Mental Health Carers NSW

Mental Health Carers NSW Inc.

Submission to the Committee on Law and Safety on the operation of the forensic division of the Mental Health Review Tribunal

Date of Submission 07 July 2026

Prasheela Karan, Policy and Advocacy Manager
Richard Baldwin, Senior Policy Officer
Jonathan Harms CEO

For enquiries about this submission contact

Prasheela Karan, prasheela.karan@mentalhealthcarersnsw.org

For general inquiries:
02 9332 0777
mhcnadmin@mentalhealthcarersnsw.org

Mental Health Carers NSW

Mental Health Carers NSW

About Mental Health Carers NSW (MHCN)

Mental Health Carers NSW (MHCN) is the peak body for carers of people who experience mental health challenges in NSW. MHCN is a community managed organisation that provides systemic advocacy, capacity development and education for the carers, family, friends, and kin of those experiencing mental health challenges across NSW.

In Australia, there are approximately 354,000 mental health carers who, each year, provide 186 million hours of unpaid support.[1] Due to the demands of their caring role, carers are at a high risk of developing mental health issues, as well as experiencing loneliness and social isolation. MHCN supports mental health carers and advocates for services and systems that support them in their caring role. MHCN ensures the voices of mental health carers in NSW, and the people they care for, are represented in policy and service reform processes. We work to uphold the rights of carers and consumers to equitable, accessible, and adequately funded mental health services.

MHCN empowers mental health carers to become champions for mental health reform and advocacy. We engage regularly with carers so they can inform our policy priorities and advocacy; for example, every month we convene the *Carers of Forensic and Corrections Patients Network* meetings, and peer led *Mental Health Carer Connection* meetings.

MHCN also provides the Disability Advocacy Futures Program. This program engages in systemic advocacy on behalf of those who experience psychosocial disability. In this role MHCN advocates to non-Health state government services under the Disability Advocacy Futures Program.

MHCN is funded by the NSW Ministry of Health and the NSW Department of Communities and Justice. We are a foundation member of Mental Health Carers Australia.

[1] Diminic, S., Lee, Y. Y., Hielscher, E., Harris, M. G., Kealton, J., & Whiteford, H. A. (2021). Quantifying the size of the informal care sector for Australian adults with mental illness: Caring hours and replacement cost. *Social Psychiatry and Psychiatric Epidemiology, 56*(3), 387–400.

Mental Health Carers NSW

Executive Summary

The Inquiry into and report on the operation of the forensic division of the Mental Health Review Tribunal (MHRT) provides an opportunity to raise key issues for persons involved with mental health and justice health systems, as well as their families and carers. This submission by Mental Health Carers NSW (MHCN) focuses on the meaningful participation of families and carers in Tribunal hearings. The perspectives in MHCN's submission are much needed, particularly as there is a dearth of research/publicly available evidence on the effectiveness of the Tribunal processes for supporting carer participation.

The Tribunal should continue to strengthen the participation of carers through:

- Providing a transcript to participating or officially recognised families and carers (Designated Carers/Principal Care Providers) of the hearing
- Ensuring carers have the opportunity ask questions and be heard during hearings
- Reports by the Tribunal should identify whether (and how many) carers were consulted by the treating team
- The Tribunal should require treating teams to consult carers before every review
- The Tribunal should ask the treating team during every hearing –
    - "Has the designated carer / principal care provider been consulted?" "What is the view of the carer?"
- Reasons for not communicating with the carer by the treating team should be documented in the record
- The Tribunal should maintain responsibility for timely notification of hearings to carers and directly send notifications to carers
- The way adjournments of hearings are managed should consider the needs of persons receiving care and treatment, as well as their families and carers (rather than being based on internal constraints within the Tribunal)
- The Tribunal should ensure that the methods used to inform carers use up to date technology, are typed and not handwritten and the form used is carer friendly and contains accurate information, which is delivered in a timely fashion.
- The Tribunal should publicly make available annual statistics on carer participation in Tribunal proceedings, including with reference to:
    - How often the Tribunal has adjourned a hearing when/if it considers that information from a carer has not been obtained, which could affect the decision
    - How often the Tribunal has commented on the lack of consultation / low quality of consultation of families and carers by the treating team.

Scope of this Submission

This submission is based on the collective experience of the carers who are members and staff of Mental Health Carers NSW.

Mental Health Carers NSW

Introduction

Mental Health Carers NSW (MHCN) welcomes the opportunity to provide a submission to the Inquiry into and report on the operation of the forensic division of the Mental Health Review Tribunal (MHRT). MHCN is pleased to respond to this inquiry and provide much needed perspectives on the experiences of families and carers supporting a person in the justice health system.

Families and carers have an important role in supporting long-term recovery. Carers have access to longitudinal and subtle information that could affect the outcomes of a hearing. While carers have had some positive experiences with the Tribunal, they have also experienced some barriers to meaningful participation in hearings.

There is a dearth of research/publicly available information on the effectiveness of the Tribunal's processes for supporting carer participation. MHCN's submission provides information on areas where current arrangements could be strengthened to address the barriers and offers recommendations.

Specifically, this submission focuses on issues relating to: Carers receiving timely communication, access to transcription/notes of hearings, use of audio-visual technology for hearings, notification of hearings, adjournments by the Tribunal, and concerns pertaining to engagement with treating teams which have implications for carer inclusion.

Meaningful Family and Carer Participation

As the peak body for the carers of people with mental health issues, our members and participants engage with us through several and differing venues and events. Over time we have received feedback from carers on the work of the Mental Health Review Tribunal, including from carers who have had an engagement with the Tribunal over a long period. Carers have reported to MHCN some positive experiences with the Tribunal. However, there are several areas of concern as demonstrated through these three cases sent to MHCN by a carer:

Case 1 – Carers are at a disadvantage of not being permitted to take notes or record the proceedings / get a transcript of the hearing.

> *As Tribunals can be overwhelming, carers may not always understand or remember everything that was said in the meeting; carers may also want to read over their notes after the meeting to confirm all that was documented was correct. Also, not all the carers may be able to attend the hearings. Rarely is the paperwork sent out to either the carer or consumer. If it is, by the time it is received it is too late to have any input into the hearing.*

Case 2: "Depending on the Chairperson at the time I have found some will not listen to the carers".

> *As in our case, there have been a few times where the Chairperson was not carer friendly and did not give the carers time to ask questions and we were dismissed with what we were trying to say. This, I must say, was only twice where this has occurred to us.*

- **That the correct interpretation was not recorded.**

> *After one Tribunal hearing incorrect documentation was written. We did not know this until the next tribunal hearing 6 months later. We tried to resolve the matter, but the tribunal panel refused to acknowledge that they had made a mistake in documenting what the consumer said. I then wrote an email to the Tribunal stating my concerns. [See Appendix for letter]*

Other feedback from Mental Health Carers

Use of audio-visual technology for hearings

Carers inform us that the conduct of hearings by audio visual technology is often to their disadvantage. Carers often don't have the level of technology that would enable them to properly participate in and contribute to the proceedings. Carers have repeatedly expressed a preference for face-to-face meetings. Support for their virtual participation should be afforded when this is not possible.

Notification of hearings

A long-standing complaint by carers, in relation both to the forensic and general divisions of the MHRT is the lack of notification, or late notice, of hearings. The notification form given to carers is not carer centred or accessible. It is bureaucratic in language, form and layout, and is quaintly designed to be handwritten and posted. When handwritten the writing is often illegible and the details of where to find the hearing room are often missing. Notification by post minimises speed of delivery.

While we recognise that notifying families and carers is the responsibility of the treating team at the health service where the consumer is cared for, many carers have asked why the notification does not come from the MHRT. It is the MHRT that is holding the hearing, and it should be the responsibility of the Tribunal to notify those concerned. As noted above, treating teams have been consistently demonstrated to be unable to provide timely (or any) notification to carers on many occasions and so should be relieved of this obligation.

It is a poor reflection of the MHRT that the communications to the carer about hearings remain haphazard, of poor quality and often of poor timing and the Tribunal should take steps to rectify this.

Adjournments by the MHRT

Recently a carer informed us that a hearing in relation to a community treatment order, had been adjourned after it had started, for two weeks. Apparently, the decision was made by the Tribunal due to the absence of a key medical staff member. While these absences cannot always be avoided, the delay of two weeks caused considerable inconvenience, anxiety, and concern to the family. It also required the consumer to wait an additional two weeks for the appropriateness of their involuntary detention to be confirmed. The family, on this occasion, could not understand why such a long delay was approved when the MHRT holds numerous hearings every week. It appeared that the two-week adjournment was because of the convenience of the Tribunal and/or the recalcitrant clinician and for no other reason.

The way that adjournments of hearings are managed are not person-centred but appear to follow an institutional centred approach. They favour the Tribunal and the hospital staff at the expense of the liberty of the consumer and participation of their families.

Consultation Needed by the Treating Team

MHCN has been advised that a representative of the Tribunal has written a letter to a relevant clinical leadership staff in the past at the Long Bay Hospital Mental Health Unit asking that families and carers be consulted by the Treating Team. However, MHCN has since then, and even until recently, been informed that the treating team does not regularly consult families and carers. This is even though families and carers possess longitudinal and subtle information unavailable to clinicians, especially during short admissions.

MHCN reiterates that excluding, or failing to take the trouble to seek relevant carer evidence may affect the accurate assessment of relapse history, medication management and adherence, awareness of risks in the community (noting that families and carers are often the victims/included among the victims), housing stability, family supports, discharge planning, and access too / effectiveness of community treatment.

Lack of preparation by the treating team

Lack of preparation by the treating team can result in traumatising questions being asked of carers. In one case, that MHCN was advised about, a family member was abruptly asked about their immediate family member, who was in fact killed by the person receiving care. The member of the treating team who had asked this question was not aware that the immediate family member had

been killed. This left the family member feeling distraught and emotional. In addition, there did not appear to be any support provided by the team for managing their distress arising from this situation.

- **Lack of a trauma informed approach**

MHCN has been informed of cases where there is a lack of concern and rudeness towards families and carers, i.e., instead of understanding that families have valuable information to contribute and would be worried about, and have a right to understand, the wellbeing and health of their person, MHCN has been informed that families have been subjected to abrupt questions along the lines of "Why do you want to know?". Families and carers might not know how to start the conversation, and which questions to ask, which is not assisted by hostility from staff.

Visiting forensic and correctional facilities is daunting and an approach which recognises what families and carers are experiencing and supports the full enjoyment of their rights under the Mental Health Act is needed. In addition, families and carers often travel long distances (back and forth) to visit their person. They experience significant distress in visiting facilities, however they do so because of concern for their person's welfare.

Recommendations

The Tribunal should continue to strengthen the participation of carers via the following mechanisms:

- Provide a transcript to participating or officially recognised families and carers (Designated Carers/Principal Care Providers) of the hearing
- Ensure carers have the opportunity to ask questions and be heard during hearings
- Reports by the Tribunal should identify whether (and how many) carers were consulted by the treating team
- The Tribunal should require treating teams to consult carers before every review
- The Tribunal should ask the treating team during every hearing –
    - "Has the designated carer / principal care provider been consulted?"
    - "What is the view of the carer?"
- Reasons for not communicating with the carer by the treating team should be documented in the record
- The Tribunal should maintain responsibility for timely notification of hearings to carers – the notification of hearings should be sent directly from the Tribunal to carers

- The way adjournments of hearings are managed should consider the needs of persons receiving care and treatment, as well as their families and carers (rather than being based on internal constraints within the Tribunal)
- The Tribunal should ensure that the methods used to inform carers use up to date technology, are typed and not handwritten and the form used is carer friendly and contains accurate information delivered in a timely fashion, allowing enough time for them to realistically be able to participate.
- The Tribunal should publicly make available annual statistics on carer participation in Tribunal proceedings, including with reference to:
    - How often the Tribunal has adjourned a hearing when/if it considers that information from a carer has not been obtained, which could affect the decision
    - How often the Tribunal has commented on the lack of consultation / low quality of consultation of families and carers by the treating team.

Mental Health Carers NSW

Appendix – Letter by a Carer to the Tribunal

To: The Registrar

Mental Health Tribunal – Forensic Department

Subject: Request for Correction of Incorrect Statement in Tribunal Documents

I am writing to lodge a formal complaint and request a correction regarding an incorrect statement that I was informed about following my recent appearance before the Mental Health Tribunal – Forensic Department.

"**The tribunal stated that I said I wanted to stay overnight in a ……..**"

However, what was actually said by me and what the accurate information should be is: **"I would never stay at a …… now or in the future**".

During the proceedings, or in subsequent discussion, the Chairperson informed me that a statement had been previously recorded at the last tribunal by a member of your staff who has obviously misunderstood what I said.

I have not yet had the opportunity to review the official document myself, as I have not been sent the transcripts/orders but I wish to make it clear that the statement, as described to me at my tribunal hearing, is incorrect and misleading.

This error misrepresents the facts and could have a significant impact on how my situation is understood or assessed for my case and ongoing management as any misunderstanding could have implications.

I respectfully request that this matter be formally investigated and corrected in the records and that I be provided with confirmation once the correction has been made.
I also ask that I be provided with a copy of the relevant document or section in which the statement appears, so that I can confirm and clarify the exact wording that requires correction.

It is important to me that the Tribunal's records accurately reflect the facts.
To clarify this matter, I am requesting copies of the full transcripts from my last two Tribunal hearings. I would like the opportunity to verify exactly what was said and ensure that the records accurately reflect the proceedings.

Please confirm receipt of this letter and advise me of the next steps to have the record corrected.

Thank you for your attention to this matter.