Mental Health Tribunal

Annual Report 2021-**2022**

Protecting the rights and dignity of people with mental illness

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10 August 2022

The Honourable Gabrielle Williams MP
Minister for Mental Health
Level 3, 1 Treasury Place,
East Melbourne Vic 3002

Dear Minister

I am pleased to present the Mental Health Tribunal's annual report of its operations for the period 1 July 2021 to 30 June 2022.

Yours sincerely

Matthew Carroll
President

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President's Message

It has been nothing short of breathtaking to observe the volume and breadth of the work currently underway to implement the recommendations of the Royal Commission into Victoria's Mental Health System. Alongside other entities and stakeholders, the Mental Health Tribunal (Tribunal) has contributed to some of these initiatives, particularly the development of the Mental Health and Wellbeing Bill.

The Bill was still being considered by the Victorian Parliament at the time of finalising this report, but its provisions largely preserve the Tribunal's current functions. This is not to suggest the implications of a new Act will not be profound for the Tribunal. Assuming the Bill passes, it will be a complex piece of work to prepare for the commencement of a new Act. However, with similar functions it will mean the focus of our capacity building can be on understanding the completely different service system the Act will establish, and the implications of the strengthened mental health principles. The Tribunal looks forward to engaging with these reforms and being part of a whole-of-system shift in relation to compulsory treatment. Most immediately, we look forward to contributing to the review of the legal framework for compulsory treatment that is planned to commence later in 2022.

A central pillar of the recommendations of the Royal Commission is that people with lived experience of mental illness or psychological distress, their family members, carers and supporters must be central to the planning and delivery of mental health treatment, care and support services. The Tribunal is committed to promoting this objective. To this end, we took some important steps this year that built on a strong foundation.

Shortly after its creation, the Tribunal established a Tribunal Advisory Group (TAG) comprising people with lived experience as a consumer or carer, as well as members of the lived experience peer workforce. The TAG is an equal partner in setting the Tribunal's strategic plan and is part of the full life cycle of projects being implemented under the plan. As in previous years, this annual report highlights a range of initiatives that have relied on working in partnership with the TAG, and I thank all the TAG members for their vital and generous contribution.

The notion of 'a seat at the table' is often cited in discussions about elevating lived experience – people with lived experience must be part of decision-making fora. The Tribunal's Consumer and Carer Engagement Officer has always been a member of the Tribunal's Governance Group, and this year we expanded on that. The Tribunal's Governance Group now also includes a Tribunal member with lived experience as a consumer, and a Tribunal member with lived experience as a carer. In addition to their role in organisational decision-making, these members also play a critical role in facilitating peer support for members with lived experience, and act as a conduit for their ideas and perspective on critical issues.

In outlining what has been achieved, it is important to stress we see ourselves at the beginning not the end of this process of change. Creating and maintaining an environment where the value and importance of the lived experience perspective is understood and appreciated is a shared responsibility of all Tribunal members and staff. It applies in the context of hearings as well as more broadly and is an ongoing process of reflection and improvement.

Matters concerning the Tribunal's functions and decision-making under the *Mental Health Act 2014* (the Act) are rarely considered by the Supreme Court, but this year in the matter of *JL v Mental Health Tribunal* [2021] VSC 868 (JL's case), important guidance was provided on two issues. Over the life of the Act there has been a question about the impact of irregularities and errors made in clinical settings in the process of making Assessment Orders and Temporary Treatment Orders. In brief, do such errors mean the Tribunal lacks jurisdiction to conduct a hearing?

The Tribunal's preferred approach has been to proceed with a hearing, not because errors are unimportant or inconsequential, but because our responsibility under the Act is to determine whether or not to make a Treatment Order. In JL's case the Court decided the error in the relevant Temporary Treatment Order (a failure to indicate whether it was for inpatient or community treatment) rendered it invalid. But the Court also confirmed the invalidity did not mean the Tribunal had no jurisdiction to conduct the hearing. If a person is made subject to a Temporary Treatment Order as a matter of fact, the Tribunal has jurisdiction to hear the matter. The Court held that the Tribunal is not required to investigate whether the Temporary Treatment Order under which a person is being treated was validly made. Rather, 'the Act expects the Tribunal will consider the person's present circumstances and decide whether a Treatment Order should be made'. According to the Court, an interpretation of the Act that allows the path to the Tribunal to be followed promptly best achieves the purpose, objectives and policy of the Act.

In JL's case, the Court also considered whether the Tribunal had discharged its obligations as a public authority under Victoria's *Charter of Human Rights and Responsibilities* (the Charter), particularly the obligation to give proper consideration to human rights when making a decision. Reassuringly, the Court concluded the Tribunal had complied with the Charter. The Court rejected the view that the Tribunal's statement of reasons demonstrated inadequate engagement with human rights. The Court determined when taken as a whole, the statement of reasons addressed the substance of the factors in the Charter that the Tribunal

was required to consider. Essentially, his Honour Justice Ginnane held that by assessing the evidence before it, considering the treatment criteria and explaining the reasons they were met, as well as the reasons for the setting and duration of the Order that was made, the Tribunal had given proper consideration to JL's human rights.

This is the third annual report that covers operations during the COVID-19 pandemic. In the first half of 2021–22 the Tribunal completed the transition to online hearings using the MS Teams platform. Online hearings have worked effectively, and we continue to look at ways of enhancing the experience of all hearing participants in an online setting. In May 2022, we undertook a survey of Health Services, legal representatives and Tribunal members seeking their views on what our future hearing model or processes might look like. Combined with our 2022 Tribunal Hearing Experience survey of consumers and carers (extended to run until August), this will provide the Tribunal with a detailed and broad sense of preferences and ideas for how the Tribunal might conduct hearings in the future.

Determining a future model is extremely complex. We need to retain the ability to offer hearing participants options for how they attend hearings, otherwise we may jeopardise their participation. Before March 2020, in-person hearings were paper-based while our processes are now paperless and require very different IT infrastructure. Critically, given the settings where in-person hearings are conducted, our process needs to be flexible, because as the winter COVID-19 wave has demonstrated, there will be times when attending hospitals and clinics will not be possible. It will take the Tribunal time to work out 'where to next', but an immediate priority will be to develop processes to respond flexibly to the needs of individuals for whom online hearings are not satisfactory. More broadly, we will assess what is possible based on the prevailing circumstances, and what is manageable in a year when preparing for legislative reform will consume a significant proportion of our capacity.

Whether it is the large number of hearings reported on in the second part of this report, or the projects and policy initiatives summarised in part three, none of this work would be possible without the commitment and skill of the remarkable staff and members of the Tribunal. Our work is also enabled through collaboration with and support from a number of stakeholders. Thank you all for your ongoing support of the Tribunal.

Matthew Carroll
President

Membership changes during 2021-22

Over the course of 2021-22 three Tribunal members retired. We acknowledge the contribution of and say farewell to psychiatrist members Dr Jo FitzGerald, Dr Stella Kwong and Dr Grant Lester.

...'the Act expects the Tribunal will consider the person's present circumstances and decide whether a Treatment Order should be made'. According to the Court, an interpretation of the Act that allows the path to the Tribunal to be followed promptly best achieves the purpose, objectives and policy of the Act.

Introduction to the Mental Health Tribunal

The Mental Health Tribunal (the Tribunal) is an independent statutory tribunal established under the Victorian *Mental Health Act 2014* (the Act).

The Tribunal is an essential safeguard under the Act to protect the rights and dignity of people with mental illness. The primary function of the Tribunal is to determine whether the criteria for compulsory mental health treatment as set out in the Act apply to a person. The Tribunal makes a Treatment Order for a person if all the criteria in the legislation apply to that person.

A Treatment Order enables an authorised psychiatrist to provide compulsory treatment to the person, who will be treated in the community or as an inpatient in a designated mental health service for a specified period. The Tribunal also reviews variations in Treatment Orders and hears applications for the revocation of an Order.

The Tribunal also determines:

- whether electroconvulsive treatment (ECT) can be used in the treatment of an adult who does not have capacity to give informed consent to ECT, or any person under the age of 18
- a variety of matters relating to security patients (prisoners or people on remand who have been transferred to a designated mental health service for compulsory treatment)
- applications to review the transfer of a patient's treatment to another mental health service
- applications to perform neurosurgery for mental illness.

Our vision

That the principles and objectives of Victoria's mental health legislation are reflected in the experience of consumers and carers.

Our mission

The Tribunal decides whether a person receives compulsory treatment under Victoria's mental health legislation. Our hearings focus on human rights, recovery, least restrictive treatment and the participation of consumers, carers and clinicians.

Our values

We value lived experience and are:

- Fair
- Respectful
- Collaborative

Our strategic priorities for 2021-2024

- Contribute to implementing the recommendations of the Royal Commission into Victoria's Mental Health System
- Continue to innovate our hearing processes with a focus on operating flexibly to respond to individual needs and improving our environmental sustainability
- Ensure fair, consistent, and solution-focused hearings.

Our obligations under the Charter of Human Rights and Responsibilities

As a public authority under the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter), the Tribunal must adhere to a number of human rights obligations. The Charter requires the Tribunal to give proper consideration to all relevant human rights when making decisions; it must also act compatibly with human rights. This requires the Tribunal to be attuned to the potential impact on human rights of all our activities. In addition, when undertaking the specific task of interpreting the Act, the Tribunal must do so in a way that is compatible with human rights, provided doing so is consistent with the purpose of the Act.

Part 1 Functions, procedures and operations of the mental health tribunal

1.1 The Tribunal's functions under the *Mental Health Act 2014*

The functions of the Tribunal as set out in s153 of the Act are to hear and determine the following:

- an application for a Treatment Order to be made
- an application to revoke a Temporary Treatment Order or Treatment Order
- an application to review the transfer of a compulsory patient to another designated mental health service
- an application for an Order to allow electroconvulsive treatment to be used in the treatment of an adult who does not have capacity to give informed consent, or any person under the age of 18
- an application to perform neurosurgery for mental illness
- a range of applications and reviews to determine whether a person continues to satisfy the relevant criteria to be treated as a security patient
- an application by a security patient in relation to refusal of leave of absence
- an application by a security patient for a review of a direction to be taken to another designated mental health service
- applications about the proposed interstate transfer of a compulsory patient

and to perform any other function which is conferred on the Tribunal under the Act, the regulations or the rules.

1.1.1 Treatment Orders

Temporary Treatment Orders and Treatment Orders

An authorised psychiatrist may make a Temporary Treatment Order of 28 days duration. The Tribunal is notified that a person has been placed on a Temporary Treatment Order and the Tribunal is required to list a hearing before the expiry of the 28-day period. This hearing is to determine whether or not the criteria are met to make a Treatment Order.

The Tribunal must be satisfied that all of the treatment criteria apply to a person before making a Treatment Order. These criteria are:

- the person has mental illness
- because the person has mental illness, the person needs immediate treatment to prevent:
  - serious deterioration in the person's mental or physical health or
  - serious harm to the person or another person
- the immediate treatment will be provided to the person if the person is subject to a Treatment Order
- there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

When the Tribunal makes an Order, the Tribunal must determine the category of the Order, being a Community Treatment Order or an Inpatient Treatment Order, based on the circumstances in existence at the time of the hearing.

The patient's treating team is required to regularly reconsider both the need for an Order (i.e. if the treatment criteria are no longer applicable, the Order should be revoked) and the treatment setting (a patient can only be on an inpatient Order if their treatment cannot occur in the community).

The Tribunal also determines the duration of a Treatment Order. The maximum duration of a Community Treatment Order is 12 months, while an Inpatient Treatment Order can be for up to six months. Where the patient is under 18 years of age, the maximum duration of any Treatment Order is three months.

In relation to Inpatient Treatment Orders, it is important to distinguish between the duration of the Order and the length of time a patient spends in hospital. In the vast majority of matters, the former will exceed the latter – meaning the patient will leave hospital when able to be treated in the community, and if that treatment needs to be on a compulsory basis, the Order will operate as a Community Treatment Order for the remainder of its duration.

A person who is subject to a Temporary Treatment Order or Treatment Order (or particular persons on their behalf) may apply to the Tribunal at any time while the Order is in force to have the Order revoked. The determination of the Tribunal must be to either revoke the Order or make a new Treatment Order (setting the duration and category).

Security patients

A security patient is a patient who is subject to either a Court Secure Treatment Order or a Secure Treatment Order.

A Court Secure Treatment Order (CSTO) is an Order made by a court to enable the person to be compulsorily taken to, and detained and treated in, a designated mental health service. A court may make a CSTO where the person is found guilty of an offence or pleads guilty to an offence and the relevant provisions specified in the sentencing legislation apply. The Order cannot exceed the period of imprisonment to which the person would have been sentenced had the Order not been made. Pursuant to s273 of the Act, the Tribunal is required to conduct a hearing within 28 days after the designated mental health service receives a security patient subject to a CSTO to determine whether the criteria for a CSTO apply to the security patient, and thereafter at intervals of no more than six-months and on an application made by the security patient (or by a person on their behalf).

A Secure Treatment Order is an Order made by the Secretary to the Department of Justice and Community Safety that enables a person to be transferred from a prison or other place of confinement to a designated mental health service where they will be detained and treated. Pursuant to s279 of the Act, the Tribunal is required to conduct a hearing within 28 days after the designated mental health service receives the security patient to determine whether the relevant criteria apply to the security patient, and thereafter at intervals of no more than six-months, or on an application made by the security patient (or by a person on their behalf).

If the Tribunal is satisfied that the relevant criteria do apply to a security patient, the Tribunal must order that the person remain a security patient. If the criteria do not apply, the Tribunal must order that the person be discharged as a security patient. If a security patient is discharged, they are returned to prison custody for the remaining duration of their sentence or remand period.

A security patient may also apply for review of the authorised psychiatrist's decision not to grant a leave of absence. The Tribunal can either grant, or refuse, the application for review.

Transfer to another designated mental health service and interstate transfers

Compulsory and security patients can apply for review of a direction to take them from one designated mental health service to another within Victoria. The Tribunal can either grant, or refuse, the application for review.

If it is done with their consent and certain pre-conditions are met, a compulsory patient can be transferred to an interstate mental health service without the need to involve the Tribunal. If a compulsory patient is unable to consent, or is refusing, the authorised psychiatrist or Chief Psychiatrist may apply to the Tribunal for an interstate transfer of a Treatment Order for a compulsory patient. The Tribunal may either grant, or refuse, the application.

1.1.2 Electroconvulsive treatment (ECT)

The Tribunal determines whether ECT can be used in the treatment of an adult if they are considered to not have capacity to give informed consent to ECT, or for any person under the age of 18.

If one or more of the criteria is not met, the Tribunal must refuse the Order. If the criteria are met, when making an Order the Tribunal must set the duration of the ECT Order (up to a maximum of six months) and the number of authorised ECT treatments (up to a maximum of 12).

For adults, whether they are on a Treatment Order or voluntary patients, the Tribunal may only approve ECT if it is satisfied that:

- the person does not have capacity to give informed consent and
- there is no less restrictive way for the patient to be treated.

For voluntary adults there is an additional requirement that either:

- they have an instructional directive in an advance care directive giving informed consent to ECT or
- their medical treatment decision maker has given informed consent in writing to the treatment.

For compulsory patients aged under 18 years, the Tribunal may only approve ECT if it is satisfied that they:

- have given informed consent or
- do not have capacity to give informed consent and there is no less restrictive way for the young person to be treated.

If the young person is a voluntary patient and does not have capacity to give informed consent, then a person who has the legal authority to consent to treatment for the young person can give informed consent in writing. For ECT to be approved, the Tribunal must also determine that there is no less restrictive way for the young person to be treated.

ECT applications must be listed and heard within five business days after receiving the application. Urgent ECT applications must be listed and heard as soon as practicable and within five business days. An urgent hearing of the application may be requested if the psychiatrist making the application is satisfied that the course of ECT is necessary to save the person's life, prevent serious damage to their health or to prevent significant pain or distress.

1.1.3 Neurosurgery for mental illness (NMI)

Neurosurgery for mental illness is defined by s3 of the Act to include:

- any surgical technique or procedure by which one or more lesions are created in a person's brain on the same or on separate occasions for the purpose of treatment; or
- the use of intracerebral electrodes to create one or more lesions in a person's brain on the same or on separate occasions for the purpose of treatment; or
- the use of intracerebral electrodes to cause stimulation through the electrodes on the same or on separate occasions without creating a lesion in the person's brain for the purpose of treatment.

The Act allows psychiatrists to apply to the Tribunal for approval to perform NMI on a person if the person has personally given informed consent in writing to the performance of NMI on himself or herself.

The Tribunal must hear and determine an application within 30 business days after the receipt of the application.

The Tribunal may grant or refuse an application. The Tribunal may only grant the application if it is satisfied the following criteria are met:

- the person in respect of whom the application was made has given informed consent in writing to the performance of neurosurgery for mental illness on himself or herself and
- the performance of neurosurgery for mental illness will benefit the person.

If the Tribunal grants an application, the applicant psychiatrist must provide progress reports to the Chief Psychiatrist regarding the results of the neurosurgical procedure.

1.2 Administrative procedures

1.2.1 Scheduling of hearings

The responsibility for scheduling hearings rests with the Tribunal's Registry, who use information provided from health services to list matters. Registry liaises with staff at each of the health services to coordinate and confirm the Tribunal's hearings list.

1.2.2 Location of hearings

The Tribunal conducts hearings for compulsory patients at 57 venues, generally on a weekly or fortnightly basis. During 2021-22 the ongoing impact of the COVID-19 pandemic has meant all hearings have been conducted remotely, the majority via online video using MS Teams and some via teleconference. For more details about our hearing platforms see section 1.6.

1.2.3 Notice

A notice of a hearing is provided to the patient (and the patient's parent, if they are under the age of 16), the authorised psychiatrist and the following, if applicable:

- any person whose application to be a party to the proceeding has been approved by the Tribunal
- the nominated person of the person who is the subject of the proceeding
- a guardian of the person who is the subject of the proceeding
- a carer of the person who is the subject of the proceeding.

In the vast majority of matters, a written notice of hearing is provided. However, depending on the listing timelines, a notice of hearing may be given verbally. For example, where an urgent application for ECT is listed, verbal notice of the hearing may be given as these applications are often heard within a day or two after the Tribunal receives the application.

In addition, where the Tribunal has the mobile phone details for patients and carers they are sent a message advising of the hearing via SMS text.

Legal Case Study 1

The Supreme Court's examination of jurisdictional issues in *JL v Mental Health Tribunal* [2021] VSC 868

JL initiated judicial review proceedings against the Tribunal and the authorised psychiatrist of the service providing him with treatment. A central issue before the Supreme Court was whether the Tribunal had jurisdiction to conduct a hearing and make a Treatment Order despite the existence of an error – in this case, an omission in the Temporary Treatment Order (TTO) made by a delegate of the authorised psychiatrist. The delegate of the authorised psychiatrist failed to tick the relevant box in the TTO to indicate whether it was a Community TTO (CTTO) or an Inpatient TTO (ITTO).

Section 53 of the *Mental Health Act 2014* (Vic) (the Act) requires the Tribunal to conduct a hearing for a person 'subject to' a TTO before the TTO expires. JL submitted before the Tribunal and in the Supreme Court that the omission in the TTO meant it was invalid because it failed to comply with a mandatory requirement in the Act, and so the Tribunal did not have jurisdiction to conduct the hearing.

In December 2021, the Supreme Court handed down its decision in *JL v Mental Health Tribunal* [2021] VSC 868. His Honour Justice Ginnane held that the requirement to designate a TTO as a CTTO or ITTO was a mandatory requirement and the failure to do this meant the TTO was invalid. However, this did not affect the Tribunal's jurisdiction to proceed with the hearing.

When a person is placed under the operation of a TTO, they are subject to it as a matter of fact. When that occurs, the Tribunal has jurisdiction to hear the matter and to decide whether to make a Treatment Order. It is not part of the Tribunal's role to investigate whether the TTO was validly made.

Accordingly, Justice Ginnane held that the Treatment Order the Tribunal made was valid even though the TTO that preceded it was invalid. In reaching this conclusion, Justice Ginnane noted that it would be contrary to the objectives of the Act to remove a compulsory patient's right to have a Tribunal hearing because of an error in the document containing the TTO. His Honour stated:

> *An interpretation of s 53 that enables the path [to the Tribunal's independent determination of whether a person should be subject to an Order] to be followed promptly best achieves the purpose, objectives and policy of the Act. The possibility of challenges being made to an Assessment Order or a TTO at any point along the path to the Tribunal on the basis that the previous order was not valid would complicate and undermine the operation of the legislative scheme.*[1]

JL also submitted that the Tribunal had limited JL's rights contained in sections 10(c) and 21(3) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the Charter) and so breached section 38(1) of the Charter. However, Justice Ginnane did not accept this submission.

Justice Ginnane held that the Tribunal's reasons established the limitations imposed on JL's human rights were demonstrably justified. The Tribunal took into account JL's submissions and addressed the substance of the factors described in section 7(2) of the Charter even though it did not refer to them directly. His Honour held that by carefully considering the criteria, the setting and duration of the Order and explaining its decision, the Tribunal had given appropriate consideration to JL's human rights:

> *... the Tribunal's reasons, read as a whole, establish that it gave proper consideration to JL's human rights.*[2]

Justice Ginnane reserved judgement as to whether the authorised psychiatrist, in making the TTO through his delegate, acted unlawfully for the purposes of the Charter. His Honour sought submissions about whether a declaration or other order should be made in the circumstances.

In *JL v Mental Health Tribunal* [No 2] [2022] VSC 222, Justice Ginnane made a declaration:

> *That the Temporary Treatment Order dated 18 August 2020 made by the delegate of the second defendant, the authorised psychiatrist, was invalid and of no force or effect and unlawful under s 38(1) of the Charter of Human Rights and Responsibilities Act 2006.*

1 *JL v Mental Health Tribunal* [2021] VSC 868, [71]

2 Ibid, [107]

1.2.4 Case management

As the Tribunal conducts well over 9,000 hearings per year, it is not possible to case manage all matters. All cases are listed in accordance with the Tribunal's *List Management Policy and Procedure*. Case management is an additional process applied to priority cases to support the participation of patients, carers, nominated persons and treating team members, and to facilitate the readiness of the matter to proceed on the date of hearing. Categories of matters that are case managed include:

- any matter that has previously been adjourned
- hearings where the circumstances require the matter to be finalised urgently
- matters involving complexity and that may require an extended hearing, such as hearings for patients who have had an exceptionally long period of inpatient treatment
- hearings relating to a patient who has had their Treatment Order revoked (meaning they ceased being a compulsory patient) but who are placed on a new Order shortly after that
- infrequent matters such as patient applications against transfer to another health service.

1.2.5 Interpreters

The Tribunal provides interpreters whenever requested by a patient or a health service. The Tribunal recognises that, even where patients have basic English skills, this may not be adequate to ensure they understand the complex legal and clinical issues raised in a hearing. Availability of a competent professional interpreter is important to ensure that patients can fully understand and participate in the hearing process. Statistics on the use of interpreting services are provided in Part Two.

1.2.6 Information products

The Tribunal has developed a variety of information products for use by consumers, carers, health services and other interested parties. These information products are available on the Tribunal's website. The Tribunal's website also links to other relevant websites; for example, the Mental Health Complaints Commissioner.

In conjunction with the Tribunal Advisory Group (see Part Three), work continues on reviewing some of the Tribunal's information products to make them more accessible and relevant to consumers and their carers, as well as providing those products in languages other than English.

Case Study

Case management to promote participation and solution focused hearings

Cases identified as requiring case management often have a support person such as a family member, friend or carer involved. Support people help the patient to prepare and support them to fully participate in their Tribunal hearing. Case management in these cases involves liaising with the support person to organise hearing dates around work and other commitments, ensuring that any written submissions from the patient or their support person are provided to the division, informing the support person of any follow up or specific hearing requirements, and providing general guidance about the Tribunal's processes and the Act more broadly.

For Richard,* his carer played an important support role, so the Tribunal's case management process was focused on working with and supporting the participation of his carer at hearings. Following the hearing where Richard's case was first identified as complex, the Tribunal undertook to ensure case management continued consistently across a number of hearings from late 2020 to early 2022.

A critical strategy was ensuring that after each hearing, discussions about 'next steps' were recorded. For Richard, both he (with the support of his carer) and his treating team agreed to particular actions after each hearing to progress his treatment and ideally develop a treatment plan that would not need a Treatment Order. This record of next steps informed the preparation for later hearings. Registry staff would liaise with Richard's carer and treating team to try and ensure updated information was available for the next hearing, and the members conducting each hearing were briefed on these matters in advance.

For Richard's most recent hearing, registry staff liaised with his carer and treating team to identify a hearing date that would take place after his first appointment with a private psychiatrist, would likely enable Richard to have a legal representative present, and which also fitted with the availability of Richard's carer and family to participate. Richard's Treatment Order was revoked at this hearing.

** Not his real name*

Legal Case Study 2

Treatment criterion (b): determining whether the person needs immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to themselves or others

The Act requires that to be subject to a Treatment Order, a person must need 'immediate treatment to prevent serious deterioration in the person's mental or physical health, or serious harm to the person or to another person' (treatment criterion b).

Two recent decisions illustrate that the Tribunal must decide whether there is a need for *immediate treatment*; not that there is an immediate risk of serious deterioration or serious harm.

In ***RED* [2022] VMHT 2**, the patient was brought into hospital by police after she was found running on a busy road. The treating team submitted that RED had been experiencing worsening paranoid beliefs in the year before her admission. At the time of her admission, RED appeared to be experiencing a number of acute symptoms. She expressed thoughts related to COVID-19 that appeared to be paranoid delusions. She also thought a memory chip had been implanted in her head and people were trying to harm her.

At the time of the hearing, RED was receiving treatment in the community, and even though the treating team's view was that her symptoms had lessened, she continued to hold beliefs that were regarded as paranoid.

RED's lawyer submitted there needed to be an immediate risk of deterioration to warrant compulsory treatment, and that RED's experience showed that any deterioration she may experience would be gradual and not immediate. The Tribunal rejected these submissions because it said the Act requires there is a need for *immediate treatment* to prevent serious deterioration, and the Act does not state the serious deterioration must be immediate.

In this case, the Tribunal acknowledged there was no way of predicting when RED may experience a relapse. However, the Tribunal was satisfied that given the serious consequences of her recent relapse, RED needed immediate treatment to prevent a serious deterioration in her mental health and serious harm to herself and others.

In ***TES* [2022] VMHT 1**, the patient was brought into hospital by police after he was found to be very agitated and threatening self-harm.

At the hearing, TES agreed he had a mental illness. However, his lawyer submitted that the second treatment criterion was not met, because there was no immediate risk of a serious deterioration in TES's mental health or harm to himself or others. TES was aware he had engaged in risk-taking behaviours when he was unwell, but he was feeling better. TES acknowledged he had previously been admitted to hospital several times, but he emphasised the past does not always repeat itself and he was committed to engaging with his treating team.

In deciding that TES needed immediate treatment to prevent serious deterioration in his mental health, the Tribunal accepted there was no immediate risk of a serious deterioration in his mental health. However, the Tribunal observed this was not the test it was required to apply. Instead, the focus is whether immediate treatment is required to prevent serious deterioration, not whether there is an immediate risk of a serious deterioration. In this case, the Tribunal was satisfied there was an immediate need for treatment which was specific and compelling. Accordingly, the Tribunal was satisfied the second criterion was met. (However, the majority of the Tribunal ultimately decided to revoke the Treatment Order because it was satisfied TES would receive the immediate treatment that he required voluntarily).

1.3 Conducting hearings

1.3.1 Divisions

The Act requires the Tribunal to sit as a division of three members.

A general division of the Tribunal can hear and determine all matters within the jurisdiction of the Tribunal except those relating to ECT or NMI. Each division of three is made up of a legal member, a psychiatrist member or registered medical practitioner member, and a community member. The legal member is the presiding member.

A special division of the Tribunal must hear and determine applications for the performance of electroconvulsive treatment or neurosurgery for mental illness. Each division of three is made up of a legal member, a psychiatrist member and a community member. The legal member is the presiding member.

1.3.2 Hearing procedure

The Act provides a framework for Tribunal procedures, but also allows considerable discretion in determining the way hearings are conducted. Hearings aim to be informal, inclusive and non-adversarial. Given the nature of its work, the Tribunal considers that this is the best way to achieve both fairness and efficiency, balancing the need to ensure that questions of liberty are dealt with appropriately and thoroughly, while remaining mindful of not disrupting the therapeutic relationship between patients and their treating teams.

Generally, those present at a hearing, other than the Tribunal members, are the patient and the treating doctor who attends as the representative of the authorised psychiatrist. When a person is on a Community Treatment Order their case manager will often attend as well – something the Tribunal encourages strongly. In some cases, friends and relatives of the patient also attend.

The Tribunal has developed a range of resources to assist members with the conduct of hearings and the discharging of their responsibilities, including:

- a *Guide to Procedural Fairness in the Mental Health Tribunal*, which details strategies specific to this jurisdiction that members can use to ensure hearings are conducted in accordance with the rules of procedural fairness
- a *Guide to Solution-Focused Hearings in the Mental Health Tribunal*, which reflects on how Tribunal hearings can be conducted in such a way as to promote the principles of the Act and be responsive to the needs of particular consumers.
- a comprehensive *Hearings Manual* that guides members through every type of hearing or application that can arise under the Act
- guidance materials on the interpretation and application of the *Mental Health Act 2014*.

Alongside these resources, professional development opportunities for members are provided during the year including members' forums, twilight seminars and practice reflection groups. After a COVID-interruption, the Members Performance Feedback Framework recommenced in the second half of this year. This is the process by which members undertake self-appraisal and are given comprehensive, structured feedback from their peers about how they approach their role in hearings. This feedback identifies training and professional development needs for individual members and the membership as a whole.

1.3.3 Legal representation

Legal representation is not an automatic right in Victoria, and it is the responsibility of patients, with the assistance of health services, to arrange their own representation. Victoria Legal Aid and the Mental Health Legal Centre can provide free advice and legal representation at hearings. Statistics relating to legal representation are shown in Part Two.

1.3.4 Determinations and Orders

The Tribunal delivers its decision orally at the conclusion of the hearing and completes a determination reflecting its decision. The registry prepares a determination, and if one is made, an Order, for the parties on the day of hearing and sends it to the health service via email the same day. If the patient is an inpatient we forward them copies of these documents via the health service; if they are in the community we send it to them directly. Any additional person who was notified of a hearing in accordance with the Act (e.g. a nominated person) is also provided with documents relating to the outcome.

1.3.5 Review by VCAT

Any party to a Tribunal proceeding may apply to the Victorian Civil and Administrative Tribunal (VCAT) for a review of the Tribunal's decision. VCAT conducts a *de novo* hearing, which means it rehears the matter, taking into account previous and new evidence relevant to the issue under consideration (most commonly whether the compulsory patient meets the treatment criteria at the time of the VCAT hearing). VCAT has the power to affirm, vary, or set aside the Tribunal's decision, and either make a substitute decision or remit the matter to the Tribunal for reconsideration.

Formally, the Tribunal is a respondent in applications for a review of its decision by VCAT; however, its involvement in actual hearings is limited. In these matters, the Tribunal submits to the jurisdiction of VCAT and does not take an active role in the proceedings. The Tribunal files all the required materials with VCAT, which then conducts a hearing involving the patient and the mental health service that is responsible for their treatment.

The Tribunal is always available to respond to questions VCAT may have regarding the relevant proceedings and determination and will attend a hearing if requested to do so by VCAT.

1.3.6 Statements of reasons

Under s198 of the Act, parties to the proceeding have a right to request a statement of reasons. A 'party' is the person who is the subject of the hearing (the patient), the psychiatrist treating the patient and any party joined by the Tribunal.

The Act requires the request to be addressed to the Tribunal in writing within 20 business days of the hearing date. The Act also requires the Tribunal to provide the statement of reasons within 20 business days of receiving the request.

The Tribunal will also provide a statement of reasons where a party applies to VCAT for a review of a decision. Occasionally, the Tribunal may provide a statement of reasons on its own initiative.

When the statement of reasons is required as a result of an application for review to VCAT, the *Victorian Civil and Administrative Tribunal Act 1998* requires that it be provided within 28 days of the Tribunal receiving the relevant notice from VCAT.

Any statement that is produced is distributed to the patient, their legal representative (if any), the authorised psychiatrist of the relevant mental health service and any party joined by the Tribunal.

Publication of Statements of Reasons

The Tribunal is committed to transparency regarding its decision-making under the Act. In line with this commitment, the Tribunal de-identifies and publishes a selection of its statements of reasons on the AustLII website: www.austlii.edu.au.

With the exception of statements of reasons that may lead to the identification of persons involved in the proceedings or where publication was not appropriate in the circumstances, all statements of reasons finalised before mid-November 2015 were published on AustLII.

Since that time, the Tribunal's policy is to publish statements of reasons that fall within the following categories:

- statements of reasons highlighting the Tribunal's interpretation and application of the provisions of the Act governing Treatment Orders, ECT Orders and Tribunal hearings. This category includes any statements of reasons addressing complex or novel legal questions, but also includes statements of reasons selected because they provide a particularly informative example of the Tribunal's decision-making
- statements of reasons that highlight the application of mental health principles or that cover other themes such as recovery-oriented practice, solution-focused hearings, or the handling of particular procedural fairness scenarios (for example, the participation of carers and family members)
- statements of reasons concerning hearings that involve particularly complex or novel facts or clinical issues.

Complementing the publication of statements of reasons on the AustLII website, the Tribunal's website has a catalogued index of published statements of reasons that links to the AustLII website.

1.3.7 Rules and Practice Notes

The Tribunal has Rules governing essential aspects of its operation, accompanied by eight Practice Notes. Practice Notes deal with:

- the form of applications, clinical reports and attendance requirements
- less common types of applications or matters that come before the Tribunal, and provide guidance on the information that needs to be available for these hearings
- observers at Mental Health Tribunal hearings
- access to documents prior to Tribunal hearings, including the process to be followed where an authorised psychiatrist applies to withhold documents.

All Practice Notes are available on the Tribunal's website.

1.4 Membership of the Tribunal

The membership of the Tribunal comprises community members, legal members, psychiatrist members and registered medical members. Members of the Tribunal are appointed by the Governor in Council for terms of up to five years; members are able to be reappointed. The membership is organised in such a way that every two to three years the terms of appointment of approximately half the members end which triggers a member appointment round. An appointment round was commencing at the time this report was being finalised. A full list of members is available at Appendix C.

Professional development and performance feedback processes

The Tribunal implemented a Member Feedback Framework in 2018 and it has been in operation since then. This Framework involves members receiving feedback from their colleagues and conducting a self-appraisal about their performance as a Tribunal member. The process requires members to reflect on their role and their performance against the standards and expectations of members which are set out in two foundational documents – the Tribunal's Principles of Conduct and the Members Competency Framework.

When initially implemented the Tribunal committed to a review of the Members Feedback Framework after all current members had participated in and completed the process (that is, received a report which incorporated feedback from their colleagues, their self-appraisal and any additional feedback from the Deputy President or President). Other than the group of members appointed in February 2021, all members have participated in the process and a review for the Framework was conducted during 2021-2022.

Given the changes in the Tribunal's operations in the last two years, refreshing the underlying standards and expectations of members was very timely. This project to review the Member Feedback Framework commenced with a review of the Principles of Conduct and the Competency Framework, and then moved on to examine the processes and methodologies of obtaining and receiving feedback. The project involved considerable consultation and a number of groups were involved – a group of members who volunteered to assist with the review, the Tribunal Advisory Group and the Tribunal's Governance Group. This consultation was extremely effective and has resulted in renewed and refreshed documents which better reflect the Tribunal's current operating environment. Notably, the review resulted in the inclusion of standards and expectations around new processes including video and teleconference hearings and the use of online documentation. In addition, it has resulted in updated language and an emphasis on themes arising from the recommendations of the Royal Commission. The revised documents and processes will be finalised and implemented in 2022-2023.

The Members Feedback Framework allows not only individual members to consider their role and performance, but it plays a central role in providing the Tribunal with information about areas where members require education or support. The Tribunal uses the information it receives from the Feedback Framework processes to identify topics for presentations at seminars and all-day forums which are conducted throughout the year.

Legal Case Study 3

Treatment criterion (c): determining whether immediate treatment will be provided to the person if the Tribunal makes a Treatment Order

The Act requires the Tribunal to be satisfied that 'immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order' (treatment criterion c).

In most cases, it will be clear that immediate treatment will be provided.

***VMZ* [2022] VMHT 6** illustrates how the Tribunal applies this criterion when the connection between a patient and their treating team has fractured.

VMZ's Community Treatment Order (CTO) had been varied to an Inpatient Treatment Order (ITO). However, VMZ had been avoiding her treating team. At the time of the hearing, she had not engaged with them in several months, and had missed the two depot (injectable) medications prescribed for her in about three months. While the treating team continued to encourage VMZ to attend the clinic or hospital to receive her depot medications, at the time of the hearing these attempts had been unsuccessful.

In the hearing, VMZ's lawyer submitted the third criterion was not met because VMZ would not receive the immediate treatment she required if the Tribunal made a Treatment Order. VMZ participated in the hearing and told the Tribunal she was stressed and felt the mental health services had ruined her life. VMZ said she was taking oral medication but would continue to refuse the prescribed depot medications.

VMZ's treating doctor said that VMZ needed immediate treatment in the form of the two prescribed depot medications. Her doctor did not believe the oral medication VMZ said she was taking was sufficient to treat her illness.

In previous decisions, the Tribunal has recognised that interruptions to treatment do not immediately mean the third criterion is no longer satisfied. The circumstances of a particular case need to be individually considered. In this instance, the Tribunal accepted the treating team had made several attempts to engage with VMZ. However, the Tribunal acknowledged that at a certain point a threshold will be crossed where it can no longer be said that VMZ was receiving immediate treatment. As VMZ had not received her prescribed two depot medications in nearly three months, the Tribunal decided the threshold had been crossed and the Tribunal could not be satisfied that VMZ would receive immediate treatment if the Tribunal made a Treatment Order. The Tribunal therefore revoked the ITO.

In ***OEQ* [2021] VMHT 21**, the Tribunal explained that the focus of the third criterion is not on whether the patient will accept the treatment, but rather whether the treatment will be provided.

OEQ had a history of receiving treatment for mental illness and numerous hospital admissions for treatment of his symptoms which included disorganised thoughts, pressured speech, elevated mood, ideas of grandiosity and persecutory beliefs. OEQ did not believe he had a mental illness or that he needed treatment.

In the hearing, OEQ's lawyer submitted that the third treatment criterion was not met because OEQ would not accept the treatment due to the distressing side effects he experienced.

The treating team submitted that OEQ had been receiving treatment in the form of a depot medication which his general practitioner (GP) had been administering and he had been doing well until he stopped attending appointments with his GP. For several weeks, OEQ's case manager encouraged OEQ to receive his depot medication. However, when OEQ's depot medication was six weeks overdue his CTO was varied to an ITO. OEQ was then taken to hospital where he received his depot medication, and his Treatment Order was varied back to a CTO. The treating team submitted that the depot medication prevented relapses and enabled OEQ to function well.

The Tribunal was satisfied that at the time of the hearing, OEQ was receiving treatment, and this would continue if the Tribunal made a Treatment Order. In reaching this view, the Tribunal rejected the legal submission, which it said was more relevant to the fourth treatment criterion: whether OEQ could be treated on a voluntary basis.

1.5 Working with our stakeholders

1.5.1 Stakeholder engagement

Legal representatives

Victoria Legal Aid (VLA) is the primary provider of legal services to people having Tribunal hearings. The Tribunal meets on a regular basis with VLA to discuss issues of common interest and maintain effective working relationships.

The Mental Health Legal Centre (MHLC) also facilitates the provision of pro-bono legal representation to people on compulsory Treatment Orders. The Tribunal liaises with the MHLC as needed.

Tribunal Advisory Group

Details relating to the invaluable and extensive role of the Tribunal Advisory Group (comprising consumers, carers and members of the lived-experience workforce) are provided in Part Three.

Health services

The Tribunal engages with health services at multiple levels. Our full and part-time members each have responsibility for several health services for which they act as the liaison member and where they sit on hearings on a regular basis. The liaison member is a point of continuity for communication and issue management between the Tribunal and health services. With a focus on local and informal issue resolution, liaison members can facilitate more appropriate and timely responses and localised solutions to emerging issues.

At an administrative level the Tribunal has established a working group (TWG) to consult and engage with Area Mental Health Services about key administrative practices. The group includes representatives from each Area Mental Health Service, providing the Tribunal with a valuable opportunity to improve our engagement with these services and to work together on the multiple challenges associated with the pandemic. Since July 2021 the TWG has met every two months. During 2021-22, one of the TWG's major focal points has been working together to successfully roll-out the transition from telephone hearings to online video hearings using the MS Teams platform. The TWG has also been consulted in relation to:

- reviewing and simplifying our hearing notices and report templates for hearings about a Treatment Order,
- improving communication and procedural advice to services about participation at hearings (especially by family and carers), and
- providing feedback for the review into the documents required for hearing.

Other engagement activities

The Tribunal maintains regular and ad-hoc communications with a wide range of other bodies, including:

- Department of Health
- VMIAC
- Tandem
- Mental Health Complaints Commissioner
- Office of the Chief Psychiatrist
- Health Information Management Association Australia (Victoria branch) Mental Health Advisory Group (MHAG).

1.5.2 Educational activities

The Tribunal takes a holistic approach to education, including for consumers, family and carers, health services, other external stakeholders and our members and staff. Our information products are co-designed with consumers and carers to be readily understood and accessible. Our website contains educational videos about our hearing processes, how to prepare for a hearing, what to do if you disagree with your treatment and writing reports for Tribunal hearings. Due to the ongoing impact of COVID-19 restrictions only a small number of online education sessions were delivered to health services this year. For more information about member professional development see the 'Membership of the Tribunal' section in Part One.

1.5.3 Quarterly Activity Report

The Tribunal is committed to transparency about its work. Quarterly Activity Reports with data about the decisions we make are published at the end of quarters one, two and three and are available on our website.

1.5.4 Complaints and feedback

The Tribunal welcomes complaints and feedback as an opportunity to monitor, review and improve our services, practices and procedures. The Complaints and feedback policy is available on our website. People can contact the Tribunal to provide feedback or make a complaint via email, letter or phone or by completing an online form via the website.

During 2021-22 the Tribunal received 20 complaints^* and 13 pieces of feedback. These related to:

	Complaints	Feedback
Clarification of procedures	3	4
Conduct of hearings	12	6
Procedural fairness	3	-
Technical or administrative difficulty or error	5	2
Customer service	3	1

^ *Where multiple contacts are received about one hearing or issue these are counted once. Where a complaint is later withdrawn it is not counted.*

* *The number of complaints and feedback do not match the count of complaint or feedback types as each contact can raise multiple issues concerns.*

1.6 On-line hearings and planning our future hearing model

During the first quarter of 2021-22 the Tribunal ran a pilot with selected health services to test Microsoft Teams as a potential platform for conducting hearings. The pilot informed our approaches to hearing management, member and health service training, patient support, and the development of registry processes. In September 2021 the Tribunal decided to implement Microsoft Teams as the platform for all hearings.

During the second half of 2021-22 the Tribunal started work to identify a suitable model for future COVID-safe hearings. The aim is that the model will maximise opportunities for patients and their support people to actively participate in hearings while ensuring high quality hearings that are responsive to individual needs that can be managed and conducted in a safe and sustainable way.

There are many complexities to be reckoned with, as a return to the way that hearings were conducted previously is not realistic in the foreseeable future. Working collaboratively with all our stakeholders the Tribunal successfully designed and implemented procedures to continue delivering hearing services throughout the first two years of the pandemic. We will take a similarly collaborative approach to the development of our next model, but the task is complex, and the Tribunal's operating environment continues to be dynamic. While the Tribunal undertakes this consultation and planning, we also need to prioritise preparatory work for the anticipated Mental Health and Wellbeing Act.

Given it will take considerable time we will be prioritising the development of processes that enable us to respond more flexibly and effectively to the needs of consumers who face barriers to participation in online hearings.

1.7 Responding to the impact of COVID-19 on health services

Alongside the mode by which the Tribunal conducts hearings, the ongoing effects of the pandemic have meant the Tribunal has had to periodically adjust its hearing requirements (set down in Practice Notes etc) to accommodate capacity constraints on health services. When the most recent Omicron wave started to affect health services, the Tribunal made temporary amendments to Practice Note 1 to allow reduced requirements for reports that services need to prepare before hearings. The amendment allows health services that are unable to provide a report in the usual format due to the impact of COVID-19 to provide the Tribunal with:

- a previous report if available for the same hearing type prepared within the last 12 months, together with a brief written update to that report, noting what has changed since the previous report; or
- If there is no report for the same hearing type from the past 12 months, a brief document setting out minimum information (set out in the Practice Note); or
- If a written summary cannot be prepared, the service should provide the usual extracts from the patient's clinical file and a treating team member with sufficient knowledge of the patient and experience with Tribunal hearings should attend the hearing to provide oral evidence addressing the matters that would otherwise be covered in a written summary.

While the Tribunal is aware that mental health services have been impacted by COVID-19 and staff availability has been reduced, the Tribunal's experience to date is that these provisions are used very sparingly and only when mental health services are severely impacted by a COVID-19 outbreak.

Legal Case Study 4

Treatment criterion (d): determining whether there is a less restrictive way to treat the person

The Act requires that for a person to be subject to a Treatment Order 'there is no less restrictive means reasonably available to enable the person to receive the immediate treatment' (treatment criterion d). That is, can the person be treated on a voluntary basis, or do they need to be compelled to have treatment on a Treatment Order?

The Tribunal is required to have regard to the mental health principles in section 11 of the Act, including the principles that patients should be provided with treatment in the least restrictive way with voluntary treatment preferred; patients should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk; and patients should have their rights, dignity and autonomy respected and promoted.

In ***ZAV* [2021] VMHT 24**, the patient was receiving treatment in hospital after experiencing a relapse of his mental illness. ZAV had previously received treatment from a private psychiatrist. He understood what led to his hospital admission. He was in the process of stopping his lithium, at the direction of his private psychiatrist and another specialist, when his mental health deteriorated. ZAV followed his GP's advice and presented to hospital for treatment.

In the hearing, ZAV said he was willing to have the Crisis and Assessment Treatment Team (CATT) monitor his medication compliance every day, but he wanted to be treated on a voluntary basis. He would continue to take the medication and engage with the treating team but wanted to return to the care of his private psychiatrist. ZAV had also developed a safety plan – ZAV would speak to his close friend every day. If ZAV's friend noticed ZAV was becoming unwell, he would let the treating team know.

ZAV was supported in the hearing by his friend who agreed with ZAV's safety plan. ZAV's friend told the Tribunal that ZAV wasn't well enough to leave hospital the week before the hearing. However, there had been a clear shift in ZAV's behaviour. He was back to his old self at the time of the hearing and was ready to leave hospital.

The treating team submitted that ZAV was on track to be discharged from hospital shortly after the hearing. However, they wanted to continue to treat ZAV as a compulsory patient so they could arrange community follow up, including a case manager, CATT involvement and a referral to ZAV's private psychiatrist before ZAV was discharged.

The Tribunal decided that ZAV could be treated on a voluntary basis. In addition to ZAV's intention to continue with treatment, he had significant community supports in place, including the support of his friend who would monitor ZAV and report any deterioration in ZAV's mental health if he became unwell again. The Tribunal accepted the evidence ZAV's friend provided in the hearing, including his assessment that ZAV was now ready to leave hospital. The Tribunal also had regard to ZAV's treatment history which supported voluntary treatment. ZAV had followed treatment advice and taken medication for more than 15 years and the Tribunal accepted that ZAV would continue to engage with his private psychiatrist. The Tribunal decided that ZAV did not need to be compelled to have treatment under a Treatment Order.

In ***BDD* [2022] VMHT 4**, BDD had also been receiving treatment in hospital. BDD experienced auditory hallucinations and delusions that she found distressing. At the time of the hearing, the treating team said BDD was ready to be discharged from hospital. However, they thought BDD needed to be treated on a Community Treatment Order because her views about treatment kept changing and she had a history of stopping medication. The treating team acknowledged this was less of an issue because BDD had agreed to a depot (injectable) medication which ameliorated some of their concerns about her adherence to treatment. At the time of the hearing, BDD had been engaging well and said she would seek help if she became unwell.

BDD's lawyer submitted that she could be treated on a voluntary basis because she had learnt from her previous discharge and re-admission. BDD was committed to continuing to take medication even if she felt well because she didn't want the voices to return.

The Tribunal acknowledged the concerns raised by BDD's treating team. However, the Tribunal accepted the information provided by BDD and decided she could be treated on a voluntary basis. During her admission, BDD had developed an improved understanding of the need to continue to take medication even when she was feeling well. She understood that if she stopped the medication, as she had done in the past, there was a risk the voices would return and BDD was motivated to prevent that from happening. The Tribunal accepted BDD would continue to engage with the treating team and would seek help if she became unwell again.

Conversely, in ***KDY* [2021] VMHT 25** the circumstances of the case led the Tribunal to decide that KDY needed to be compelled to have treatment under a Treatment Order. KDY had experienced significant challenges and required several hospital admissions in the last couple of years. KDY experienced delusions about victimisation, identity theft, fraud and burglaries and the intensity of his beliefs had impacted his relationships with family. While KDY wanted to return to work, the treating team was concerned his symptoms would prevent him from successfully achieving this.

The treating team believed KDY needed to continue to be treated as a compulsory patient even though KDY's mental state had significantly improved and he was ready to leave hospital. The treating team was concerned that KDY would not consistently engage with the treating team and take his medication if he was not compelled to do so, as he had done in the past.

Although KDY said he was happy to continue working with the treating team, he also wanted to make decisions about the form and dosage of his treatment. He wanted oral rather than depot (injectable) medication and wanted to reduce the dosage. The Tribunal was concerned that KDY minimised his treating team's concerns about the times when he had decided to cease treatment in the past, and the impact on his life when interruptions to his treatment had resulted in a relapse of his symptoms.

The Tribunal considered that stable mental health was vital for KDY to achieve his goal of returning to work, and ongoing treatment was critical to maintaining that stability. The Tribunal decided there was no less restrictive way to treat KDY and so made a Treatment Order.

Part 2 Hearing statistics for 2021–22

Key statistics at a glance*

	2021-22	2020-21^	2019-20^
**Hearings listed ** **	**13,643**	13,333	12,771
Hearings conducted	**9,347**	9,543	8,787
Decision made	**7,925**	8,212	7,762
Adjourned	**1,422**	1,331	1,025
Treatment Orders made	**6,569**	6,679	6,227
Temporary Treatment Orders / Treatment Orders revoked	**449**	546	531
ECT Orders made	**507**	539	539
ECT applications refused	**67**	80	78
NMI hearings conducted	**4**	3	4
Statement of reasons requested	**221**	238	178
Applications to VCAT	**36**	26	31

* *The figures in Parts 2.1 to 2.8 represent determinations at substantive hearings and exclude hearings that were adjourned or finalised without a determination.*

** *There are more hearings listed than conducted because hearings may not proceed due to changes in a patient's circumstances. For example, a hearing may be listed for a patient but prior to the hearing date the patient's Order is revoked, meaning the person is no longer a compulsory patient and they no longer required a hearing.*

^ *Figures for 2019-20 and 2020-21 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

Attendance at hearings[3]

	2021-22	2020-21	2019-20
Patients	**5,743**	5,956	5,043
Family members	**1,691**	1,712	1,544
Carers	**357**	373	372
Nominated persons	**269**	250	195
Medical treatment decision-makers	**23**	26	37
Support persons	**4**	1	0
Interpreters	**458**	455	433
Legal representatives	**1,167**	1,257	1,158

The Tribunal gathers and reports statistics on the basis of case types, hearings and Treatment Orders.

A case type can be defined as the 'trigger' for a hearing. For example, an application for a Treatment Order, an application to perform ECT and an application by a patient seeking revocation of an Order are all triggers for a hearing and dealt with as distinct case types. A hearing is the 'event' where the Tribunal hears evidence from the patient, their treating team and, where involved, their carer and advocate to determine whether to make or revoke a Treatment Order or make or refuse an ECT Order.

Sometimes the Tribunal will receive notification of two different case types at a similar time. An example of this is where a patient is placed on a Temporary Treatment Order – this will automatically trigger a hearing that must be conducted before the Temporary Treatment Order expires. That patient might also make an application to the Tribunal to revoke the Order – giving rise to a second case type. Wherever practicable, the Tribunal Registry will list the two case types for hearing at the same time. For the purpose of recording statistics, this scenario is counted as one hearing and one outcome.

3 Attendance of patients in 2019-20 includes instances where the Tribunal visited the patient on the ward.

2.1 Treatment Orders

2.1.1 Outcomes of hearings regarding Treatment Orders

In 2021-22, the Tribunal made a total of 6,569 Treatment Orders and revoked 449 Temporary Treatment Orders and Treatment Orders. There were five of matters where the Tribunal found it did not have jurisdiction to conduct a hearing, and 114 applications were struck out. The most common reason for a strike out is where a patient has made an application for revocation and fails to appear at the hearing. When an application is struck out, the underlying Treatment Order or Temporary Treatment Order is not affected and continues to operate; furthermore, a patient is able to make a further application if they wish to do so.

The following graphs and tables provide a breakdown of the total number of Orders made and revoked, the category of Orders made (that is, whether they were Community or Inpatient Treatment Orders) and the duration of Orders.

Figure 1: Determinations regarding Treatment Orders

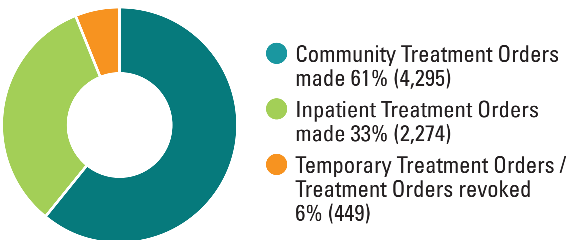


Table 1: Determinations regarding Treatment Orders

	2021–22	2020–21	2019–20
Community Treatment Orders made	**4,295 (61%)**	4,381 (61%)	3,865 (57%)
Inpatient Treatment Orders made	**2,274 (33%)**	2,298 (32%)	2,362 (35%)
Temporary Treatment Orders / Treatment Orders revoked	**449 (6%)**	546 (7%)	531 (8%)
Total Orders made or revoked	**7,018 (100%)**	7,225 (100%)	6,758 (100%)

Figure 2: Duration of Community Treatment Orders made

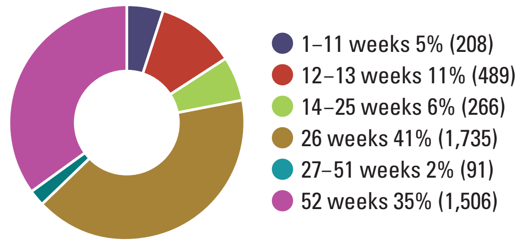


Table 2: Duration of Community Treatment Orders made

	2021–22	2020–21	2019–20
1-11 weeks	**208 (5%)**	189 4%	139 4%
12-13 weeks	**489 (11%)**	483 11%	354 9%
14-25 weeks	**266 (6%)**	298 7%	222 6%
26 weeks	**1,735 (41%)**	1,751 40%	1,524 39%
27-51 weeks	**91 (2%)**	119 3%	96 2%
52 weeks	**1,506 (35%)**	1,541 35%	1,530 40%
Total	**4,295 (100%)**	4,381 100%	3,865 100%

Figure 3: Duration of Inpatient Treatment Orders made

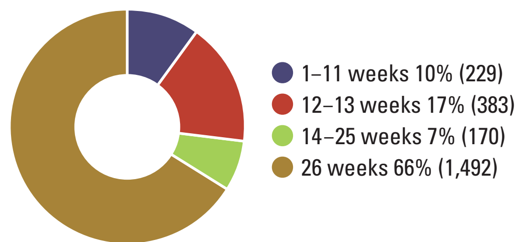


Table 3: Duration of Inpatient Treatment Orders made

	2021–22	2020–21	2019–20
1-11 weeks	**229 (10%)**	235 (10%)	231 (10%)
12-13 weeks	**383 (17%)**	368 (16%)	341 (14%)
14-25 weeks	**170 (7%)**	193 (8%)	192 (8%)
26 weeks	**1,492 (66%)**	1,502 (65%)	1,598 (68%)
Total	**2,274 (100%)**	2,298 (100%)	2,362 (100%)

2.1.2 Treatment Order hearing outcomes by initiating case type

Hearings regarding Treatment Orders can be initiated in a number of ways. The preceding graphs summarise the Tribunal's total determinations regarding Treatment Orders. The tables below break down these figures by initiating case type – that is, the 'event' that triggered the requirement for the hearing.

28-day hearings

The Tribunal must conduct a hearing to determine whether to make a Treatment Order for a person who is subject to a Temporary Treatment Order within 28 days of a patient being placed on a Temporary Treatment Order. After conducting the hearing, the Tribunal must either make a Treatment Order or revoke the Temporary Treatment Order.

Table 4: Outcomes of 28-day hearings

	2021–22	2020–21	2019–20
Community Treatment Orders made	**1,423 (46%)**	1,532 (46%)	1,544 (47%)
Inpatient Treatment Orders made	**1,438 (46%)**	1,481 (45%)	1,477 (44%)
Temporary Treatment Orders revoked	**261 (8%)**	289 (9%)	288 (9%)
Total Treatment Orders made or revoked	**3,122 (100%)**	3,302 (100%)	3,309 (100%)

The Tribunal revokes a Temporary Treatment Order when one or more of the criteria for treatment in s5 of the Act is not met. The reasons for revocation of a Temporary Treatment Order were as follows:

*Table 5: Reasons the Tribunal revoked Temporary Treatment Orders in 28-day hearings**

	2021–22	2020–21	2019–20
Treatment was able to be provided in a less restrictive manner	**86%**	85%	79%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**4%**	4%	6%
Immediate treatment was not able to be provided	**8%**	6%	10%
The person did not have a mental illness	**2%**	5%	5%
Total	**100%**	100%	100%

** Results are displayed in percentages because more than one criterion may be unmet in a single hearing.*

Applications for a Treatment Order by the authorised psychiatrist

An authorised psychiatrist can apply to the Tribunal for a further Treatment Order in relation to a compulsory patient who is currently subject to a Treatment Order.

Table 6: Outcomes of authorised psychiatrist application hearings

	2021–22	2020–21	2019–20
Community Treatment Orders made	**2,609 (84%)**	2,534 (83%)	2,132 (80%)
Inpatient Treatment Orders made	**356 (12%)**	353 (11%)	367 (14%)
Treatment Orders revoked	**128 (4%)**	175 (6%)	155 (6%)
Total Treatment Orders made or revoked	**3,093 (100%)**	3,062 (100%)	2,654 (100%)

As with Temporary Treatment Orders, the Tribunal revokes a Treatment Order when one or more of the criteria for treatment in s5 of the Act is not met. The reasons for revocation of the Treatment Order with respect to applications by the authorised psychiatrist were as follows:

*Table 7: Reasons the Tribunal revoked Treatment Orders in authorised psychiatrist application hearings**

	2021–22	2020–21	2019–20
Treatment was able to be provided in a less restrictive manner	**79%**	81%	74%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**6%**	7%	10%
Immediate treatment was not able to be provided	**9%**	8%	11%
The person did not have a mental illness	**6%**	4%	5%
Total	**100%**	100%	100%

** Results are displayed in percentages because more than one criterion may be unmet in a single hearing.*

Applications for revocation by or on behalf of a patient

A patient subject to a Temporary Treatment Order or Treatment Order, or someone on their behalf, can apply to the Tribunal at any time to revoke the Order.

Table 8: Outcomes of revocation hearings

	2021–22	2020–21	2019–20
Community Treatment Orders made	**429 (57%)**	541 (59%)	376 (47%)
Inpatient Treatment Orders made	**248 (33%)**	297 (32%)	339 (42%)
Temporary Treatment Orders / Treatment Orders revoked	**71 (10%)**	87 (9%)	92 (11%)
Total Treatment Orders made or revoked	**748 (100%)**	925 (100%)	807 (100%)

The reasons for revoking a Temporary Treatment Order or Treatment Order in proceedings initiated by the patient were as follows:

*Table 9: Reasons the Tribunal revoked Temporary Treatment Orders / Treatment Orders in revocation hearings**

	2021–22	2020–21	2019–20
Treatment was able to be provided in a less restrictive manner	**71%**	72%	68%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**12%**	13%	14%
Immediate treatment was not able to be provided	**7%**	3%	6%
The person did not have a mental illness	**10%**	12%	12%
Total	**100%**	100%	100%

**Results are displayed in percentages because more than one criterion may be unmet in a single hearing.*

Variation hearings

The Tribunal must initiate a variation hearing when an authorised psychiatrist varies a Community Treatment Order to an Inpatient Treatment Order. The hearing must occur within 28 days of the variation and the Tribunal must determine whether to make a Treatment Order or revoke the Inpatient Treatment Order.

Table 10: Outcomes of variation hearings

	2021–22	2020–21	2019–20
Community Treatment Orders made	**95 (15%)**	100 (16%)	78 (12%)
Inpatient Treatment Orders made	**501 (79%)**	483 (77%)	522 (80%)
Treatment Orders revoked	**37 (6%)**	46 (7%)	56 (8%)
Total Treatment Orders made or revoked	**633 (100%)**	629 (100%)	656 (100%)

The reasons for revocation of the Treatment Order in hearings triggered by variations were:

*Table 11: Reasons the Tribunal revoked Treatment Orders in variation hearings **

	2021–22	2020–21	2019–20
Treatment was able to be provided in a less restrictive manner	**29%**	19%	12%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**3%**	2%	3%
Immediate treatment was not able to be provided	**68%**	79%	85%
The person did not have a mental illness	**0%**	0%	0%
Total	**100%**	100%	100%

** Results are displayed in percentages because more than one criterion may be unmet in a single hearing.*

2.2 ECT Orders - Adults

2.2.1 Outcomes of applications for an ECT Order

In 2021-22 the Tribunal heard a total of 571 applications for an electroconvulsive treatment (ECT) Order in relation to an adult. ECT Orders were made in 461 hearings for adult compulsory patients and 64 applications were refused. ECT Orders were made in 44 hearings for adults being treated as voluntary patients and two applications were refused.

Table 12: Outcomes of applications for an ECT Order

	2021–22	2020–21	2019–20
Compulsory adult patient			
ECT Orders made	**461**	482	477
ECT applications refused	**64**	77	74
Voluntary adult patient			
ECT Orders made	**44**	50	55
ECT applications refused	**2**	3	4
Total ECT Orders made and applications refused	**571**	612	610

The following graphs provide details of the ECT Orders made and refused, the duration of Orders, number of ECT treatments authorised, and timeframes for the hearing of applications.

Figure 4: Determinations regarding ECT applications

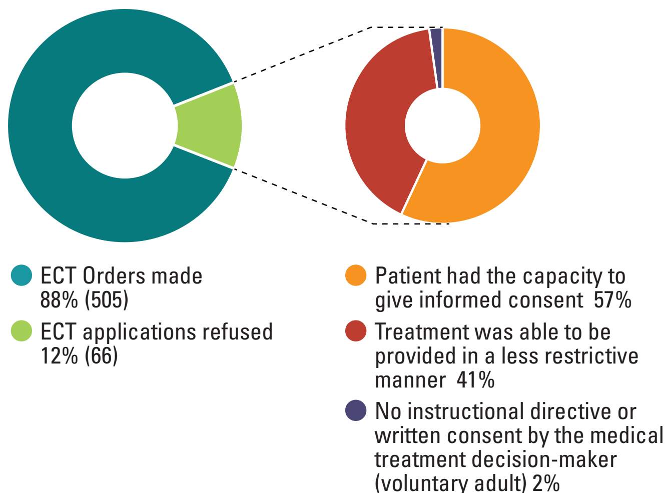


Table 13: Determinations regarding ECT applications

	2021–22	2020–21	2019–20
ECT Orders made	**505 (88%)**	532 (87%)	532 (87%)
ECT applications refused	**66 (12%)**	80 (13%)	78 (13%)
Total ECT Orders made and applications refused	**571* (100%)**	612 (100%)	610^ (100%)

** One additional ECT application was determined as no jurisdiction and one additional ECT application was struck out.*

^ Five additional ECT applications were struck out.

*Table 14: Reasons applications for an ECT Order were refused **

	2021–22	2020–21	2019–20
Treatment was able to be provided in a less restrictive manner	**41%**	41%	45%
Patient had the capacity to give informed consent	**57%**	58%	55%
No instructional directive or written consent by the medical treatment decision maker (voluntary adult)	**2%**	1%	0%
Total	**100%**	100%	100%

** Results are displayed in percentages because more than one criterion may be unmet in a single hearing.*

Figure 5: Duration of ECT Orders

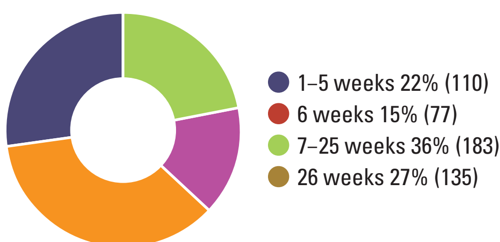


Table 15: Duration of ECT Orders

	2021–22	2020–21	2019–20
1–5 weeks	**110 (22%)**	99 (19%)	108 (20%)
6 weeks	**77 (15%)**	63 (12%)	54 (10%)
7–25 weeks	**183 (36%)**	177 (33%)	158 (30%)
26 weeks	**135 (27%)**	193 (36%)	212 (40%)
Total	**505 (100)%**	532 (100%)	532 (100%)

Figure 6: Number of ECT treatments authorised

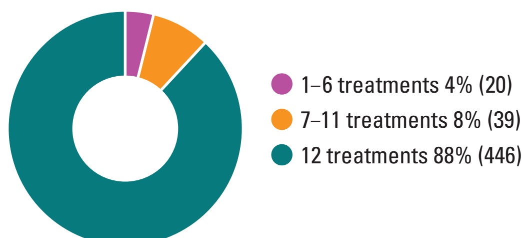


Table 16: Number of ECT treatments authorised

	2021–22	2020–21	2019–20
1-6 treatments	**20 (4%)**	27 (5%)	28 (5%)
7-11 treatments	**39 (8%)**	33 (6%)	32 (6%)
12 treatments	**446 (88%)**	472 (89%)	472 (89%)
Total	**505 (100%)**	532 (100%)	532 (100%)

Figure 7: Proportion of applications for ECT Orders which were urgent

Table 17: Proportion of applications for ECT Orders that were urgent

	2021–22	2020–21	2019–20
Urgent applications for ECT	**344 (60%)**	326 (53%)	301 (49%)
Standard applications for ECT	**227 (40%)**	286 (47%)	309 (51%)
Total ECT applications	**571 (100%)**	612 (100%)	610 (100%)

2.2.2 Urgent after-hours ECT applications

An urgent after-hours application is one that cannot wait to be heard on the next business day. The Tribunal is committed to making all reasonable efforts to enable these applications to be heard on Sundays and specified public holidays. Urgent after-hours ECT hearings are conducted as a telephone conference call.

In 2021-22, the Tribunal heard five urgent after-hours ECT applications. Four applications were granted and one was refused.

2.2.3 Elapsed time from receipt of ECT applications to hearing

The Tribunal's registry has strict processing requirements to assist it to decide when to list ECT applications, including urgent applications. The Tribunal's listing processes consider patient participation in hearings as well as the urgency of the application. Particular caution is taken in relation to listing hearings on the same day or the day after an application is received.

Urgent applications are still handled expeditiously but, the Tribunal will, where appropriate, seek to allow more time for preparation and participation by consumers and carers.

Figure 8: Elapsed time from receipt of ECT applications to hearing

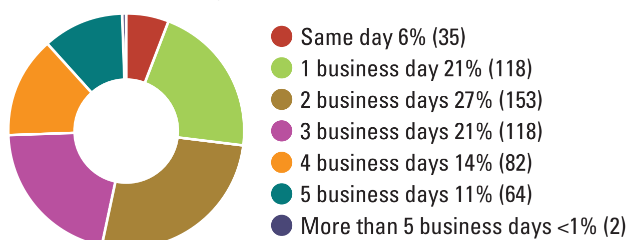


Table 18: Elapsed time from receipt of ECT applications to hearing

	2021–22	2020–21	2019–20
Same day	**35 (6%)**	24 (4%)	41 (7%)
1 business day	**118 (21%)**	148 (24%)	128 (21%)
2 business days	**153 (27%)**	170 (28%)	152 (25%)
3 business days	**117 (21%)**	111 (18%)	131 (21%)
4 business days	**82 (14%)**	82 (13%)	102 (17%)
5 business days	**64 (11%)**	76 (13%)	56 (9%)
More than 5 business days	**2 (<1%)**	1 (<1%)	0 (0%)
Total	**571 (100%)**	612 (100%)	610 (100%)

2.3 ECT Order applications related to a young person under 18 years

Compulsory patients

During 2021-22, three applications for an ECT Order were received relating to a compulsory patient under 18 years of age. Two applications were granted, and one was refused.

Voluntary patients

The Tribunal also determines whether ECT can be performed on a voluntary patient under the age of 18. During 2021-22, the Tribunal did not receive any applications concerning voluntary patients under 18 years old.

Table 19: Determinations regarding young person ECT applications

	2021–22	2020–21	2019–20
Compulsory patients – ECT Orders made			
Patient's age: 15	**2**	1	0
Patient's age: 16	**0**	2	1
Patient's age: 17	**0**	2	2
Compulsory patients – ECT application refused			
Patient's age: 17	**1**	0	0
Voluntary patients – ECT Orders made			
Patient's age: 14	**0**	0	1
Patient's age: 15	**0**	0	2
Patient's age: 16	**0**	1	1
Patient's age: 17	**0**	1	0
Total	**3**	7	7

2.4 Neurosurgery for mental illness

During 2021-22, the Tribunal received four applications to perform neurosurgery for mental illness (NMI). All applications were granted.

Table 20: Number and outcomes of applications to perform NMI

Application	Applicant mental health service	Diagnosis	Proposed treatment	Patient location	Hearing outcome
1	Royal Melbourne Hospital, Neurosurgery Unit	Obsessive Compulsive Disorder	Deep brain stimulation	Victoria	Granted
2	Royal Melbourne Hospital, Neurosurgery Unit	Obsessive Compulsive Disorder	Deep brain stimulation	SA	Granted
3	Royal Melbourne Hospital, Neurosurgery Unit	Obsessive Compulsive Disorder	Deep brain stimulation	QLD	Granted
4	Royal Melbourne Hospital, Neurosurgery Unit	Obsessive Compulsive Disorder	Deep brain stimulation	NSW	Granted

2.5 Security patients

During 2021-22, the Tribunal made 89 determinations in relation to security patients. The types of hearings and outcomes are detailed below.

Table 21: Determinations made in relation to security patients by case type

	2021–22	2020–21	2019–20
Hearings for a security patient			
28 day review			
Remain a security patient	**80**	110	88
Discharge as a security patient	**4**	5	3
Six month review			
Remain a security patient	**3**	10	5
Discharge as a security patient	**0**	0	0
Application for revocation by or on behalf of the patient			
Remain a security patient	**2**	2	2
Discharge as a security patient	**0**	1	1
Total	**89**	128	99
Application by a security patient regarding leave			
Applications granted	**0**	0	0
Applications refused	**0**	0	0
Total	**0**	0	0

2.6 Applications to review the transfer of patient to another service

During 2021-22, the Tribunal received five applications to review the transfer of a patient to another health service.

Table 22: Number and outcomes of applications to review transfer of patient to another service

	2021–22	2020–21	2019–20
Applications granted	**2**	1	0
Applications refused	**3**	3	5
Applications struck out	**0**	0	0
No jurisdiction	**0**	0	1
Total	**5**	4	6

2.7 Applications to transfer a patient interstate

During 2021-22 there were no applications received by the Tribunal to transfer a patient interstate.

Table 23: Number and outcomes of applications to transfer a patient interstate

	2021–22	2020–21	2019–20
Applications granted	**0**	0	0
Applications refused	**0**	0	0
Applications struck out	**0**	0	0
No jurisdiction	**0**	0	0
Total	**0**	0	0

2.8 Applications to deny access to documents

During 2021-22, the Tribunal received 115 applications to deny access to documents.

Table 24: Number and outcomes of applications to deny access to documents

	2021–22	2020–21	2019–20
Applications granted	**106**	99	128
Applications refused	**7**	10	31
Applications struck out	**1**	6	5
No jurisdiction	**1**	0	1
Total	**115**	115	165

2.9 Applications for review by VCAT

During 2021-22, 36 applications were made to VCAT for a review of a Tribunal decision.

Table 25: Applications to VCAT and their status

	2021–22	2020–21	2019–20
Applications made	**36**	26	31
Applications withdrawn	**9**	9	13
Applications struck out	**0**	0	2
Applications dismissed	**5**	3	5
Hearings vacated	**8**	2	2
Decision set aside by consent	**0**	0	0
No jurisdiction	**1**	0	0
Applications proceeded to full hearing and determination	**19**	10	13
Applications pending at 30 June	**6**	4	2

Table 26: Outcomes of applications determined by VCAT

	2021–22	2020–21	2019–20
Decisions affirmed	**17**	9	12
Decisions varied	**0**	1	0
Decision set aside and another decision made in substitution	**0**	0	1
Orders revoked	**1**	0	0
Other*	**1**	–	–

** One application was adjourned part heard.*

2.10 Adjournments

The Act specifies a range of deadlines for the finalisation of hearings by the Tribunal.

The Tribunal cannot adjourn a hearing to a date that is after the date on which a patient's current Treatment Order expires unless the Tribunal is satisfied that exceptional circumstances exist. If exceptional circumstances do exist, the Tribunal may extend the duration of the patient's Temporary Treatment Order or Treatment Order, but only for a maximum of ten business days, and the Tribunal must not extend the Order more than once.

The reasons for the Tribunal concluding that exceptional circumstances justified an adjournment that extended a patient's Order are collated under three categories: procedural fairness (including to enable participation of the patient or other relevant persons in the hearing), to enable legal representation, and where the mental health service was not ready to proceed with the hearing.

Figure 9: Hearings adjourned

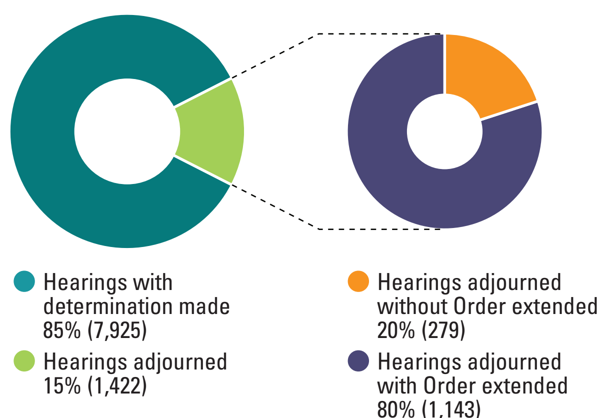


Table 27: Hearings adjourned

	2021–22	2020–21	2019–20
Hearings adjourned without Order extended	**279 (20%)**	259 (19%)	211 (21%)
Hearings adjourned with Order extended	**1,143 (80%)**	1,072 (81%)	814 (79%)
Total	**1,422 (100%)**	1,331 (100%)	1,025 (100%)
Hearings adjourned as a percentage of total hearings conducted	**15%**	14%	12%

Figure 10: Reasons for adjournments with extension of Order

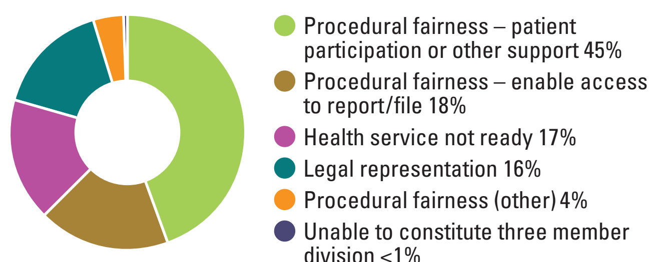


Table 28: Reasons for adjournments with extension of Order

	2021–22	2020–21	2019–20
Procedural fairness - patient participation or other support	**45%**	38%	42%
Procedural fairness - enable access to report/file	**18%**	16%	11%
Health service not ready	**17%**	18%	20%
Legal representation	**16%**	21%	20%
Procedural fairness (other)	**4%**	7%	6%
Unable to constitute three member division	**< 1%**	0%	1%
Total	**100%**	100%	100%

2.11 Attendance and legal representation at hearings

Part Three of the Annual Report highlights the Tribunal's commitment to promoting the participation in hearings of patients and the people who support them. Pursuant to s189 of the Act, the Tribunal must provide notice of the hearing to the patient, the patient's parent if they are under the age of 16, the authorised psychiatrist and the following persons if applicable:

- any person whose application to be a party to the proceeding has been approved by the Tribunal
- the nominated person of the person who is the subject of the proceeding
- a guardian of the person who is the subject of the proceeding
- a carer of the person who is the subject of the proceeding.

The Tribunal seeks to maximise the notice period as much as possible and strongly encourages the attendance of patients and those who support them at all hearings.

Table 29: Number and percentage of hearings with the patients and support people in attendance

	2021–22	2020–21	2019–20
Patient	**5,743 (62%)**	5,956 (63%)	5,043 (59%)
Family member	**1,691 (18%)**	1,712 (18%)	1,544 (18%)
Carer	**357 (4%)**	373 (4%)	372 (4%)
Nominated person	**269 (3%)**	250 (3%)	195 (2%)
Medical treatment decision-maker	**23 (<1%)**	26 (<1%)	37 (<1%)
Support person	**4 (<1%)**	1 (<1%)	0 (0%)
Interpreter	**457 (5%)**	455 (5%)	433 (5%)
Legal representative	**1,133 (12%)**	1,222 (13%)	1,107 (13%)

Legal representation at hearings

As noted in Part One, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. The following table shows the number of patients who were legally represented at a hearing in 2021-22.

Table 30: Legal representation at hearings

	2021–22	2020–21	2019–20
Victoria Legal Aid	**929 (10%)**	1,048 (12%)	970 (12%)
Mental Health Legal Centre	**158 (2%)**	126 (1%)	95 (1%)
Private Lawyer	**36 (<1%)**	31 (<1%)	28 (<1%)
Other Community Legal Centre	**10 (<1%)**	17 (<1%)	14 (<1%)
Total legal representation	**1,133 (12%)**	1,222 (13%)	1,107 (13%)

2.12 Mode of conducting hearings

During 2021-22 the Tribunal implemented Microsoft Teams as the platform for the conduct of hearings. Since 29 November 2021 all hearings have been conducted online using Teams, giving participants the choice to participate online or by telephone. See Part One for further details.

Table 31: Hearings conducted by mode

	2021–22	2020–21	2019–20
In-person	**0 (0%)**	0 (0%)	5,215 (60%)
Online via Teams	**6,088 (65%)**	– –	– –
Video conference	**– –**	0 (0%)	1,435 (16%)
Teleconference*	**3,259 (35%)**	9,543 (100%)	2,137 (24%)
Total hearings conducted	**9,347 (100%)**	9,543 (100%)	8,787 (100%)

** Complete data about the number of hearings conducted with ancillary video in 2019-20 is not available.*

2.13 Compliance with statutory deadlines

A key element of the Registry's listing procedures is to ensure that a hearing will be conducted within the relevant timeframe specified in the Act. In a small number of matters, statutory deadlines are missed.

Table 32: Hearings not conducted within statutory deadlines

	Number
Hearing unable to proceed because the patient's Treatment Order had expired #	1
Hearings adjourned by the Tribunal to be heard out of time*	34
Hearing conducted out of time ^	8
Total	43

 # One hearing could not proceed due to an error on the part of the health service.

** Occasionally the Tribunal will adjourn a matter to a date that is after the relevant statutory deadline; most commonly this is done where it is necessary to afford a patient procedural fairness and this is only done in variation hearings.*

^ Some matters can be heard even when the applicable statutory deadline is missed; six arose because of an error on the part of a health service and two because of an error by the Tribunal.

2.14 Customer service

The Tribunal's Service Charter is published on our website and outlines the service standards people can expect from the staff of the Tribunal. These standards include that the Tribunal will answer 90% of phone calls within 15 seconds, and respond to email enquiries within two business days, unless the enquiry is complex and/or requires investigation and cannot be fully responded to within that timeframe. In 2021-22, the Tribunal responded to all email and website enquiries in accordance with the Service Charter, and responded to 82% of phone calls within 15 seconds. A number of factors contributed to the Tribunal's inability to meet the service charter for phone calls. These include technical issues delaying or preventing Tribunal staff from receiving calls, implementation of new call centre software and periods of low staffing levels due to unplanned leave.

The Tribunal's Registry aims to send Treatment Orders and ECT Orders to relevant parties within five working days of a hearing. In 2021-22, the Tribunal achieved this target 100% of the time.

Table 33: Sending Treatment and ECT Orders to relevant parties

	2021–22	2020–21	2019–20
Percentage of Orders sent to parties within five working days of a hearing	**100%**	99%	64%
Average number of days to send Orders to parties	**Same day**	Same day	6 days

Part 3 Embedding the mental health principles and recommendations of the Royal Commission

The new system stewards must redefine and broaden what constitutes expertise; they must elevate lived experience by treating consumers, families, carers and supporters as partners and experts in their own right; and they must embrace and invite new actors – people and organisations – into the system. This requires new ways of working to harness commitment and diverse ideas:

> *For consumers to be heard, especially at the higher levels, or at any level of an organisation, organisations need to go out of their way to listen to them. Rather than encouraging consumers to speak in ways that are easier to listen to, sometimes organisations need to improve their ability to hear.*
>
> *[Better solutions would be possible if] the decision makers heard from and actually understood the people experiencing the problem.*[4]

Creating opportunities for, and embedding the contribution of, people with lived experience in a new mental health system is a key pillar of the proposed reforms in the Final Report of the Royal Commission into Victoria's Mental Health system (the Royal Commission Report), as the above quotation from the Royal Commission Report illustrates.

This year, the Royal Commission Report has become an important guide for the work of the Tribunal. Our new Strategic Plan for 2021–2024 includes a new strategic priority, namely to contribute to implementing the recommendations of the Royal Commission, including the commitment to strengthen the involvement of consumers and carers with lived experience in all aspects of our operations.

Alongside and complementing the focus on lived experience the Tribunal's work continues to be guided by the 12 mental health principles set down in the *Mental Health Act 2014* (Vic). As the Victorian Supreme Court confirmed in its landmark decision in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, persons performing duties or functions or exercising powers under the Act, including the Tribunal, must have regard to these principles.[5] Among other things the principles focus on least restrictive treatment and promote recovery and full participation in community life. The principles emphasise that consumers should be involved in all decisions about their treatment and recovery, and they should be supported to make, or participate in, decisions. The principles state that the rights, dignity and autonomy of persons receiving mental health services should be respected and promoted and that people should be allowed to make decisions about their treatment and recovery that involve a degree of risk.

This part of the Annual Report describes how the focus on strengthening the involvement of people with lived experience in line with the Royal Commission Report as well as the mental health principles inform and underpin the work of the Tribunal across the whole organisation.

4 Royal Commission into Victoria's Mental Health System, Final Report, Volume 1, A new approach to mental health and wellbeing in Victoria, State of Victoria, February 2021, 43, citations omitted.

5 *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, [67] and [256].

The mental health principles

Section 11(1) of the Mental Health Act contains the following 12 principles to guide the provision of mental health services:

- **Persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred.**
- **Persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.**
- **Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.**
- **Persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.**
- **Persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.**
- **Persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.**
- **Persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.**
- **Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to.**
- **Children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.**
- **Children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected.**
- **Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.**
- **Carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.**

Mental Health Tribunal

Strategic Plan 2021-2024

Our Strategic Priorities

Our Vision

That the principles and objectives of Victoria's mental health legislation are reflected in the experience of consumers and carers.

Our Mission

The Mental Health Tribunal decides whether a person receives compulsory treatment under Victoria's mental health legislation. Our hearings focus on human rights, recovery, least restrictive treatment and the participation of consumers, carers and clinicians.

Our Values

We value lived experience and are:

- Fair
- Respectful
- Collaborative

1 Contribute to implementing the recommendations of the Royal Commission into Victoria's Mental Health System.

We will implement the system reforms and embrace the cultural change in the recommendations of the Royal Commission.

Over the life of this plan the Tribunal will:

- Contribute to the development of the Mental Health and Wellbeing Act and the progress of other reforms where input is needed.
- Work collaboratively with all stakeholders to implement the Mental Health and Wellbeing Act.
- Continue to strengthen the involvement of consumers and carers with lived experience in all aspects of our operations.

2 Continue to refine our hearing processes with a focus on operating flexibly and sustainably.

We will work with stakeholders to design and implement process reforms that support hearing participants and provide high-quality hearings that are responsive to individual needs.

Over the life of this plan the Tribunal will:

- Engage with stakeholders to design flexible hearing models that enable the delivery of high-quality hearings that are responsive to the needs of hearing participants.
- Expand our case management capacity to deliver innovative and responsive hearing schedules.
- Collaborate with health services and advocates to improve pre-hearing preparation procedures.
- Survey consumers, carers, treating teams and legal representatives about their experience of hearings to identify opportunities for improvement.
- Continue to explore and implement information technology enhancements to achieve efficiencies and improve our environmental sustainability.

3 Ensure fair, consistent, and solution-focused hearings.

We continually strive to improve our skills and systems to deliver fair and solution-focussed hearings.

Over the life of this plan the Tribunal will:

- Enhance our competency-based education strategy for members.
- Increase opportunities for dialogue between members about the performance of our functions.
- Continue to improve report templates for hearings.
- Develop a Reconciliation Action Plan.
- Continue to collaborate with Victoria Legal Aid and the Mental Health Legal Centre on a framework to guide advocacy in hearings.

Mental Health Tribunal

3.1 Tribunal Advisory Group

The Tribunal Advisory Group (TAG) consists of consumers, carers and lived experience workforce members, along with the Deputy President, Chief Executive Officer, and Consumer and Carer Engagement Officer of the Tribunal. The role of the TAG is to provide strategic and operational advice to the Tribunal.

TAG members are generally engaged for up to two terms of two years each. We aim to renew up to half of our TAG membership every two years to maintain a balance of experienced TAG members and new member perspectives.

In 2021–22, the TAG farewelled three members: Julie McNamara, Fiona Smethurst and Pauline Ferguson. We thank these members for their contribution to the work of the Tribunal.

The Tribunal welcomed three new members: Jacqueline Rozario, Brittany McVeigh and Jeanette Murphy. We look forward to continuing to learn from the expertise our current and newest members bring to the work of the TAG.

During 2021–22, the TAG undertook or advised on a number of strategic activities, including:

- updating the Tribunal's Consumer and Carer Engagement Framework
- advising on the third Tribunal Hearing Experience (THE) survey, which commenced in May
- participating in the Advocacy Project
- presenting at Twilight Seminars for Tribunal members.

Results of this year's THE survey will be shared and used to continue to improve how patients and their carers and family members experience Tribunal hearings. We anticipate the results will be shared, and responses workshopped at the next Consumer and Carer Forum.

The TAG is continually involved in the ongoing development and review of information products for consumers and carers, including the information that is available on the Tribunal's website. This year, TAG advised on the first review of the template for Treatment Order hearing reports to try and ensure reports are clear, accessible, strengths-based and recovery-focused, and is working with Tribunal staff on the design of revised report templates for additional types of hearings.

Case Study

Lived experience perspectives informing the Tribunal's work via the TAG

I joined the Tribunal Advisory Group (TAG) in 2018 as a carer member. While being a member of the TAG I have also attended Tribunal hearings to support the person I care for. It has been so reassuring to experience the direct impact of the work of the TAG and see the positive shift in the hearings conducted by the Tribunal.

The TAG has been able to contribute to developing a treating team report template which assists the person and their carer to better understand the reasons why the treating team are asking for an Order. The report reflects who the person is, now focusing on recent information and no longer harks back to historical matters from years ago. The report is a lot more hopeful and concise.

Being a member of the TAG, I have been part of the website development and the mapping of the whole patient and carer journey with the Tribunal and every piece of written communication from the Notice of Hearing, the report and the letter that confirms the hearing outcome. Communications are short, simple and straight forward.

It is notable that the Tribunal has worked very hard on how it works in a solution- and recovery-focused way, to foster hope and recovery. As a TAG member I have been asked to contribute to foundational resources such as the Solution-focused Hearings Guide, the Members Competency Framework, Code of Conduct and Feedback Framework as well as the Tribunal's strategic plan. I have been a member of many advisory groups and committees over the years, and I think the way the Tribunal works with the TAG demonstrates it is firmly committed to keeping the rights of people at the heart of its work.

Top row, left to right:
Mary Eckel, Fiona Smethurst, Jan Dundon, Tony Lupton (consulting with TAG), Ali Pain,

Bottom row, left to right:
Peter McDonald, Julie McNamara, Pauline Ferguson, Elvis Martin.

Not pictured:
Tracey Taylor, Troy Barty

3.2 Elevating consumer and carer perspectives in strategic and business activities

Alongside our well-established TAG, the Tribunal took a number of steps in 2021–22 to expand the inclusion of people with lived experience in organisational decision-making, projects and internal education programs. This included:

- appointing two lived experience Tribunal members to the Tribunal's Governance Group; one with lived experience as a consumer and one with lived experience as a carer
- establishing a lived experience members working group to provide strategic advice on how we support, value and work with Tribunal members with lived experience
- recruiting three consumers and one carer to the Tribunal's Advocacy Project working group.

Where possible, the Tribunal endeavours to include presentations from those with lived experience expertise when we conduct seminars on specific subjects. In 2021–22, two twilight seminars focused directly on lived experience and included consumers, carers and lived experience workforce members sharing their experiences with our members.

Case Study

Member using lived experience in a hearing

Tribunal members with lived experience frequently reflect on the question of whether they should refer to their lived experience in a hearing. While there is a consensus there isn't a 'hard and fast rule', referring to their lived experience in hearings is a rare exception for Tribunal members, not the norm.

One member with lived experience as a consumer recently reflected on an occasion when they did disclose:

> ***We were being asked to decide whether a 17-year-old should be placed on a Community Treatment Order after his first experience of hospital and psychosis. He came to the hearing with his mum, dressed in his school uniform. He looked very young and overwhelmed.***
>
> ***After the decision had been given (and having discussed it with my colleagues during our deliberation) I addressed the young patient directly, 'you're probably thinking what would this lot of oldies know about what it is like to be in your position? I was 17 and in Year 12 like you when I was first admitted to hospital. And there were times when I felt resentful about this happening to me. I worried that my life was now ruined. I want to let you know that despite being hospitalised and having an experience like yours at 17, I've had a good life so far. I've had good jobs, friends, I've travelled, I'm happily married'.***
>
> ***I told him that I couldn't promise it would be easy but if he could find people he trusted and could work with, his life had as much opportunity and options as anyone else. In that moment we connected. Hope matters.***

3.3 Improving the documents provided for hearings

Treating teams provide a report for each Tribunal hearing. These reports help consumers and Tribunal members understand the treating team's perspective, making it easier for consumers to participate in hearings and respond to what the treating team provides as the rationale for a Treatment Order. This is an important aspect of ensuring that hearings are procedurally fair and solution-focused.

In early 2021, the Tribunal released a report template that was simpler and spoke to consumers directly. When the new report template was released, we committed to reviewing and refining it in late 2021. We began that review by surveying Tribunal members, treating teams and legal representatives. Tribunal members then proposed solutions to identified issues at a members' forum. We then discussed those proposed solutions at a co-design workshop with Tribunal members and our TAG. We have completed the review of the report template. The improved template will be released later in 2022.

Work is also underway to develop an updated policy on the documents that should be routinely extracted from a person's clinical file and provided alongside a hearing report. A number of services currently provide extracts too large to be meaningfully considered, and more targeted extracts are essential. Smaller, targeted extracts mean critical information is before the Tribunal, and they are more accessible for consumers who choose to review the documents. Our aim is to complete this work as early as possible in 2022–23.

3.4 Advocacy Project

The Advocacy Project is an undertaking of the Tribunal, the Mental Health Legal Centre, and Victoria Legal Aid. It is a collaboration that aims to promote and enhance the quality of Tribunal hearings where legal representatives appear.

In a specialist jurisdiction such as the Tribunal, legal representation can provide invaluable support and advocacy for a person who is the subject of a hearing. The Advocacy Project's objectives recognise that high quality advocacy can contribute to constructive and recovery-focused hearings.

The Advocacy Project was launched before the handing down of the Royal Commission Report. The Royal Commission's recommendations and overarching themes resulted in some repositioning and restructuring of the project. Consequently, the Advocacy Project working group has expanded considerably to include members with lived experience, and there is acknowledgement that further initiatives may occur in response to the Royal Commission's recommendations that could impact legal advocacy in Tribunal hearings, with likely consequences for the Advocacy Project.

The Advocacy Project is in its early stages, with project team members initially exploring how advocacy can assist the Tribunal to fulfil its functions in accordance with the intentions and principles of the current Act, and to collaborate on a shared view and understanding of the role of lawyers in Tribunal hearings.

Ultimately the Advocacy Project will consider not just 'what' happens in Tribunal hearings, but also 'how' hearings are conducted and how advocates can contribute to effective hearings. With the introduction of the Mental Health and Wellbeing Bill into the Victorian Parliament in 2022, the Advocacy Project is willing and ready to respond to further developments.

Appendices

Appendix A

Financial Management Compliance Attestation Statement and Summary

Financial Management Compliance Attestation Statement

I, Jan Dundon, on behalf of the Mental Health Tribunal, certify that the Mental Health Tribunal has complied with the applicable Standing Directions of the Minister for Finance under the *Financial Management Act 1994* and its Instructions.

Jan Dundon
Chief Executive Officer

The table below provides a summary of the Tribunal's funding sources and expenditure. The Tribunal's full audited accounts are published as part of the accounts of the Department of Health in its annual report.

Funding sources and expenditure

The Tribunal receives a government appropriation directly from the Department of Health.

Appropriation

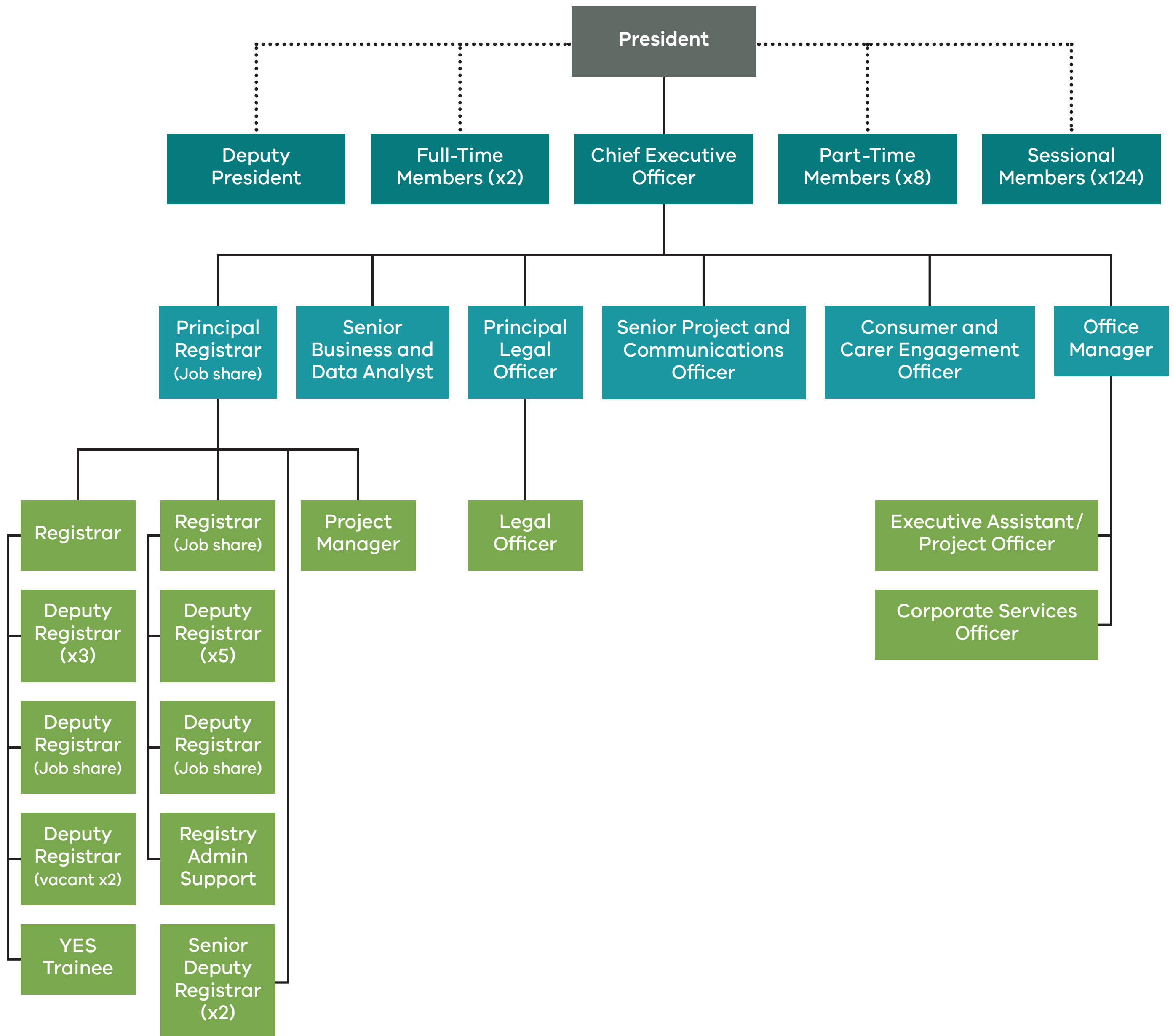
	2021-22	2020-21	2019-20
TOTAL	**$10,363,022**	$10,331,839	$10,372,077

Expenditure

Full and part-time member salaries	**$1,817,052**	$1,875,462	$1,640,080
Sessional member salaries	**$4,873,544**	$4,202,829	$4,523,247
Staff Salaries (includes contractors)	**$2,541,333**	$2,415,542	$1,956,181
Total Salaries	**$9,231,929**	$8,493,833	$8,119,508
Salary On costs	**$1,598,950**	$1,526,654	$1,259,696
Operating Expenses	**$472,353**	$583,100	$770,794
TOTAL	**$11,303,233**	$10,603,587	$10,149,998
Balance	**-$940,211***	-$271,748	$222,079

** The 2021-22 budget deficit is impacted by accrual related anomalies totalling $502,348. Accounting for these anomalies, the Tribunal's adjusted deficit is estimated at $437,863.*

Appendix B
Organisational Chart as at 30 June 2022



Appendix C

Membership List on 30 June 2022

The composition of the Tribunal includes 80 female and 57 male members, made up of four full-time members (the President, Deputy President and two Senior Legal Members), eight part-time members and 125 sessional members across all categories (legal, psychiatrist, registered medical practitioner and community).

FULL-TIME MEMBERS	Period of Appointment
President	
Mr Matthew Carroll	1 June 2003 – 1 June 2025 *Appointed President 23 May 2010*
Deputy President	
Ms Troy Barty	1 June 2003 – 9 June 2023 *Appointed Deputy President 15 March 2017*
Senior Legal Members (Full-time)	
Ms Emma Montgomery	25 Aug 2014 – 9 June 2023
Mr Tony Lupton	25 Feb 2016 – 1 Sept 2025 *Appointed Senior Legal Member 15 March 2017*

PART-TIME MEMBERS	Period of Appointment
Legal Members	
Mr Robert Daly	25 Feb 2011 – 1 Sept 2025 *Appointed Part Time Legal Member 15 September 2020*
Ms Kim Magnussen	25 Feb 2011 – 1 Sept 2025
Psychiatrist Members	
Dr Sue Carey	25 Feb 2011 – 1 Sept 2025
Dr Michael McCausland	10 June 2018 – 9 June 2023 *Appointed Part Time Psychiatrist member 15 September 2020*
Community Members	
Mr Ashley Dickinson	25 Feb 2011 – 1 Sept 2025
Dr Diane Sisely	25 Feb 2006 – 1 Sept 2025
Ms Helen Walters	10 June 2013 – 9 June 2023
Mr Graham Rodda	10 June 2018 – 9 June 2023

SESSIONAL MEMBERS	Period of Appointment
Legal Members	
Mr Darryl Annett	25 Feb 2016 – 1 Sept 2025
Mr Matthew Anstee	25 Feb 2021 – 1 Sept 2025
Ms Wendy Boddison	7 Sept 2004 – 9 June 2023
Ms Venetia Bombas	10 June 2013 – 9 June 2023
Ms Melissa Bray	25 Feb 2021 – 1 Sept 2025
Ms Meghan Butterfield	10 June 2018 – 9 June 2023
Mr Andrew Carson	3 Sept 1996 – 9 June 2023
Mr Jeremy Cass	25 Feb 2021 – 1 Sept 2025
Ms Arna Delle-Vergini	10 June 2018 – 9 June 2023
Ms Jennifer Ellis	25 Feb 2016 – 1 Sept 2025
Ms Susan Gribben	5 Sept 2000 – 9 June 2023
Ms Tamara Hamilton-Noy	25 Feb 2016 – 1 Sept 2025
Mr Jeremy Harper	10 June 2008 – 9 June 2023
Mr Brook Hely	25 Feb 2011 – 1 Sept 2023
Ms Amanda Hurst	10 June 2013 – 9 June 2023
Ms Kylie Lightman	10 June 2013 – 9 June 2023
Ms Jo-Anne Mazzeo	10 June 2013 – 9 June 2023
Ms Alison Murphy	25 Feb 2016 – 1 Sept 2025
Ms Fotini Panagiotidis	25 Feb 2021 – 1 Sept 2025
Ms Susan Tait	10 June 2013 – 9 June 2023
Assoc Prof Michelle Taylor-Sands	10 June 2013 – 9 June 2023
Mr Jayr Teng	25 Feb 2021 – 1 Sept 2025
Dr Andrea Treble	23 July 1996 – 1 Sept 2025
Ms Helen Versey	10 June 2013 – 9 June 2023
Mr Stuart Webb	10 June 2018 – 9 June 2023
Ms Jennifer Williams	7 Sept 2004 – 9 June 2023
Dr Bethia Wilson	10 June 2013 – 9 June 2023
Ms Tania Wolff	10 June 2018 – 9 June 2023
Ms Magdalena Wysocka	25 Feb 2021 – 1 Sept 2025

SESSIONAL MEMBERS	Period of Appointment
Psychiatrist Members	
Dr Peter Adams	10 June 2018 – 9 June 2023
Dr Shruti Anand	25 Feb 2021 – 1 Sept 2025
Dr George Antony	25 Feb 2021 – 1 Sept 2025
Dr Mark Arber	25 Feb 2016 – 1 Sept 2025
Dr Robert Athey	9 Oct 2012 – 1 Sept 2025
Dr Anthony Barnes	6 Nov 2019 – 9 June 2023
Dr David Baron	22 Jan 2003 – 1 Sept 2025
Dr Fiona Best	10 June 2013 – 9 June 2023
Prof Sidney Bloch	14 July 2009 – 9 June 2023
Dr Ruth Borenstein	10 June 2018 – 9 June 2023
Dr Daniel Brass	25 Feb 2021 – 1 Sept 2025
Dr Peter Braun	25 Feb 2021 – 1 Sept 2025
Dr Pia Brous	10 June 2008 – 9 June 2023
Dr Peter Burnett	10 June 2018 – 9 June 2023
Dr Robert Chazan	25 Feb 2016 – 1 Sept 2025
Dr Peter Churven	10 June 2018 – 9 June 2023
Dr Eamonn Cooke	14 July 2009 – 9 June 2023
Dr Blair Currie	9 Oct 2012 – 1 Sept 2025
Dr Joanne Fitz-Gerald	25 Feb 2016 – 1 Sept 2025 *Retired 29 October 2021*
Dr Stanley Gold	10 June 2008 - 9 June 2023
Dr Fintan Harte	13 Feb 2007 - 1 Sept 2025
Dr Harold Hecht	9 Oct 2012 - 1 Sept 2025
Dr David Hickingbotham	25 Feb 2016 - 1 Sept 2025
Dr Stephen Joshua	27 July 2010 - 1 Sept 2025
Dr Spridoula Katsenos	9 Oct 2012 - 1 Sept 2025
Dr Diana Korevaar	25 Feb 2021 - 1 Sept 2025
Dr Miriam Kuttner	7 Sept 2004 - 9 June 2023
Dr Stella Kwong	29 June 1999 - 1 Sept 2025 *Retired 1 April 2022 – awaiting confirmation by Governor in Council*
Dr Jennifer Lawrence	9 Oct 2012 – 1 Sept 2025
Dr Sheryl Lawson	10 June 2018 – 9 June 2023
Dr Grant Lester	11 March 2014 – 9 June 2023 *Retired 4 November 2021*
Dr Margaret Lush	3 Sept 1996 – 9 June 2023
Dr Barbara Matheson	9 Oct 2012 – 1 Sept 2025
Dr Peter McArdle	14 Sept 1993 – 9 June 2023
Dr Peter Millington	30 Oct 2001 – 9 June 2023
Dr Frances Minson	30 Oct 2001 – 9 June 2023
Dr Ilana Nayman	9 Oct 2012 – 1 Sept 2025
Prof Daniel O'Connor	27 June 2010 – 1 Sept 2025
Dr Nicholas Owens	10 June 2013 – 9 June 2023
Dr Philip Price	10 June 2018 – 9 June 2023
Dr Philip Roy	09 Oct 2012 – 1 Sept 2025
Dr Amanda Rynie	25 Feb 2016 – 1 Sept 2025
Dr Joanna Selman	11 March 2014 – 9 June 2023
Dr John Serry	14 July 2009 – 9 June 2023
Dr Anthony Sheehan	10 June 2008 – 9 June 2023
Dr Robert Shields	10 June 2018 – 9 June 2023
Assoc Prof Dean Stevenson	25 Feb 2021 – 1 Sept 2025
Dr Jennifer Torr	11 March 2014 – 9 June 2023
Dr Maria Triglia	25 Feb 2011 – 1 Sept 2025
Assoc Prof Ruth Vine	9 Oct 2012 – 1 Sept 2025
Dr Sue Weigall	10 June 2018 – 9 June 2023

SESSIONAL MEMBERS	Period of Appointment
Registered Medical Members	
Dr Adeola Akadiri	25 Feb 2021 – 1 Sept 2025
Dr Trish Buckeridge	1 July 2014 – 9 June 2023
Dr Kaye Ferguson	25 Feb 2016 – 1 Sept 2025
Prof Charles Guest	25 Feb 2021 – 1 Sept 2025
Dr Naomi Hayman	1 July 2014 – 9 June 2023
Dr John Hodgson	1 July 2014 – 9 June 2023
Dr Helen McKenzie	1 July 2014 – 9 June 2023
Dr Sharon Monagle	1 July 2014 – 9 June 2023
Dr Sandra Neate	25 Feb 2016 – 1 Sept 2025
Dr Debbie Owies	1 July 2014 – 9 June 2023
Dr Stathis Papaioannou	1 July 2014 – 9 June 2023
Community Members	
Dr Nadja Berberovic	25 Feb 2021 – 1 Sept 2025
Prof Lisa Brophy	10 June 2008 – 9 June 2023
Mr Duncan Cameron	10 June 2008 – 9 June 2023
Dr Leslie Cannold	10 June 2013 – 9 June 2023
Ms Katrina Clarke	10 June 2018 – 9 June 2023
Ms Paula Davey	29 Oct 2014 – 9 June 2023
Ms Robyn Duff	25 Feb 2011 – 1 Sept 2025
Ms Sara Duncan	10 June 2013 – 9 June 2023
Ms Angela Eeles	10 June 2018 – 9 June 2023
Cr Josh Fergeus	25 Feb 2021 – 1 Sept 2025
Mr Harry Gelber	25 Feb 2021 – 1 Sept 2025
Ms Jacqueline Gibson	10 June 2018 – 9 June 2023
Mr John Griffin	25 Feb 2011 – 1 Sept 2025
Prof Margaret Hamilton	25 Feb 2016 – 1 Sept 2025
Ms Philippa Hemus	25 Feb 2021 – 1 Sept 2025
Mr Ben Ilsley	10 June 2013 – 9 June 2023
Ms Erandathie Jayakody	10 June 2018 – 9 June 2023
Mr Jie (George) Jiang	25 Feb 2021 – 1 Sept 2025
Mr John King	1 June 2003 – 1 Sept 2025
Ms Danielle Le Brocq	10 June 2013 – 9 June 2023
Mr John Leatherland	25 Feb 2011 – 1 Sept 2025
Ms Anne Mahon	10 June 2013 – 9 June 2023
Dr Kylie McShane	29 June 1999 – 1 Sept 2025
Dr Patricia Mehegan	10 June 2008 – 9 June 2023
Ms Sarah Muling	25 Feb 2016 – 1 Sept 2025
Mr Aroon Naidoo	25 Feb 2016 – 1 Sept 2025
Mr Jack Nalpantidis	23 July 1996 – 1 Sept 2025
Ms Linda Rainsford	10 June 2013 – 9 June 2023
Ms Lynne Ruggiero	10 June 2013 – 9 June 2023
Ms Veronica Spillane	25 Feb 2011 – 1 Sept 2025
Ms Helen Steele	25 Feb 2016 – 1 Sept 2025
Ms Charlotte Stockwell	10 June 2013 – 9 June 2023
Ms Zara Van Twest Smith	25 Feb 2021 – 1 Sept 2025
Dr Penny Webster	25 Feb 2006 – 1 Sept 2025
Prof Penelope Weller	10 June 2013 – 9 June 2023

Appendix D

Compliance reports

In 2020-21, the Tribunal maintained policies and procedures concerning the *Freedom of Information Act 1982* (the FOI Act), the *Public Interest Disclosures Act 2012* (the PID Act) and its records disposal authority under the *Public Records Act 1973* (the PR Act). The Tribunal has published freedom of information and protected disclosure guidelines on its website.

Application and operation of the *Freedom of Information Act 1982*

Victoria's FOI Act provides members of the public the right to apply for access to information held by ministers, state government departments, local councils, public hospitals, most semi government agencies and statutory authorities.

The FOI Act allows people to apply for access to documents held by an agency, irrespective of how the documentation is stored. This includes, but is not limited to, paper and electronic documents.

The main category of information normally requested under the FOI Act is hearing-related information from persons who have been the subject of a hearing conducted by the Tribunal. It should be noted that certain documents may be destroyed or transferred to the Public Records Office in accordance with the PR Act.

Where possible, the Tribunal provides information administratively without requiring a freedom of information request.

This financial year, the Tribunal received 30 requests for access to documents and one request that was not finalised in the previous financial year. In 20 of the requests, the information that was the subject of the request was information that related to the applicant's hearings with either the Tribunal or the former Mental Health Review Board; accordingly, the Tribunal released the documents administratively. Eight of the requests were not proceeded with, no documents were found in relation to two requests and one request had not yet been finalised on 30 June.

How to lodge a request

The Tribunal encourages members of the public to contact the Tribunal before lodging a request under the FOI Act to ascertain if the documents may be released administratively. Otherwise, a freedom of information request must be made in writing and must clearly identify the documents being requested. The request should be addressed to:

The Freedom of Information Officer
Mental Health Tribunal
Level 30, 570 Bourke Street
Melbourne Vic 3000
Phone: (03) 9032 3200
email: mht@mht.vic.gov.au

The Tribunal has developed a comprehensive guide to freedom of information. It can be accessed on the Tribunal's website.

Further information regarding freedom of information, including current fees, can be found at www.ovic.vic.gov.au.

Part II information statement

Part II of the FOI Act requires agencies to publish lists of documents and information relating to types of documents held by the agency, the agency's functions and how a person can access the information they require. The purpose of Part II of the FOI Act is to assist the public to exercise their right to obtain access to information held by agencies. Part II Information Statements provide information about the agency's functions, how it acts, the types of information the agency holds and how to access that information. The Tribunal has published its Part II Information Statement on its website.

Application and operation of the *Public Interest Disclosure Act 2012*

The PID Act encourages and facilitates disclosures of improper conduct by public officers, public bodies and other persons, and disclosures of detrimental action taken in reprisal for a person making a disclosure under that Act. The PID Act provides protection for those who make a disclosure and for those persons who may suffer detrimental action in reprisal for that disclosure. It also ensures that certain information about a disclosure is kept confidential (the content of the disclosure and the identity of the person making the disclosure).

Disclosures about improper conduct can be made by employees or by any member of the public.

During the 2021-22 financial year the Tribunal did not receive any disclosures of improper conduct.

How to make a disclosure

Disclosures of improper conduct of the Mental Health Tribunal, its members or its staff can be made verbally or in writing (but not by fax) depending on the subject of the complaint.

Disclosures about Tribunal staff may be made to the Department of Health or the Independent Broad-based Anti-Corruption Commission (IBAC). The Department's contact details are as follows:

Department of Health
Public Interest Disclosures Coordinator, Integrity, Prevention and Detection Unit
50 Lonsdale Street
Melbourne VIC 3001
Telephone: 1300 024 324
Email: publicinterestdisclosure@health.vic.gov.au

Disclosures about a Tribunal member or the Tribunal as a whole must be made directly to IBAC. IBAC's contact details are as follows:

Independent Broad-based Anti-Corruption Commission
GPO Box 24234
Melbourne VIC 3001
Telephone: 1300 735 135
Email: info@ibac.vic.gov.au
Website: www.ibac.vic.gov.au

The Tribunal has developed a comprehensive guide to protected disclosures. It can be accessed on the Tribunal's website.

Further information regarding protected disclosures can be found at www.ibac.vic.gov.au.

Mental Health Tribunal

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