In 2018-19, the Tribunal sought additional funding from both the Mental Health Commission and the Treasury to continue to perform its statutory functions in accordance with the Act. No ongoing additional appropriation was secured. Both the Mental Health Commission and Treasury encouraged the Tribunal to explore cost reduction. For these reasons, the Tribunal has been exploring the possibility of reducing its reliance on sessional Tribunal members by transitioning to a full and part-time member workforce.

In early 2019, the Public Sector Commissioner issued a remuneration determination setting remuneration for full-time legal and psychiatrist members at $181,637 per annum and community members at $111,590 per annum. In April 2019, the Minister authorised recruitment of members on a full and part-time basis. Positions were advertised in June 2019, and more than 160 applications were received. The calibre of the candidates was very impressive, and included existing sessional members who sought to be considered for full or part-time appointment.

Once the shortlisting process is complete, the Minister will be briefed on all considerations in recommending candidates for appointment to Cabinet and the Governor in Council.

Tribunal member professional development

During the 2018-19 financial year, the Tribunal commenced a professional development program for Tribunal members. The Council of Australasian Tribunals' Competency Framework identifies eight key competencies for tribunal members, with associated qualities and performance indicators. These will eventually form the basis for developing a formal professional development program (including new member induction and training) and a performance appraisal program. These will provide a framework for objectively assessing candidates for appointment to the Tribunal.

In May 2019, the Tribunal held a whole-of-Tribunal training session on the theme 'First do no harm: Promoting patient well-being during the hearing process'. Matthew Carroll, President of the Victorian Mental Health Tribunal, was the keynote speaker on the topic of 'Solution-Focused Hearings under the Mental Health Legislation – Theory and Practice'. Members received copies of the Victorian Tribunal's materials on solution-focused hearings to assist them in developing practical techniques to promote solution-focused hearings. On behalf of the Tribunal, I thank President Carroll for his valuable time in traveling to Perth to speak to our members.

In addition to formal whole-of-Tribunal training, members meet periodically within their specialist areas to discuss issues. Legal members participate in a formal continuing professional development program monthly, during which they discuss legal issues arising under the Act. This is to ensure consistent application of the legislation across Tribunal members. Psychiatrist members also participate in monthly peer review meetings.

Development of a standard medical report template

A critical feature of every Tribunal hearing is the psychiatrist's report on the patient's current status. To fulfil its statutory role, the Tribunal must determine, on the medical evidence presented, whether the patient is still in need of the involuntary treatment order at the time of the hearing. Where the psychiatrist's report is absent or does not provide the required information, the Tribunal must adjourn the hearing. This outcome can be highly distressing for patients and families, and results in considerable wasted resources for hospitals, treating teams, advocates, and the Tribunal. The importance of a comprehensive, highly targeted report addressing the evidence required by the Tribunal to determine the matter cannot be overstated.

To provide busy psychiatrists with guidance on what to include in a Tribunal medical report, most other Australian Mental Health Tribunals provide doctors with a standard medical report template. Our Tribunal does not have a standard medical report template. During 2018-19, the Tribunal's psychiatrist members participated in a project to create one. After significant refining and consultation with psychiatrists, the Tribunal conducted a trial of the medical report template during the month of May 2019. The Tribunal is assessing feedback arising from the trial, with a view to making improvements to the template before final rollout in late 2019.

New website

The Tribunal's existing website was developed many years ago, and by 2018-19 was no longer fit for purpose. The Tribunal had no access to content on its website, and attempts to contact the website host to make very simple updates to content were unnecessarily difficult. Accordingly, the Tribunal website was taken off-line.

The Tribunal commissioned a new website to function as an information source for patients, carers and families, as well as stakeholders, such as the Mental Health Advocacy Service and the Mental Health Law Centre. The website will serve as a repository for application forms, brochures, report templates and

Tribunal publications and policies. The Tribunal will retain control over access to content and perform updates itself.

The website became operational in July 2019.

Document and records management

The Tribunal is committed to aligning its information management practices with legislative requirements and best practice. The Tribunal continues to develop and implement policies, processes, and training to meet its information management responsibilities. Notable achievements this financial year include:

- Submitting a draft Record Keeping Plan to the State Records Office under section 21 of the *State Records Act 2000* (WA). The Tribunal keeps records in accordance with principles and standards established by the State Records Commission under section 61 of the *State Records Act* whilst awaiting the outcome of the State Records Office review of the draft Record Keeping Plan.
- Customising the Mental Health Commission's Electronic Document and Records Management System (EDRMS) to move the Tribunal towards electronic document management. The Tribunal will work closely with the Mental Health Commission around the security of its information management practices.

The next stage is to train staff in the EDRMS and to audit and arrange the migration of key existing documents into the EDRMS. The system will modernise the record keeping practices of the Tribunal. However, there is no funding in the 2019-20 appropriation for this project. It remains on hold until a funding source is identified.

Significant issues

Case management system

None of the significant issues raised in the 2017-18 Report about the Tribunal's case management system or the need to access further funding for technology has been resolved.

The most immediate issue for the Tribunal's operations remains the case management system. In its present form, it is not fit for purpose. It is neither aligned to the legislation nor effective as a tool for managing the day-to-day operations of the Tribunal. Without extensive customisation, or alternatively replacement, the objectives of the strategic plan cannot be achieved, and the Tribunal is unable to guarantee delivery of its statutory functions.

Because the Tribunal's case management system remains customised to reflect the repealed *Mental Health Act 1996* (WA), it has effectively been abandoned in favour of manual production of Tribunal documentation (such as orders and forms).

Furthermore, the Tribunal's case management system is not customised to monitor key performance indicators, such as compliance with statutory timeframes for hearings. Of further concern is that the component of the case management system which calculates and schedules hearing timeframes was not

programmed with regard to the provisions for time computation in the *Interpretation Act 1984* (WA). The Tribunal is unable to assess whether it meets its statutory obligations and timeframes in every matter.

The Tribunal's inability to collect quantitative data to determine compliance with the Act was the subject of specific recommendations in the Mental Health Commission's *Post-Implementation Review of the Mental Health Act 2014*.

Recommendation 22 of the *Post-Implementation Review* recommended that the Tribunal 'facilitate the ongoing collection of all relevant quantitative data regarding [the Tribunal's hearings] for further data analysis and to contribute to the statutory review of the Act'.

Recommendation 30 of the *Post-Implementation Review* further recommended that:

> *The MHT to improve systems and processes to improve data collection to determine compliance with the requirements of the Act, which will assist with obtaining evidence of the MHT's functions, to better identify and ensure compliance with the Act in this regard and inform the statutory review of the Act.*

The Tribunal must comply with its statutory functions in every matter. To ensure that the Tribunal does so, the Tribunal must address its technological issues urgently. Until these matters are addressed, the Tribunal remains unable to monitor and report on its compliance with its statutory obligations or to contribute any meaningful data to the statutory review of the Act.

The Tribunal purchases IT support from the Mental Health Commission. Accordingly, the Tribunal is working closely with the Mental Health Commission in deciding whether to invest in the extensive work needed to customise the current case management system to make it fit-for-purpose or, alternatively, to invest in a new system.

Funding for technology

Once again, the greatest challenge to the Tribunal in addressing these issues is securing the necessary funding. The Tribunal continues to explore the most cost-effective way to achieve its technological goals, as well as alternative funding options.

Notable events and thanks

During the 2018-19 financial year, the following Tribunal members resigned, retired, or did not seek reappointment when their terms expired:

- Ryan Arndt (lawyer)
- Rachel Yates (lawyer)
- Dr Adam Brett (psychiatrist)
- Dr Jacques Classen (psychiatrist)
- Dr Russell Date (psychiatrist)
- Dr Larissa Harding (psychiatrist)
- Dr Caroline Zanetti (psychiatrist)

I thank them on behalf of the Tribunal for their involvement and wish them well in their futures.

Also during 2018-19, Karen Jones, the Tribunal's Registrar since late 2017 resigned to pursue an opportunity in the Department of Justice. Karen was a highly valued member of our team, and made an outstanding contribution to the development of not only the Registry, but the Tribunal as a whole. She left the Registry in a significantly improved state, and I am grateful for her work. Thank you Karen, we will all miss you very much, and wish you all the best for your future.

Finally, I thank all Tribunal members and Registry staff for their continuing support during the 2018-19 financial year. I remain grateful to the Deputy Premier, The Honourable Roger Cook MLA, and the Mental Health Commission (particularly the Corporate Services team) for their ongoing support.

Karen Whitney
President

The Tribunal's Functions

The Tribunal is an independent decision-making body established by the Act to safeguard the rights of involuntary patients in Western Australia.

The Act permits psychiatrists in Western Australia to treat certain patients without their consent. The Act refers to these patients as 'involuntary patients'. A psychiatrist makes a patient 'involuntary' by making an 'involuntary treatment order'. There are two types of involuntary treatment orders. An inpatient treatment order requires the patient to stay in hospital for treatment without consent. A community treatment order requires treatment without consent, but in the community rather than in hospital.

The Tribunal's main job is to review every involuntary treatment order made by a psychiatrist in Western Australia. However, the Tribunal can also decide many other questions under the Act. This section outlines the Tribunal's hearing process and the different types of decisions the Tribunal makes.

Conducting hearings

The Tribunal makes decisions based on information provided at a hearing. A hearing is a meeting where the Tribunal listens to participants' views and then makes a decision.

The Act provides many rules for the hearing process. The hearing must be as informal as possible. It must not be overly technical. It must only be as long as it needs to be. The hearing must be procedurally fair. It must also be private. The Act limits publication of private patient information, and provides criminal penalties for unauthorised disclosure of such information.

When the Tribunal holds hearings, it usually sits in a panel of three. One member is a lawyer, one is a psychiatrist, and the third is a community member. The legal member is always the 'presiding member'. This means that the legal member manages the hearing and delivers the decision on behalf of the three Tribunal members. Legal members also decide all questions of law (including questions about how the law applies to the facts). A majority of the three members decides other questions.

Tribunal proceedings are free. The Tribunal does not charge application or hearing fees.

The Tribunal usually holds its hearings at the hospital or health service treating the patient. This is for the convenience of participants only. The Tribunal is independent and is not part of the treating team or the health service. Sometimes, hearings will be by videoconference.

The Tribunal expects the patient's psychiatrist and treating team to attend the hearing. The Tribunal also strongly encourages patients and their families to attend the hearings. Patients may bring an advocate or a lawyer to speak for them if they choose. Where required, the Tribunal provides interpreters.

At the hearing, the Tribunal allows each party to call evidence, examine or cross-examine witnesses, and make submissions. The formal rules of evidence do not apply.

In conducting hearings and making decisions, the Tribunal must have regard to the objects of the Act (s10) and the Charter of Mental Health Care Principles. The objects of the Act and the Charter are reproduced at Appendix Three.

At the end of each hearing, the Tribunal tells the participants its decision and the reasons for its decision.

Types of hearings

Initial and periodic reviews

The Tribunal's main job is to review every involuntary treatment order made by a psychiatrist in Western Australia within 35 days (10 days for children). This is an 'initial review' (s 386). The Tribunal reviews each order again every three months (every 28 days for children) whilst the order remains in place. This is a 'periodic review' (s 387). For patients who have been on a community treatment order for more than a year, the Tribunal reviews the order every 6 months.

The purpose of the Tribunal's initial and periodic reviews is to determine whether the patient still needs the involuntary treatment order.

Requested reviews

Patients and other interested persons can also complete an application form to ask the Tribunal to review certain types of orders. The Tribunal will then schedule a hearing to review the order. These are 'requested reviews' (s 390). The Tribunal can review:

- involuntary treatment orders, to decide whether the patient still needs the order (s 390(1)(a));
- inpatient treatment orders, to decide whether the patient still needs the order (s 390(1)(b));
- community treatment orders, to decide whether the terms of the order are appropriate (s 390(1)(c));
- orders authorising transfer of involuntary patients to or between authorised hospitals (s 390(1)(d));
- orders transferring patient responsibility between supervising psychiatrists (s 390(1)(e));
- orders transferring patient responsibility between treating practitioners (s 390(1)(f)); and
- orders transferring certain inpatients interstate (s 390(1)(g)).

The Tribunal can also review these orders on its own initiative (s 391).

Applications for declaration about the validity of treatment orders

Patients and other interested persons can complete an application form to ask the Tribunal to declare that certain orders are (or were) valid or invalid (ss 397 and 400). These include:

- involuntary treatment orders;
- continuation orders; or
- variation orders.

If the order is no longer in force at the hearing date, the Tribunal may decide to hear the application anyway if it is satisfied the application raises a question of law or a matter of public interest (s 403).

Applications to review admission of long-term voluntary inpatients

Patients and other interested persons can also complete an application form to ask the Tribunal to review the admission of long-term voluntary inpatients (s 405(1)). A long-term voluntary inpatient is:

- an adult who has been a voluntary inpatient for more than six months; or
- a child who has been a voluntary inpatient for more than three months (s 404).

After completing such a review, the Tribunal may recommend the treating psychiatrist:

- reconsider the need for the admission;
- prepare and regularly review a treatment, support and discharge plan for the patient; or
- discharge the patient (s 408).

The Tribunal has the power to make recommendations only.

Applications to approve electroconvulsive therapy

Psychiatrists cannot use electroconvulsive therapy (ECT) on certain patients without the Tribunal's approval. These patients include:

- children aged between 14 and 17; and
- adult involuntary patients or mentally impaired accused (s 409).

If a psychiatrist recommends ECT for one of these patients, the psychiatrist must complete an application form to ask the Tribunal for permission to perform ECT (s 410). The application must identify why the patient's psychiatrist recommends ECT, and provide a treatment plan.

In deciding whether to approve ECT, the Tribunal must have regard to the *Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia* (s 413). The Tribunal must also have regard to all of the factors in section 414 of the Act, including:

- the patient's wishes;
- the views of the patient's parent or guardian (for children);
- the views of the patient's close family member, carer, and nominated person;
- why ECT should be performed;
- the consequences of not performing ECT;
- any significant risk of performing ECT;
- whether ECT will promote and maintain the health and wellbeing of the patient; and
- whether any alternative treatment is available and any significant risks of alternative treatment.

Applications to approve psychosurgery

Likewise, psychosurgery cannot be performed without the Tribunal's approval. With the Tribunal's approval, psychosurgery may be performed only on adults or children between the ages of 16 and 18 who consent to the treatment (s 208).

If a patient's psychiatrist recommends psychosurgery, the psychiatrist must complete an application form to ask the Tribunal for permission (s 417). The application must set out why the psychiatrist recommends psychosurgery and include a treatment plan.

The Tribunal cannot approve the psychosurgery unless satisfied that:

- the patient gives informed consent;
- the psychosurgery has clinical merit and is appropriate;
- all alternatives have been appropriately trialled but have not resulted in a sufficient and lasting benefit to the patient;
- the neurosurgeon is suitably qualified and experienced; and
- the proposed hospital is a suitable place.

In deciding whether to approve psychosurgery, the Tribunal must have regard to:

- the views of the patient's carers, close family members, or personal supporters;
- the consequences of not performing the psychosurgery;
- the nature and degree of the risks of the psychosurgery; and
- whether the psychosurgery will promote and maintain the health and wellbeing of the patient.

The Tribunal has not yet considered an application for psychosurgery.

Applications to issue compliance notices

Patients and other interested persons can complete an application form to ask the Tribunal to issue a *service provider* with a *compliance notice* for non-compliance with a *prescribed requirement* of the Act (s 423).

A 'service provider' is the person required by the Act to comply with a 'prescribed requirement' (s 422).

A 'prescribed requirement' is a requirement under the Act to:

- give a document or provide information to someone, or include a document or information on a patient's medical record, or comply with a request; or
- ensure a patient's treatment, support and discharge plan is prepared, reviewed or revised (s 422).

If after the hearing the Tribunal thinks the service provider has not complied with the prescribed requirement, the Tribunal may issue a compliance notice. The compliance notice may direct the service provider to:

- take action within a set period to comply with the prescribed requirement; and
- report to the Tribunal about the outcome.

Before deciding to issue a compliance notice, the Tribunal must consider whether to refer the matter to one or more of the following:

- the Commissioner of the Mental Health Commission;
- the Director General of the Health Department;
- the Chief Psychiatrist; or
- a registration board (s 423).

The President of the Tribunal must include in the Annual Report the name of each service provider issued with a compliance notice during that year; and the number of compliance notices issued during that year.

During 2018-19, The Tribunal did not issue any compliance notices. However, the Tribunal did issue several recommendations to psychiatrists to review a patient's treatment support and discharge plan (TSDP) to ensure it fully complied with the Act.

Section 423 arises most frequently in the area of TSDPs. To facilitate greater compliance with TSDPs, before every periodic review the Tribunal writes to the responsible practitioner or case manager asking for an updated and compliant TSDP (one that complies with both the Act and the Chief Psychiatrist's Guidelines). The Tribunal attaches a copy of the Chief Psychiatrist's Guidelines to its request. The Tribunal also asks that the treating teams send a copy of the TSDP to the patient and the Tribunal at least 3 days before the hearing date.

Applications to review orders restricting a patient's freedom of communication

Section 261 of the Act provides that patients have the right of freedom of lawful communication, including the freedom to:

- see and speak with other people in the hospital;
- have uncensored communications with people, including visits, telephone calls, mail and electronic communications; and
- receive visits and other contact from legal practitioners, mental health advocates and others.

Nevertheless, in certain circumstances a psychiatrist may make an order limiting or preventing the exercise of these rights (s 262). These orders must be in the approved form, placed on the patient's file, and a copy given to the patient and personal supporters.

Patients and other interested persons can complete an application form to ask the Tribunal to review a psychiatrist's order limiting or preventing exercise of these rights (s 427). After completing the hearing, the Tribunal can confirm, amend, or revoke the psychiatrist's order.

Applications to resolve certain questions arising in respect of nominated persons

Patients may nominate a person to assist them to ensure their rights are observed, and their wishes and interests are considered. Patients and other interested persons can complete an application form to ask the Tribunal to make declarations about the validity of a nomination, or to revoke a nomination (s 430).

On an application for a declaration about validity, the Tribunal may declare that a nomination is valid or invalid. The Tribunal may also vary the terms of the nomination to give effect to the intention of nomination (s 431).

On an application to revoke a nomination, the Tribunal may revoke a nomination if satisfied that the nominated person is not appropriate because they are:

- likely to adversely affect the interests of the patient; or
- not capable of performing that role because of mental or physical incapacity; or
- not willing or able to perform the role (s 432).

Applications to review any other decision affecting a patient's rights

Finally, patients and other interested persons can complete an application form to ask the Tribunal to review other decisions made under the Act that affect a person's rights and cannot be heard by the Tribunal under another provision (s 434).

On completing the review, the Tribunal may make any orders, and give any directions, the Tribunal considers appropriate.

Determinations, orders, and reasons for decision

At the end of each hearing, the Tribunal tells the participants its decision, and the reasons for its decision. Tribunal members provide parties with oral reasons which contain enough information for the parties to understand (although not necessarily accept) the outcome. The reasons need to be in terms the patient is likely to understand. However, the reasons must also have enough detail to identify, for the State Administrative Tribunal (SAT), the factual and legal basis for the decision and the Tribunal's reasoning.

The Tribunal sends a Notice of Decision to the parties by post or email shortly after the hearing. This is the Tribunal's formal order arising from the hearing. The Tribunal's order informs the party of the right to seek reasons for Tribunal's decision, and the right to apply to the SAT for a review of the Tribunal's decision.

Because the Tribunal has already given oral reasons at the end of the hearing, parties who request reasons are given a transcript of the oral reasons provided at the hearing. The Tribunal does not otherwise provide written reasons for decision unless the member has not provided adequate reasons at the hearing. Such matters are referred to the President for further action.

Review by the State Administrative Tribunal

Decisions of the Tribunal are reviewable by the SAT. Such matters fall within the SAT's review jurisdiction, and are conducted by way of a hearing *de novo*. In other words, the SAT is not confined to matters that were before the Tribunal and may consider new material whether or not it existed at the time of the Tribunal hearing. The purpose of the SAT's review is to produce the correct and preferable decision at the time of the decision upon review.

The SAT may affirm the Tribunal's decision, vary the Tribunal's decision, or set aside the Tribunal's decision, and either substitute its own decision or send the matter back to the Tribunal for reconsideration.

Because the SAT determines matters based on the evidence available at the date of its hearing, rather than the materials before the Tribunal at the original hearing, a decision to revoke or set aside a decision of the Tribunal does not necessarily indicate an error in the Tribunal's original decision.

Performance and Statistics

What we measure

We measure our performance based on the number of hearings we list, not the number of hearings we conduct. This is because the Tribunal has a statutory obligation to list every involuntary patient for a review hearing within a prescribed timeframe.

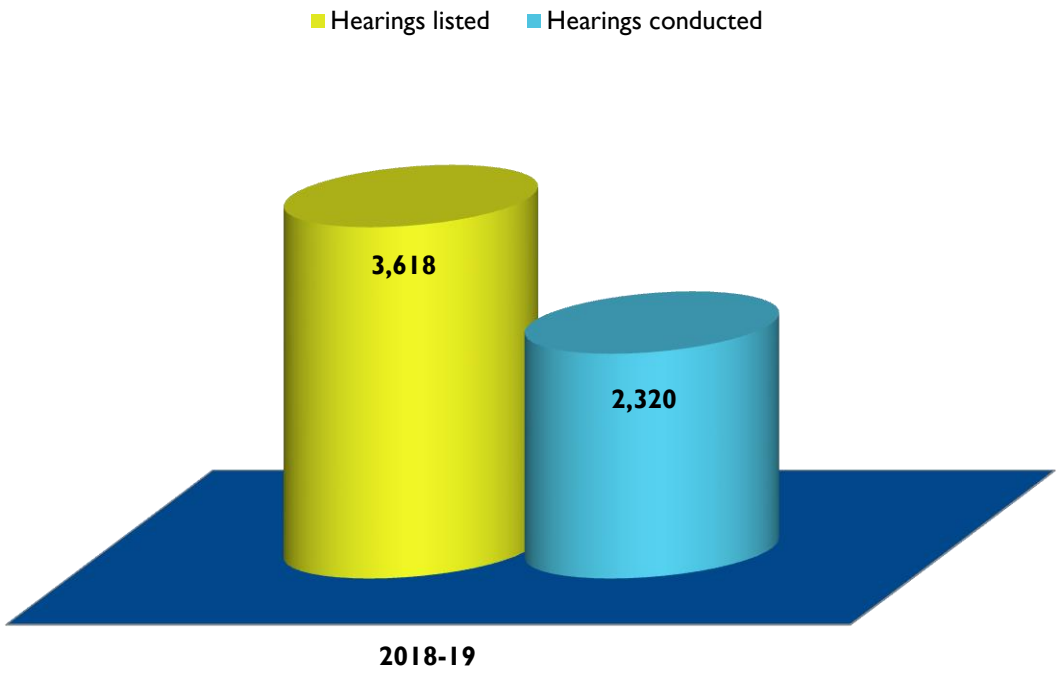
In about one-third of matters, the psychiatrist revokes the involuntary treatment order a few days or hours before the hearing. This means that the patient no longer requires the hearing and we must discontinue it. In these circumstances, the Registry and Tribunal members have already performed all of the work to list and conduct the hearing. In most cases, the Tribunal cannot fill this vacancy with another hearing because it cannot give the participants enough notice to attend.

Hearing numbers

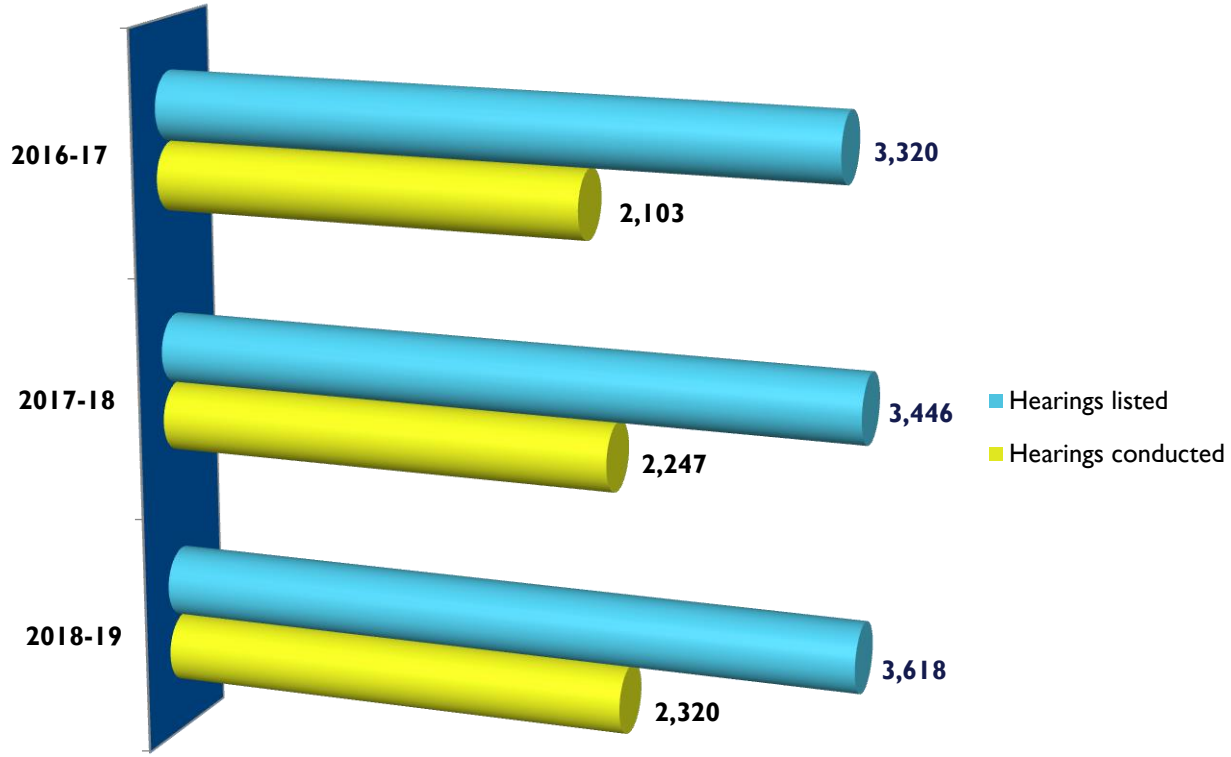
In 2018-19, the Tribunal listed 3,618 hearings, an increase of 172 (5%) from 2017-18. This is a 9% increase since 2016-17.

Of the 3,618 hearings listed in 2018-19, 2,320 (64%) proceeded to a hearing. This is relatively consistent with previous financial years, where between 63-65% of listings have proceeded to hearing.

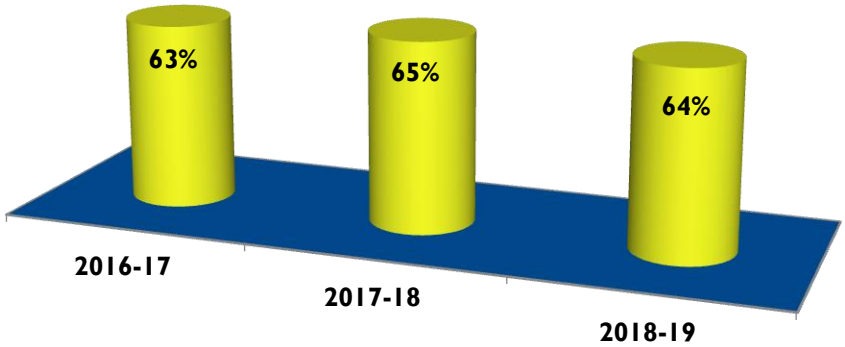
Number of hearings listed vs conducted 2018-19



Yearly comparison of number of hearings listed vs conducted



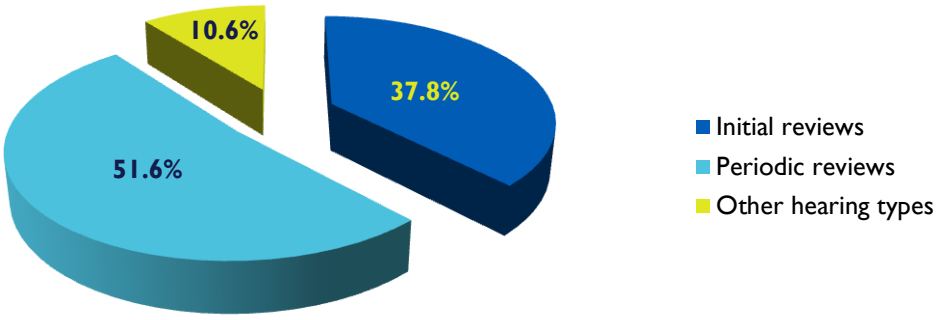
Percentages of listings proceeding to hearing by year



Hearings conducted by matter types

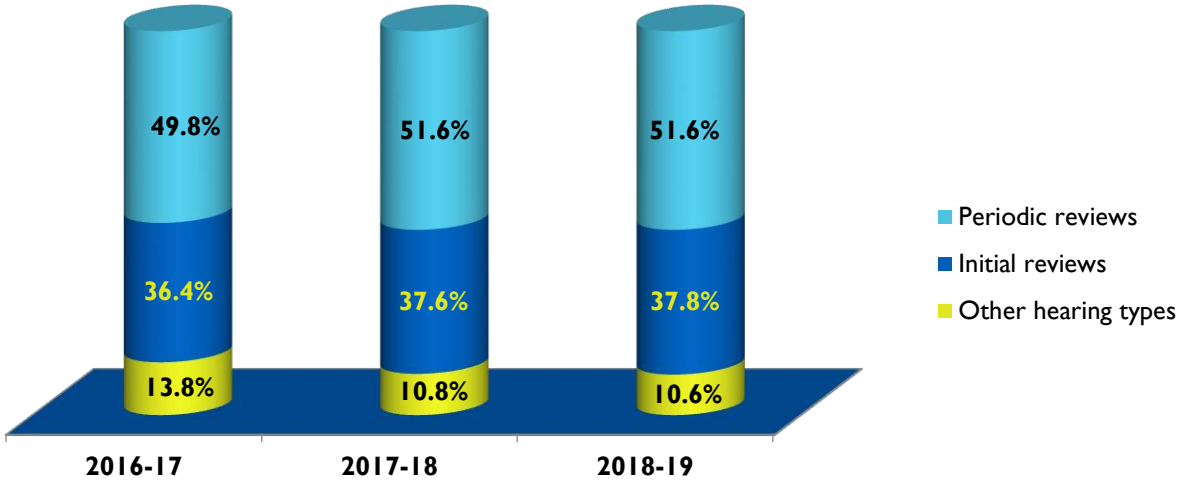
In 2018-19, the Tribunal conducted 2,320 hearings. Of these, 876 (37.8%) were initial review hearings conducted pursuant to section 386 of the Act. A further 1,197 (51.6%) were periodic review hearings conducted pursuant to section 387 of the Act. The balance of 247 (10.6%) were classified by our case management system as 'requested reviews'. This category represents 17 different types of hearings for which statistics cannot be recorded because of the current configuration of our case management system.

2018-19 hearings conducted by matter type



As demonstrated below, the breakdown between initial, periodic, and requested review hearings has been consistent since 2016.

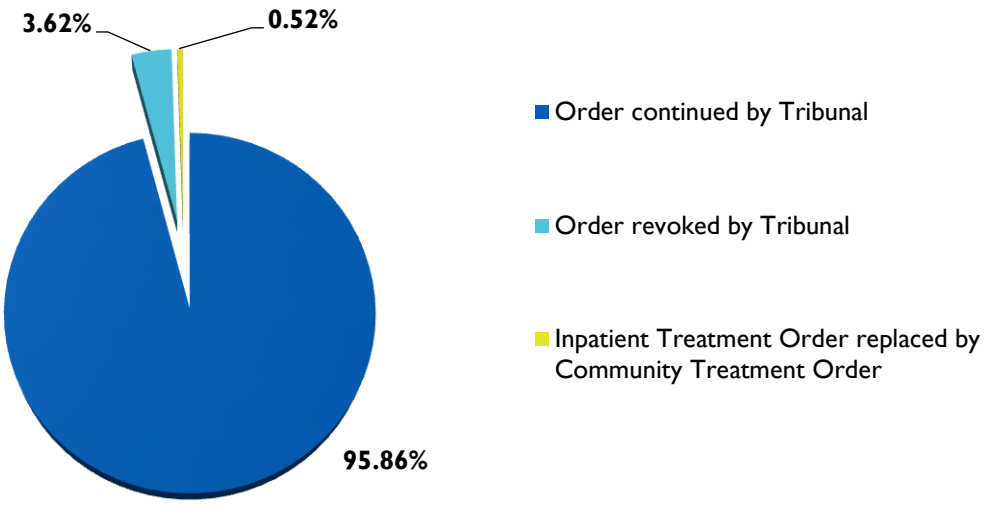
Comparison of percentage of hearings conducted by matter type by year



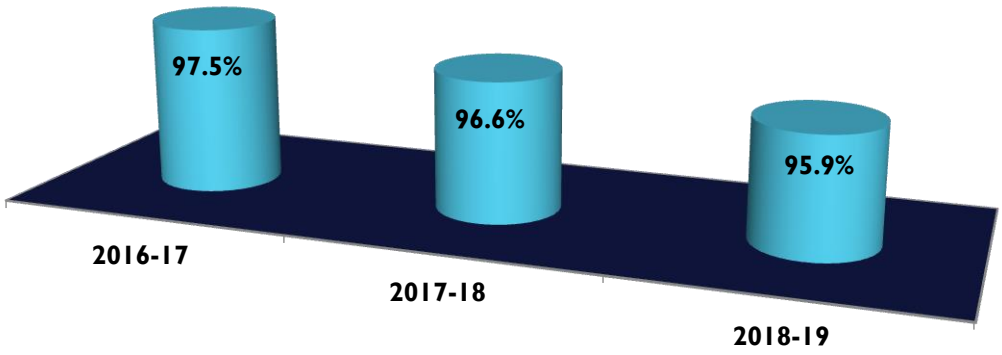
Hearings conducted by outcome

Of the 2,320 hearings conducted in 2018-19, in 2,224 matters (95.86%) the Tribunal was satisfied that the involuntary patient remained in need of the involuntary treatment order and continued the order. In 84 matters (3.62%) the Tribunal was not satisfied the involuntary patient remained in need of the involuntary treatment order and revoked the order. In 12 (0.52%) matters the Tribunal was not satisfied the involuntary patient remained in need of an inpatient treatment order and directed the psychiatrist to issue a community treatment order instead. These percentages have remained relatively consistent since 2016.

2018-19 hearing outcomes



Percentages of orders continued by Tribunal by year

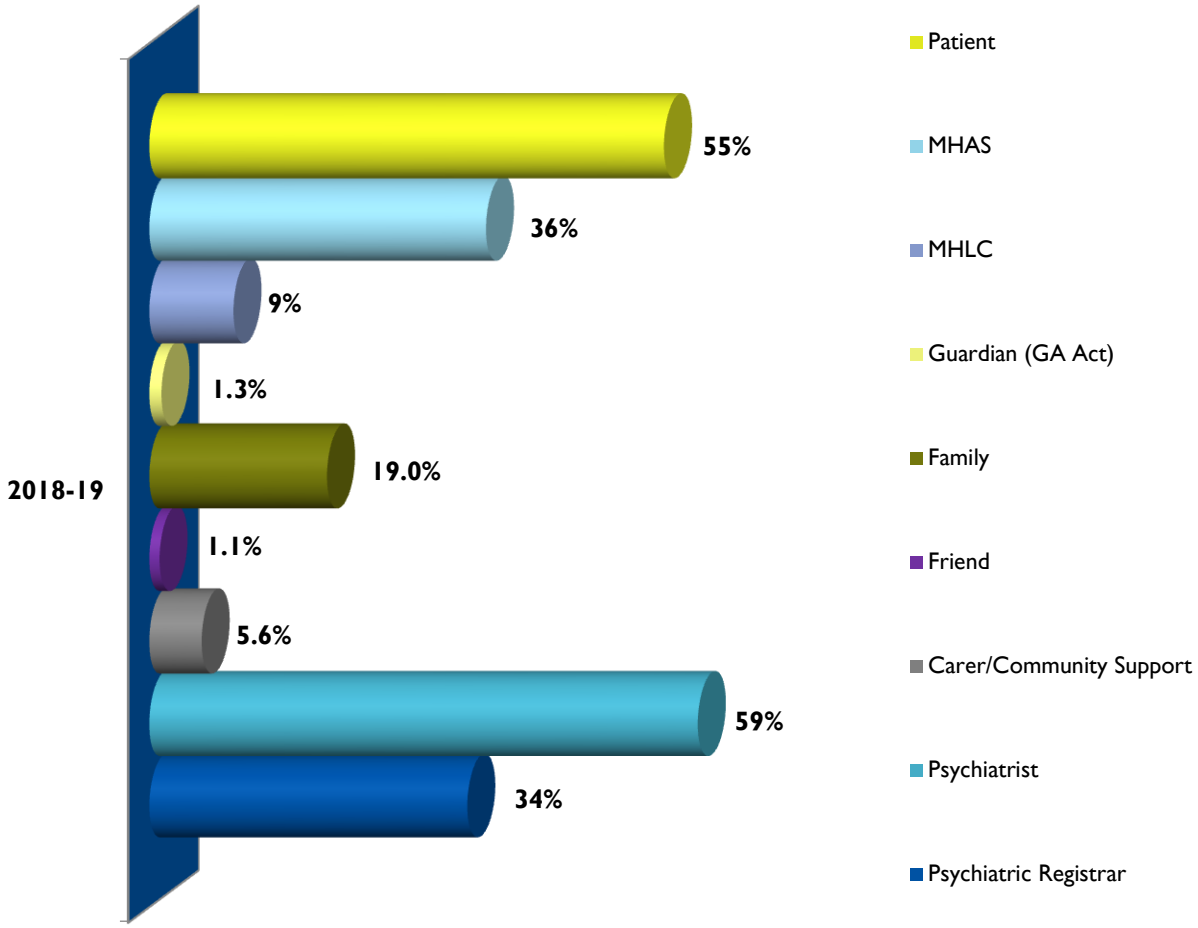


Attendance at hearings

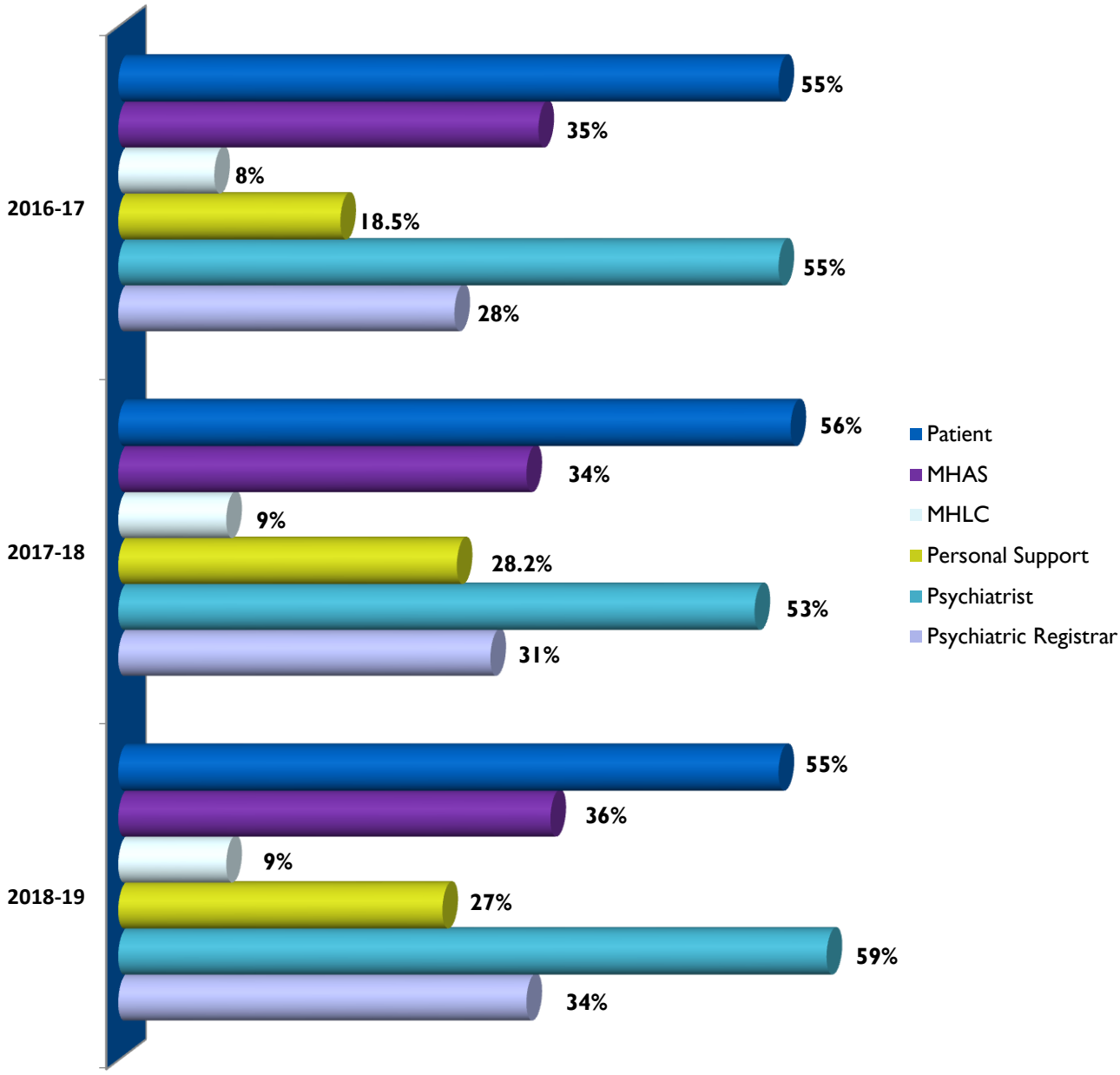
In 2018-19, the Tribunal conducted 2,320 hearings. Patients attended their own hearings 55% of the time. Patients were represented by the Mental Health Advocacy Service (MHAS) at 36% of hearings. Patients were represented by the Mental Health Law Centre (MHLC) at 9% of hearings. Patients had Guardians (appointed under the *Guardianship and Administration Act 1990* (WA) (GA Act)) present at 1.3% of hearings, and family members present at 19% of hearings. Patients attended the hearing with a friend or carer at 6.7% of hearings. Psychiatrists attended 59% of hearings, and psychiatric registrars attended at 34% of hearings (either with a psychiatrist or alone).

Note: multiple parties attend most hearings, so total attendees will exceed the number of hearings.

2018-19 percentage of parties attending hearings



Comparison of percentage of parties attending hearings by year



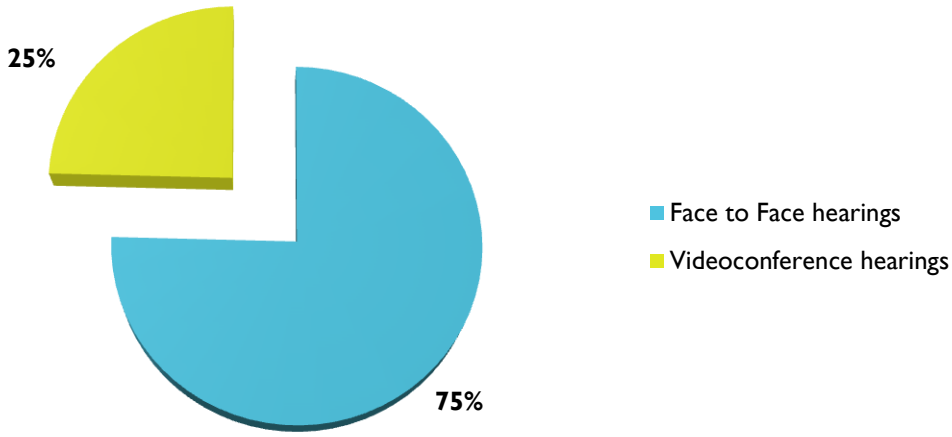
Note: In 2016-17, separate figures for attendance by Guardians, Family, Friends, and Carer/Community support were not reported. As all four categories were combined, direct comparisons are not available for these categories. For the purposes of comparison between 2016-17 and future years, a combined category of 'Personal Support' has been used.

As demonstrated above, there was a small increase in participation by psychiatrists and psychiatric registrars in 2018-19. Additionally, 2017-18 and 2018-19 show an overall increase in personal support for patients at hearings. Participation rates have otherwise been relatively consistent since 2016.

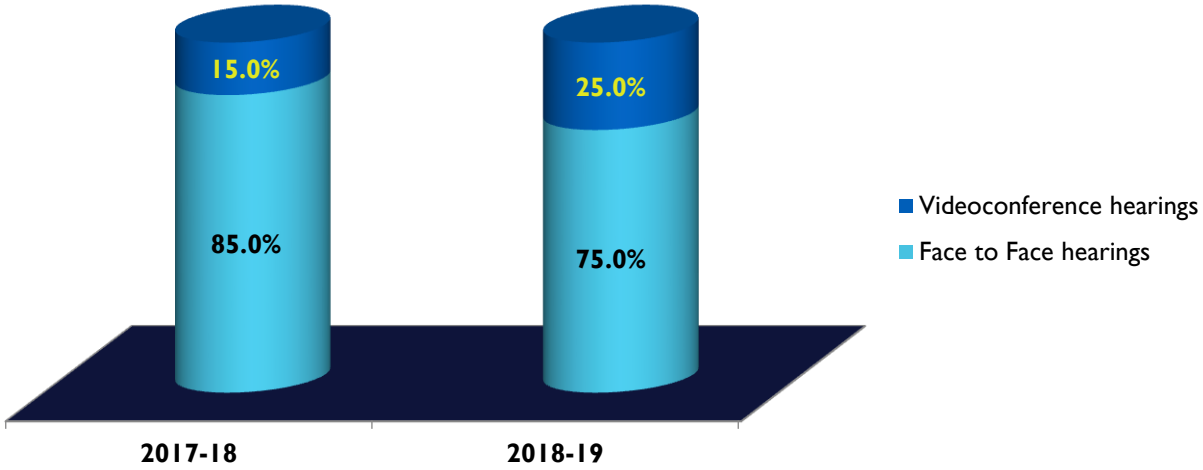
Mode by which hearing conducted

In 2018-19, the Tribunal conducted 1,749 of its 2,320 hearings (75%) in-person at a hospital or clinic. The Tribunal conducted 571 hearings by videoconference (25%). Videoconferences were up by 10% over 2017-18. The increase in the use of videoconference hearings during 2018-19 is a consequence of the security audit referred to in the President's Report. During the two week audit, the Tribunal conducted all hearings by videoconference. Furthermore, because one hospital was unable to provide a safe venue for hearings, the Tribunal conducted hearings at this venue by videoconference during the remainder of the financial year.

2018-19 hearing mode

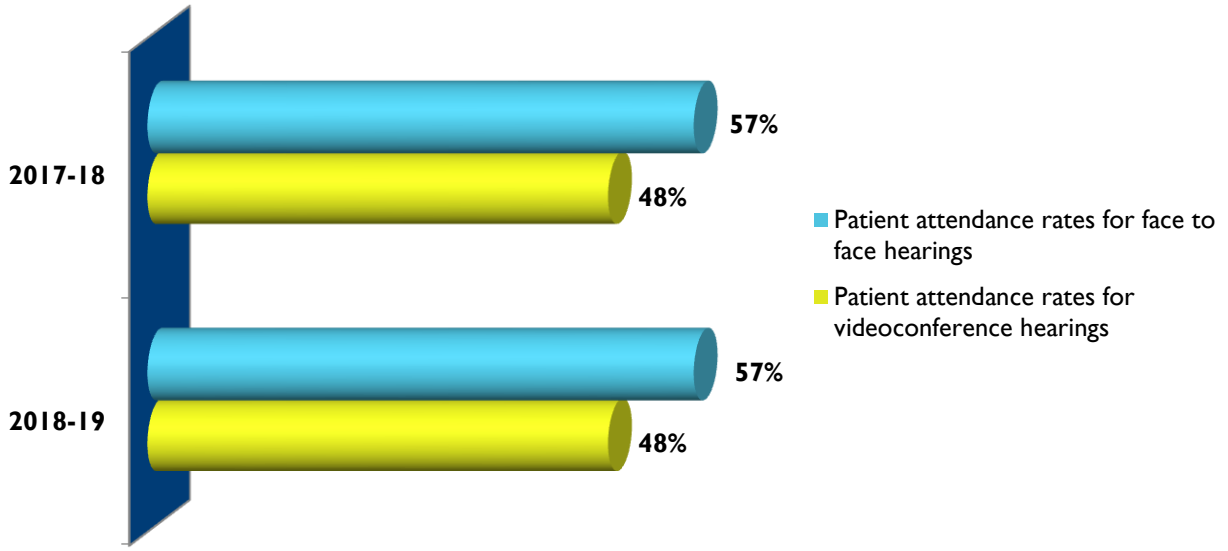


Comparison of hearing mode by year



In 2018-19, patients attended in-person hearings at a rate of 57% and attended videoconference hearings at a rate of 48%. As demonstrated by the graphic below, these percentages have remained relatively consistent since 2017. Data for previous years is not available.

2018-19 Patient attendance rates at hearings by hearing mode

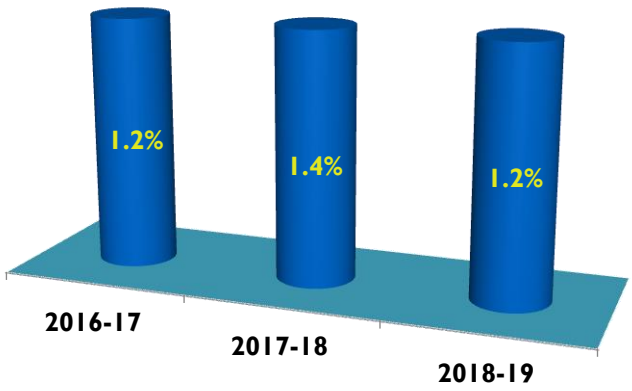


Most videoconferences involve patients living in remote locations. Often there are significant distances between the patient's residence and the location of the videoconference. This affects attendance rates.

Requests for written reasons for decisions

Patients request written reasons for the Tribunal's decision in only a very small percentage of hearings. In 2018-19, the Tribunal provided a written transcript of the reasons for decision on request in 27 out of 2,320 matters (1.2%). This compares with 1.4% in 2017-18 and 1.2% in 2016-17.

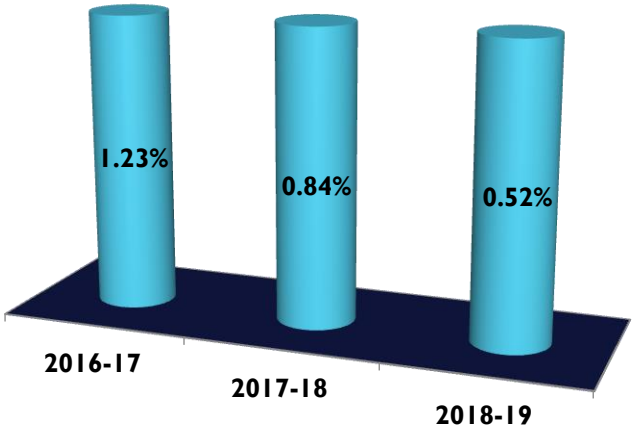
Comparison of percentage of requests for written reasons for decision



Applications to the State Administrative Tribunal for review

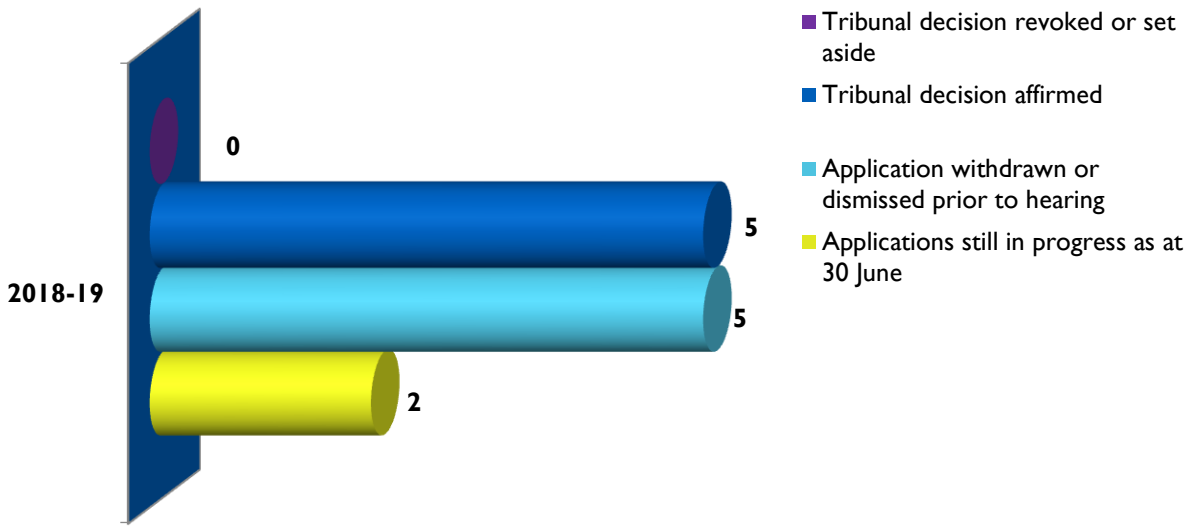
In 2018-19, only 12 out of 2,320 (0.52%) of the Tribunal's decisions were the subject of an application to the SAT for review under section 494 of the Act. As shown below, this number has steadily decreased from 2016-17.

Comparison percentage of review applications to the State Administrative Tribunal by year

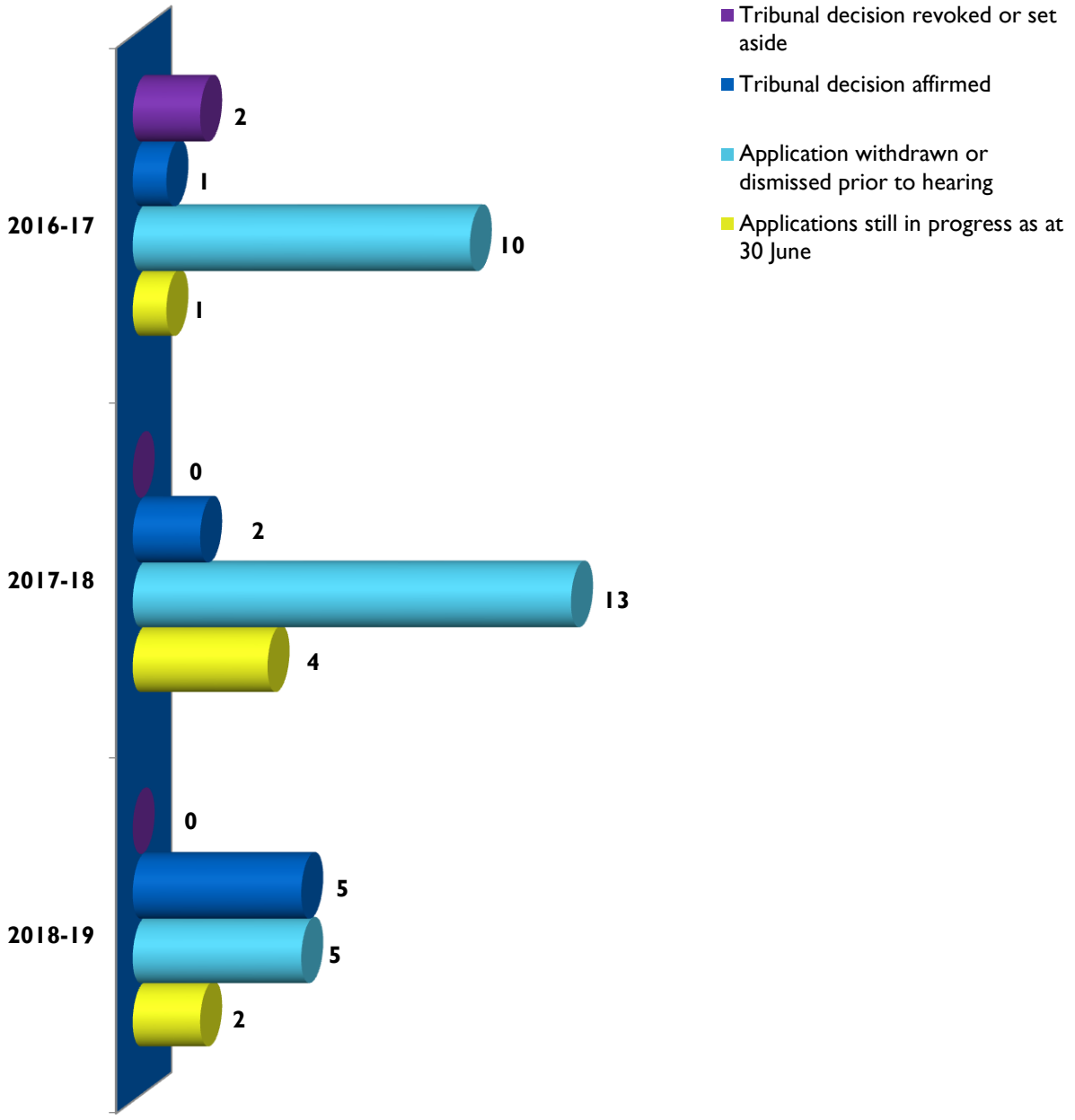


Of these applications, even fewer proceed to a hearing on the merits at the SAT. Most applications fall away because either the psychiatrist revokes the involuntary treatment order prior to hearing or the applicant withdraws the application.

In 2018-19, the SAT affirmed the Tribunal's decision in all five of the matters that proceeded to hearing. Five matters were withdrawn or dismissed. Two applications remained in progress on 30 June 2019.



Comparison outcomes of review applications to the State Administrative Tribunal by year



The SAT determines matters based on the evidence available at the date of its hearing, rather than the materials before the Tribunal at the original hearing. For this reason, the SAT's decision to revoke or set aside a decision of the Tribunal does not necessarily indicate an error on the part of the Tribunal in deciding the matter.

Financial Report

In 2018-19, the Tribunal was funded by Parliamentary appropriation of $2,778,000. This included a non-recurring appropriation of $155,000 from the consolidated account for expenses associated with relocation from privately-owned premises to Government-owned premises at Albert Facey House.

The Tribunal is an affiliated body of the Mental Health Commission within the meaning of section 60(1)(b) of the *Financial Management Act 2006* (WA). Its Parliamentary appropriation is paid directly to, and administered by, the Mental Health Commission.

The Mental Health Commission includes in its Annual Report a financial statement for the Tribunal detailing the amount or value of financial assistance provided by the Mental Health Commission during the financial year.

Appendix One: Tribunal Members at 30 June 2019

Legal Members

Tribunal Member Name	Commencement of Current Term	Expiry of Current Term
Geoffrey Abbott	20 December 2016	19 December 2021
*Kathryn Barker**	*2 May 2017*	*1 May 2022*
Harriette Benz	2 May 2017	1 May 2022
Peter Curry	2 May 2017	1 May 2022
Jeanette De Klerk	2 May 2017	1 May 2022
Andrea McCallum	2 May 2017	1 May 2022
Dr Hannah McGlade	2 May 2017	1 May 2022
Michael Nicholls QC	2 May 2017	1 May 2022
Anne Seghezzi	2 May 2017	1 May 2022
Merranie Strauss	2 May 2017	1 May 2022
Jennifer Wall	2 May 2017	1 May 2022
Karen Whitney	30 December 2017	29 December 2022

Psychiatrist Members

Tribunal Member Name	Commencement of Current Term	Expiry of Current Term
Dr Dawn Barker	1 May 2018	30 April 2023
Dr Ann Bell	1 May 2018	30 April 2023
Dr Emma Crampin	1 May 2018	30 April 2023
Dr Rowan Davidson	20 December 2016	19 December 2021
Dr Daniel De Klerk	1 May 2018	30 April 2023
Dr Kevin Dodd	2 May 2017	1 May 2022
*Dr Alexksandra Jaworska**	*20 December 2016*	*19 December 2021*
Dr Fiona Krantz	1 May 2018	30 April 2023
Dr David Lord	20 December 2016	19 December 2021
*Dr Roland Main**	*20 December 2016*	*19 December 2021*
Dr Elizabeth Moore	1 May 2018	30 April 2023
*Dr Ahmed Munib**	*1 May 2018*	*30 April 2023*
*Dr Steven Patchett**	*2 May 2017*	*1 May 2022*
Dr Nada Raich	2 May 2017	1 May 2022
Dr Mircea Schineanu	1 May 2018	30 April 2023
*Dr Gordon Shymko**	*20 December 2016*	*19 December 2021*

Dr Helen Slattery	20 December 2016	19 December 2021
*Dr Alexander Tait**	*20 December 2016*	*19 December 2021*
Dr Bryan Tanney	2 May 2017	1 May 2022
Dr Gabor Ungvari	20 December 2016	19 December 2021
Dr Helen Ward	1 May 2018	30 April 2023
Dr Anthony Zorbas	2 May 2017	1 May 2022

Community Members

Tribunal Member Name	Commencement of Current Term	Expiry of Current Term
Alan Alford	2 May 2017	1 May 2022
Jennifer Bridge-Wright	2 May 2017	1 May 2022
Reverend Rodger Bull	2 May 2017	1 May 2022
Donna Dean	2 May 2017	1 May 2022
Stuart Flynn	2 May 2017	1 May 2022
John Gardiner	2 May 2017	1 May 2022
Susan Grace	2 May 2017	1 May 2022
Emeritus Prof. David Hawks AM	2 May 2017	1 May 2022
John James	2 May 2017	1 May 2022
Manjit Kaur	2 May 2017	1 May 2022
Lorrae Loud	20 December 2016	19 December 2021
Dr David Rowell	2 May 2017	1 May 2022
Maxinne Sclanders	2 May 2017	1 May 2022
Leone Shiels	2 May 2017	1 May 2022
Anthony Warner AM LVO	2 May 2017	1 May 2022
Ann White	2 May 2017	1 May 2022
The Hon. Keith Wilson AM	2 May 2017	1 May 2022

* *Denotes inactive member – did not participate in Tribunal hearings during the 2018-19 financial year.*

Appendix Two: Strategic Plan 2018 – 2020

our vision

Accessible justice for those whose rights are affected by decisions made under the *Mental Health Act 2014*.

our mission

Safeguarding rights and promoting compliance and accountability under the *Mental Health Act 2014* by:

- Ensuring involuntary treatment authorised under the Act strictly complies with the provisions and objects of the Act;
- Determining applications for treatment by electroconvulsive therapy and psychosurgery;
- Addressing non-compliance with prescribed requirements under the Act; and
- Providing independent review of the validity of involuntary treatment orders, the admission of long-term voluntary patients, the validity and appropriateness of nominated persons, and the reasonableness of certain decisions under the Act restricting freedoms and affecting rights.

our values

- Respect for the law
- Equality before the law
- Fairness
- Impartiality
- Independence
- Accessibility
- Efficiency
- Accountability
- Competence
- Integrity

strategic objectives	action plan
We will achieve high quality patient-centred outcomes in every matter.	▪ The Tribunal will conduct a respectful, fair hearing resulting in a consistent, just decision in every matter by: ✓ conducting hearings in accordance with the principles of procedural fairness; ✓ deciding matters solely on the application of the relevant law to the facts of the case; ✓ making factual findings based on an independent assessment of the quality and weight of the evidence presented, including the expert evidence; ✓ interpreting the law consistently, impartially, and independently; and ✓ treating everyone with fairness, courtesy, tolerance, and compassion. ▪ The Tribunal will meet statutory objects, functions, obligations, and timeframes in every matter by: ✓ ensuring the Tribunal is validly constituted in every matter; ✓ conducting every matter in accordance with the timeframes set out in the Act; ✓ ensuring Tribunal proceedings, notices, orders and reasons are consistent with the Act; ✓ having regard to the mandatory statutory factors required for each matter type; and ✓ ensuring Registry functions comply with the Act.

We will support stakeholder participation in the hearing process.	▪ The Tribunal will provide patients, carers, families, and supporters with the information they need to actively participate in hearings. ▪ The President will make rules and or publish practice directions to ensure that hearing materials (including medical reports) are available to participants sufficiently in advance of hearings to facilitate proper consideration. ▪ The Tribunal will provide a range of convenient participation options (including telephone, videoconference, or in-person). ▪ The Tribunal will ensure participants know their participation at hearings is valuable and contributes to the outcome. ▪ The Tribunal will make information about the Tribunal's processes publically available and will refer participants to these sources of information.
We will improve how we work and maximise our use of technology.	▪ The Tribunal will implement a case management system which facilitates, monitors, and reports on compliance with statutory functions and statutory timeframes and supports the transition to electronic delivery of hearing materials. ▪ The Tribunal will enhance its website to provide greater access to information and Tribunal forms. ▪ The Tribunal will conduct video/tele-conference hearings as required to meet urgent timeframes and maximise Tribunal efficiency. ▪ The Tribunal will transition to an electronic records management system to comply with its statutory record-keeping obligations.
We will build our capacity and make best use of our resources.	▪ The Tribunal will recruit and reappoint members solely on the basis of merit through an open recruitment process. ▪ The President will develop and implement a mandatory continuing professional development program for members. ▪ The Tribunal will appoint members on a full-time, part-time, or sessional basis as required to ensure availability and to maximise Tribunal efficiency. ▪ Tribunal members will demonstrate mastery of the core competencies identified in the COAT Tribunal Competency Framework, conduct themselves in accordance with relevant Codes of Conduct, and demonstrate commitment to ongoing development. ▪ The Tribunal Registry will utilise best practice in case flow management. ▪ The Tribunal Registry will articulate its administrative processes in a manual which will be publically available. ▪ The President will commence implementation of the COAT Tribunal Excellence Framework. ▪ The President will maintain links and exchange ideas with Mental Health Tribunals and other Tribunals throughout Australia. ▪ All members and staff will demonstrate a commitment to best practice and maximising Tribunal efficiency.

Appendix Three: Relevant Principles – *Mental Health Act*

Section 10 - Objects of the *Mental Health Act 2014*

(1) The objects of this Act are as follows —

(a) to ensure people who have a mental illness are provided the best possible treatment and care —

(i) with the least possible restriction of their freedom; and

(ii) with the least possible interference with their rights; and

(iii) with respect for their dignity;

(b) to recognise the role of carers and families in the treatment, care and support of people who have a mental illness;

(c) to recognise and facilitate the involvement of people who have a mental illness, their nominated persons and their carers and families in the consideration of the options that are available for their treatment and care;

(d) to help minimise the effect of mental illness on family life;

(e) to ensure the protection of people who have or may have a mental illness;

(f) to ensure the protection of the community.

(2) A person or body performing a function under this Act must have regard to those objects.

Schedule 1 - Charter of Mental Health Care Principles

Purpose

The Charter of Mental Health Care Principles is a rights-based set of principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness.

The Charter is intended to influence the interconnected factors that facilitate recovery from mental illness.

Principle 1: Attitude towards people experiencing mental illness

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.

Principle 2: Human rights

A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

Principle 3: Person-centred approach

A mental health service must uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including by recognising life experiences, needs, preferences, aspirations, values, and skills, while delivering goal-oriented treatment, care, and support.

A mental health service must promote positive and encouraging recovery-focused attitudes towards mental illness, including that people can and do recover, lead full and productive lives and make meaningful contributions to the community.

Principle 4: Delivery of treatment, care and support

A mental health service must be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is consistent with their needs.

Principle 5: Choice and self-determination

A mental health service must involve people in decision-making and encourage self-determination, cooperation and choice, including by recognising people's capacity to make their own decisions.

Principle 6: Diversity

A mental health service must recognise and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

Principle 7: People of Aboriginal or Torres Strait Islander descent

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

Principle 8: Co-occurring needs

A mental health service must address physical, medical, and dental health needs of people experiencing mental illness and other co-occurring health issues, including physical and intellectual disability, and alcohol and other drug problems.

Principle 9: Factors influencing mental health and wellbeing

A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, accommodation, recreation, education, financial circumstances and employment.

Principle 10: Privacy and confidentiality

A mental health service must respect and maintain privacy and confidentiality.

Principle 11: Responsibilities and dependants

A mental health service must acknowledge the responsibilities and commitments of people experiencing mental illness, particularly the needs of their children and other dependants.

Principle 12: Provision of information about mental illness and treatment

A mental health service must provide, and clearly explain, information about the nature of the mental illness and about treatment (including any risks, side effects, and alternatives) to people experiencing mental illness in a way that will help them to understand and to express views or make decisions.

Principle 13: Provision of information about rights

A mental health service must provide, and clearly explain, information about legal rights, including those relating to representation, advocacy, complaints procedures, services and access to personal information, in a way that will help people experiencing mental illness to understand, obtain assistance, and uphold their rights.

Principle 14: Involvement of other people

A mental health service must take a collaborative approach to decision making, including respecting and facilitating the right of people experiencing mental illness to involve their family members, carers and other personal support persons in planning, undertaking, evaluating, and improving their treatment, care and support.

Principle 15: Accountability and improvement

A mental health service must be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the treatment, care and support of people experiencing mental illness, including their family members, carers and other personal and professional support persons.

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