Mental Health Tribunal

Annual Report
2022-2023

Protecting the rights and dignity of people with mental illness

Mental Health Tribunal

Protecting the rights and dignity of people with mental illness

Mental Health Tribunal

Level 30
570 Bourke St, Melbourne
Victoria 3000 Australia

T +61 3 9032 3200
F +61 3 9032 3223
T 1800 242 703 (toll-free)

E mht@mht.vic.gov.au
W mht.vic.gov.au

14 August 2023

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 2022 to 30 June 2023.

Yours sincerely

Matthew Carroll
President

Contents

President's Message **4**

Introduction to the Mental Health Tribunal **6**

Our vision 6

Our mission 6

Our values 6

Our strategic priorities for 2021–2024 6

Our obligations under the Charter of Human Rights and Responsibilities 6

Part One
Functions, procedures and operations of the Mental Health Tribunal **8**

1.1 The Tribunal's functions under the *Mental Health Act 2014* 8

1.2 Administrative procedures 11

1.3 Conducting hearings 13

1.4 Membership of the Tribunal 15

1.5 Working with our stakeholders 16

1.6 Online hearings and planning our future hearing model 17

Part Two
Hearing statistics for 2022-23 **18**

Key statistics at a glance 18

2.1 Treatment Orders 19

2.2 ECT Orders – Adults 22

2.3 ECT Order applications related to a young person under 18 years 24

2.4 Neurosurgery for mental illness 24

2.5 Security patients 24

2.6 Applications to review the transfer of patient to another service 25

2.7 Applications to transfer a patient interstate 25

2.8 Applications to deny access to documents 25

2.9 Applications for review by VCAT 25

2.10 Adjournments 26

2.11 Attendance and legal representation at hearings 27

2.12 Mode of conducting hearings 27

2.13 Compliance with statutory deadlines 28

2.14 Customer service 28

Part Three
Embedding the mental health principles and recommendations of the Royal Commission **30**

3.1 Tribunal Advisory Group 31

3.2 Elevating and embedding lived experience 31

3.3 Improving the documents provided for hearings 32

3.4 Preparation for the *Mental Health and Wellbeing Act 2022* 33

3.5 *Reflect* Reconciliation Action Plan 33

3.6 Implementing a process for ad hoc hybrid hearings 34

3.7 Advocacy and legal representation at the Tribunal 34

Appendix A **36**
Financial Management Compliance Attestation Statement and Summary

Appendix B **37**
Organisational Chart as at 30 June 2023

Appendix C **38**
Membership List on 30 June 2023

Appendix D **40**
Compliance reports

Accessibility

To receive this publication in an accessible format phone the Mental Health Tribunal on (03) 9032 3200, using the Translating and Interpreting Service by phoning 131 450 if required or email us at: mht@mht.vic.gov.au

President's Message

When finalising this Annual Report, the commencement of the *Mental Health and Wellbeing Act 2022* (MHW Act) was imminent. It will therefore come as no surprise that over the past year the primary focus of the Tribunal, alongside our usual business, has been preparing for the new MHW Act. While the MHW Act will preserve the same scheme of orders and hearing triggers set down in the current *Mental Health Act 2014* (MH Act), there are significant changes. The Tribunal has revised and re-written all its guidance materials for members to reflect the broader, more contemporary mental health and wellbeing principles and the elevated standards of adherence, as well as some critical changes to the law. We have also worked with the Department of Health to design and build a new hearings management system, which in turn necessitated a redesign of all our registry procedures.

Alongside preparing for the MHW Act, the Tribunal also contributed to the review of the compulsory assessment and treatment criteria contained in that Act. The Tribunal met with the Independent Panel that was formerly undertaking the review and provided a submission in response to their consultation paper. The Tribunal's submission was deliberately brief as most questions posed in the consultation paper concerned matters about which the Tribunal does not hold a view and would not seek to comment on.

The Tribunal's functions under the MH Act do enable us to provide an in-depth perspective on the way in which the current compulsory treatment criteria operate. It is premature to make too many assumptions about how the MHW Act will operate, but much can still be learned from the interpretation and application of the criteria in the current legislative scheme. Understandably a focus of the Tribunal's submission was possible changes and improvements to oversight mechanisms, particularly oversight by the Tribunal. The Tribunal continues to hold the view that for some cases that come before it, conferencing may provide an opportunity to promote the realisation of the mental health and wellbeing principles in complex matters. The Tribunal also responded to the reference in the consultation paper to the possible application of the rules of evidence in Tribunal hearings and explained why we think this would be a retrograde step.

A key achievement this year was Reconciliation Australia's endorsement of the Tribunal's *Reflect* Reconciliation Action Plan (RAP). The RAP is the Tribunal's first step in a journey towards reconciliation, with a focus on scoping and beginning to develop our capacity, and in particular starting to build relationships with Aboriginal and Torres Strait Islander stakeholders. Coincidentally, this year the Victorian Aboriginal Legal Service (VALS) established a service to provide legal representation for Aboriginal consumers of mental health services who have a Tribunal hearing. The Tribunal has worked with VALS to establish the connections needed to support this new service and play a part in promoting the service so Aboriginal consumers are aware it is available.

With the terms of appointment of approximately half of Tribunal members expiring on 9 June 2023, a member appointment round also needed to be completed this year. Appointment rounds are a joint undertaking of the department and the Tribunal and involve an enormous amount of work. This appointment round was conducted in compliance with the revised *Diversity on Victorian Government Boards* guidelines. It also built on past strategies to attract applications from individuals with lived and living experience as consumers and carers. Approximately 100 interviews were conducted, with selection panels including at least one member with lived experience and nearly all having a majority of members with lived experience. Several Tribunal members elected to retire at the end of their terms. A number had served on the Tribunal and former Mental Health Review Board for more than 20 years. I take this opportunity to acknowledge the invaluable contribution of retiring members and to welcome our newly appointed members. I also extend my thanks to Troy Barty who stepped down as Deputy President – Troy's contribution in the role of Deputy President was immense and fundamental to building the Tribunal's capacity to respond to future challenges.

An unanticipated challenge this year was a significant increase in the number of hearings the Tribunal was required to conduct. For the first half of the year there was a year-on-year increase in hearings of 3% – not insignificant but manageable. A sustained spike in the second half of the year meant our year-on-year increase rose to 7%. The Tribunal was able to conduct all these hearings but, as for any entity grappling with surging demand, it was challenging. This significant increase also adds complexity to the environment within which the new MHW Act will commence. While a clear longer-term objective of the MHW Act is to reduce the use of compulsory treatment, it is widely acknowledged that in the short to medium term it is likely to lead to more Tribunal hearings as a consequence of community treatment orders having a maximum duration of six months rather than 12 months. The Tribunal is planning for a further potential increase of 10 to 15% in the number of hearings over the next one to two years.

Last year's Annual Report acknowledged that determining 'where to next' regarding the mode the Tribunal uses to conduct hearings would be a complex undertaking. Given the need to prioritise work to prepare for the MHW Act, undertake a member appointment round, and respond to the significant increase in hearing numbers, there was no capacity to do this. Throughout 2022–23 the Tribunal has continued to conduct all hearings online. We do have a process for requests to be made for a hearing to be conducted with one Tribunal member present at the health service with the consumer, their support people and treating team. A small number of hearings were conducted as hybrid hearings and there were a number of matters for which plans for a hybrid hearing were being made but it did not proceed as the relevant Order was revoked, and the hearing was not required.

For now, the Tribunal will continue to conduct hearings online, and wherever possible conduct hearings by a different mode when needed. We do want to work with health services to settle on consistent facilities and processes that allow for straightforward flexibility and responsiveness, and utilisation of the technological advances of the past three years that are now an indispensable part of Tribunal hearings. We hope to start this work in the coming year, but that will depend on capacity and other demands on all those who need to be part of developing these systems.

Everything highlighted in this Annual Report (and the many things that aren't specifically mentioned) is a product of the hard work and commitment of the members and staff of the Tribunal working in partnership with our Tribunal Advisory Group. This year has asked much of everyone. Alongside the constantly growing demands of 'business as usual' there has been the need to frequently change gear to think deeply about and plan for the profound changes ahead. Everyone has risen to this challenge and I extend thanks to all.

Matthew Carroll
President

Membership changes during 2022-23

A member appointment round was finalised in March 2023. In June 2023, we welcomed nine new legal members, nine new psychiatrist members, three new registered medical members and six new community members. Further, we welcomed former Senior Legal Member, Emma Montgomery, to her new appointment as Deputy President. See Appendix C for the full list of members.

Over the course of 2022-23 several members retired. We acknowledge the contribution of and say farewell to:

Community members
Ms Sara Duncan
Ms Jacqueline Gibson
Dr Patricia Mehegan

Legal members
Ms Meghan Butterfield
Mr Andrew Carson
Ms Susan Gribben
Mr Jeremy Harper
Ms Kylie Lightman
Mr Stuart Webb
Ms Jennifer Williams

Psychiatrist members
Dr Peter Adams
Dr Robert Athey
Dr Fiona Best
Prof Sidney Bloch
Dr David Hickingbotham
Dr Miriam Kuttner
Dr Sheryl Lawson
Dr Margaret Lush
Dr Peter McArdle
Dr Frances Minson

Registered medical members
Dr Sharon Monagle
Dr Patricia Buckeridge

> An unanticipated challenge this year was a significant increase in the number of hearings the Tribunal was required to conduct.

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 increasing our ability to operate flexibly and sustainably,
- 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.

Legal Case Study 1

Treatment criterion (d): How the Tribunal determines whether a person can be treated less restrictively as a voluntary patient.

When deciding whether a person requires compulsory treatment, the Mental Health Act requires the Tribunal to consider whether '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 subject to a Treatment Order.

In QCE [2022] VMHT 9, QCE wanted to be treated on a voluntary basis. QCE had recently experienced a relapse of his mental illness that resulted in QCE being admitted to hospital for about three weeks. With treatment in hospital, QCE's mental health had stabilised and he had been discharged from hospital a few days before the hearing.

In the hearing, QCE agreed he had experienced a psychotic episode and needed to continue receiving depot (injectable) medication which had stabilised his mental health. However, QCE wanted to receive the depot medication from his general practitioner, rather than the treating team, and QCE did not believe he needed further case management support.

The treating team acknowledged that in the past QCE had a limited understanding of his illness. The treating team was pleased to see a shift during QCE's recent hospital admission – QCE now understood that the medication helped him feel more level and relaxed. However, the treating team was concerned that at the time of the hearing, QCE was in an early recovery phase and his views were still changeable. From the treating team's perspective, medication was an important part of QCE's recovery, but so too was ongoing case management support.

In this case, the Tribunal was not satisfied that QCE would receive the treatment he required if he was a voluntary patient. The Tribunal accepted that at the time of the hearing, QCE was in an early recovery stage which was a vulnerable stage as QCE's improving understanding of his illness and the importance of treatment was still fluctuating. The Tribunal accepted the information provided by the treating team that medication and case management support were necessary and GP care alone would be insufficient to support QCE's recovery. The Tribunal also considered that GP care alone had not been sufficient to keep QCE well in the lead up to his recent hospital admission, because QCE had not attended appointments with his GP due to fears about Covid-19, and because he did not have case management support at that time he was not followed up.

In JYS [2022] VMHT 8, JYS had experienced a relapse of her illness that resulted in a compulsory hospital admission. At the time of the hearing, JYS said she felt more centred and calmer, and she was able to prepare written submissions for the hearing. JYS's written submission explained her views about being a compulsory patient.

JYS wanted to be treated on a voluntary basis. She viewed compulsory treatment as offensive and soul destroying. She disagreed with the suggestion in the treating team's report that she needed compulsory treatment due to her history of refusing treatment which had resulted in multiple hospital admissions. JYS said that she had mostly agreed to treatment during her 20-year history of receiving treatment for her mental health. JYS agreed that she preferred not to continue to have lithium medication due to the side effects she experienced. She acknowledged she had stopped taking her lithium twice in the lead up to her hospital admission. Whilst her preference was to leave hospital and return to work and her family, the most important issue for JYS was that she be treated on a voluntary basis. To that end, JYS said she was willing to follow her treating psychiatrist's advice, including his recommendation to remain in hospital and continue to take lithium while she was in hospital and when she was discharged from hospital, because she trusted his advice. JYS was confident she could manage her treatment with her treating psychiatrist's advice. JYS was also aware of the warning signs that her mental health was deteriorating, which included disturbed sleep, flashbacks, seeing things, eating badly and too much, and not exercising.

The treating psychiatrist said that lithium was the most effective medication for JYS, and the other medications that had been trialled in the past were not effective. Even though at the hearing the treating psychiatrist agreed that JYS had improved considerably, he was concerned that JYS needed further treatment in hospital because her mental state had not fully stabilised and she was in the early stages of her recovery. The treating psychiatrist was concerned that if JYS was a voluntary patient she would discharge herself from hospital, refuse the lithium medication and require another hospital admission, as had occurred in the past, and he did not want this pattern to repeat.

The Tribunal acknowledged the treating team's concerns that due to JYS's recent history she may not receive immediate treatment as a voluntary patient. However, the Tribunal accepted JYS's mental health had improved during her hospital admission. At the time of the hearing, JYS's views about treatment had changed and she was willing to stay in hospital and continue the lithium. For these reasons, the Tribunal was satisfied that JYS would continue to receive the immediate treatment she needed as a voluntary patient. This meant JYS did not need to be treated on a compulsory basis.

Part One

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.

Compulsory and security patients can apply for review of a direction to take them from one mental health service to another within Victoria

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. Since February 2022 most hearings have been conducted remotely via online video using Microsoft Teams.

For some patients it is identified that an online hearing is not suitable, and a request is made to the Tribunal for their hearing to be conducted with at least one Tribunal member attending the health service in person. This is known as a hybrid hearing. The process for requesting a hybrid hearing is available on our website.

For more information about our hearings see section 1.3.

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.

> Since February 2022 most hearings have been conducted remotely online. Where this is not suitable, a hybrid hearing may be held, with at least one Tribunal member attending the health service in person

1.2.4 Case management

As the Tribunal conducts over 10,000 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:

- complex adjournments, including those where we need to ensure the participation of parties at the next hearing
- 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.

Registry's case management work to facilitate patient participation

The online hearing platform has enabled patients and their support persons to participate in Tribunal hearings without having to travel to a health service. Whilst this has made hearings more accessible most of the time, sometimes a patient's hearing experience can be adversely impacted by poor online connectivity, lack of confidence or support with the online process or other technical issues. Where the Tribunal's Registry team is informed of a barrier affecting a patient's ability to participate, we will work with the patient and health service to maximise participation and improve the patient's hearing experience.

This year the Registry team received feedback from a patient following a Tribunal hearing where the patient reported they and their support person had been unable to join and take part in their hearing.

The patient requested another hearing which was case managed by the Registry team. The patient was provided more information about how they and their support person could participate on the day. Registry sent the hearing details to the patient directly (instead of to the health service) to enable them to provide the details to their support person. As the patient had been transferred to a new health service, Registry liaised with the new health service to help the treating team support the patient to join the online hearing. Registry also ensured that extra time was allocated for the hearing to resolve any technical issues that arose.

1.2.5 Interpreters

The Tribunal provides interpreters whenever requested by a patient or a health service. The Tribunal recognises that, even where patients or their carer 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 and carers 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 and in languages other than English. The Tribunal's website also links to other relevant websites; for example, IMHA and the Mental Health Complaints Commissioner.

> The Tribunal has developed a variety of information products for use by consumers, carers, health services and other interested parties.

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 general division 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 special division 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.

Feedback from the Members Performance Feedback Framework process (see Membership of the Tribunal) informs 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, the Mental Health Legal Centre and the Victorian Aboriginal Legal Service 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.

A full list of members is available at Appendix C.

Professional development and performance feedback processes

The Tribunal has had a Member Feedback Framework in place since 2018. It was updated and refreshed last year and is well-embedded in the Tribunal's operations.

The Tribunal has a Competency Framework and Principles of Conduct for members which deliberately and closely underpin the topics addressed in the Feedback Framework. As part of this process members undertake self-appraisal and receive feedback from other members, including the Deputy President or President.

The outcomes from these processes provide valuable information about member training needs – for individual members and for the collective membership. This support and training can take the form of informal discussions and coaching, or the provision of specific, formal presentations at any of the various member training opportunities which occur throughout the year. As part of the ongoing professional development opportunities for members, the Tribunal holds members' forums, twilight seminars and practice reflection groups.

The membership of the Tribunal comprises community members, legal members, psychiatrist members and registered medical members.

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.

The Victorian Aboriginal Legal Service (VALS) provide casework, referrals and advice for Aboriginal clients with Tribunal matters. The Tribunal meets on a regular basis with VALS to discuss issues of common interest and maintain effective working relationships.

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. The TWG meets every two months.

During 2022-23, the TWG has worked together to consolidate online hearings using the MS Teams platform, improve templates and communication, plan for the legislative reform and explore option for a future flexible hearing model. The TWG continues to be consulted and informed about:

- reviewing and simplifying our hearing notices and report templates for hearings about a Treatment Order
- the Tribunal's implementation of the *Mental Health and Well Being Act 2022*
- venue calendar review
- data breach impacts to consumers
- improving communication and procedural advice to services about participation at hearings (especially by family and carers)
- seeking feedback for the Tribunal's review into the documents required for hearings.

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
- Independent Mental Health Advocacy service
- 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.

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 were published at the end of quarters one and two and are available on our website. Quarter three was not able to be produced this year as resources were redirected to preparation for the Mental Health and Wellbeing Act.

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 2022-23 the Tribunal received 20 complaints^* and 10 pieces of feedback. These related to:

	Complaints	Feedback
Clarification of procedures	3	5
Conduct of hearings	9	4
Procedural fairness	1	–
Technical or administrative difficulty or error	6	–
Customer service	1	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 Online hearings and planning our future hearing model

The Tribunal consolidated its Microsoft Teams online hearings model by the end of 2022 following a pilot program with selected health services. The model maximises 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.

Using a similar collaborative approach with health services, the Tribunal is developing its hybrid hearings model. This model includes hearings that are conducted with at least one Tribunal member attending the hearing venue in person while the other member/s attend by online video. For further information about this hybrid hearings model, please refer to Part Three of this Annual Report.

> The Tribunal is developing a hybrid hearings model where at least one Tribunal member attends the hearing venue in person while the other member/s attend by online video.

Part Two

Hearing statistics for 2022-23

Key statistics at a glance*

	2022-23	2021-22^	2020-21^
Hearings listed**	**14,377**	13,642	13,333
Hearings conducted	**10,042**	9,346	9,544
Decisions made	**8,629**	7,925	8,213
Adjourned	**1,413**	1,421	1,331
Treatment Orders made	**7,239**	6,569	6,679
Temporary Treatment Orders / Treatment Orders revoked	**479**	449	547
ECT Orders made	**530**	507	539
ECT applications refused	**60**	67	80
NMI hearings conducted	**3**	4	3
Statement of reasons requested	**239**	221	238
Applications to VCAT	**25**	36	26

* *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 2020-21 and 2021-22 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

Attendance at hearings

	2022-23	2021-22	2020-21
Patients	**6,251**	5,744	5,957
Carers and family members	**2,266**	1,978	2,008
Nominated persons	**236**	266	250
Medical treatment decisions makers	**39**	24	26
Support persons	**3**	4	1
Interpreters	**574**	462	456
Legal representatives	**1,411**	1,167	1,257

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.

2.1 Treatment Orders

2.1.1 Outcomes of hearings regarding Treatment Orders

In 2022-23, the Tribunal made a total of 7,239 Treatment Orders and revoked 479 Temporary Treatment Orders and Treatment Orders. There were three matters where the Tribunal found it did not have jurisdiction to conduct a hearing and 90 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

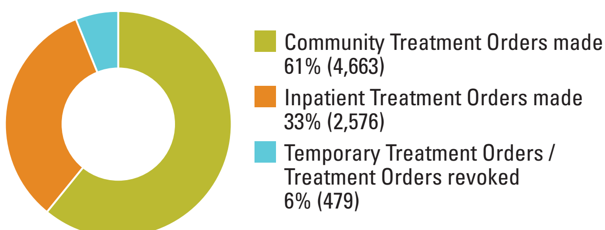


Table 1: Determinations regarding Treatment Orders

	2022-23	2021-22	2020-21
Community Treatment Orders made	**61% (4,663)**	61% (4,295)	61% (4,381)
Inpatient Treatment Orders made	**33% (2,576)**	33% (2,274)	32% (2,298)
Temporary Treatment Orders / Treatment Orders revoked	**6% (479)**	6% (449)	7% (547)
Total Orders made or revoked	**100% (7,718)**	100% (7,018)	100% (7,226)

Figure 2: Duration of Community Treatment Orders made

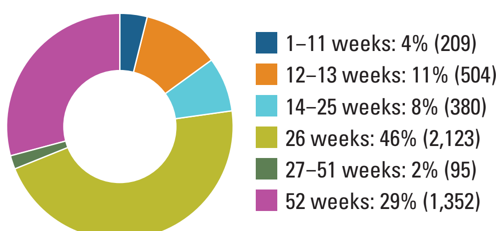


Table 2: Duration of Community Treatment Orders made

	2022-23	2021-22	2020-21
1-11 weeks	**4% (209)**	5% (208)	4% (189)
12-13 weeks	**11% (504)**	11% (489)	11% (483)
14-25 weeks	**8% (380)**	6% (265)	7% (298)
26 weeks	**46% (2,123)**	41% (1,736)	40% (1,751)
27-51 weeks	**2% (95)**	2% (91)	3% (119)
52 weeks	**29% (1,352)**	35% (1,506)	35% (1,541)
Total	**100% (4,663)**	100% (4,295)	100% (4,381)

Figure 3: Duration of Inpatient Treatment Orders made

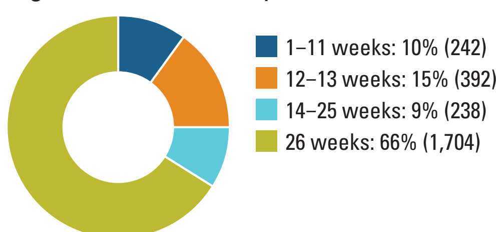


Table 3: Duration of Inpatient Treatment Orders made

	2022-23	2021-22	2020-21
1-11 weeks	**10% (242)**	10% (229)	10% (235)
12-13 weeks	**15% (392)**	17% (383)	16% (368)
14-25 weeks	**9% (238)**	7% (170)	8% (193)
26 weeks	**66% (1,704)**	66% (1,492)	66% (1,502)
Total	**100% (2,576)**	100% (2,274)	100% (2,298)

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

	2022-23	2021-22	2020-21
Community Treatment Orders made	**48% (1,624)**	46% (1,423)	46% (1,532)
Inpatient Treatment Orders made	**45% (1,544)**	46% (1,438)	45% (1,481)
Temporary Treatment Orders / Treatment Orders revoked	**7% (254)**	8% (261)	9% (289)
Total Orders made or revoked	**100% (3,422)**	100% (3,122)	100% (3,302)

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**

	2022-23	2021-22	2020-21
Treatment was able to be provided in a less restrictive manner	**86%**	86%	85%
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%**	4%	4%
Immediate treatment was not able to be provided	**9%**	8%	6%
The person did not have a mental illness	**2%**	2%	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

	2022-23	2021-22	2020-21
Community Treatment Orders made	**82% (2,724)**	84% (2,609)	83% (2,534)
Inpatient Treatment Orders made	**13% (433)**	12% (356)	11% (353)
Temporary Treatment Orders / Treatment Orders revoked	**5% (156)**	4% (128)	6% (176)
Total Orders made or revoked	**100% (3,313)**	100% (3,093)	100% (3,063)

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**

	2022-23	2021-22	2020-21
Treatment was able to be provided in a less restrictive manner	**84%**	79%	81%
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	**5%**	6%	7%
Immediate treatment was not able to be provided	**9%**	9%	8%
The person did not have a mental illness	**2%**	6%	4%
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

	2022-23	2021-22	2020-21
Community Treatment Orders made	**55% (496)**	57% (429)	58% (541)
Inpatient Treatment Orders made	**35% (316)**	33% (249)	32% (297)
Temporary Treatment Orders / Treatment Orders revoked	**10% (87)**	10% (71)	10% (88)
Total Orders made or revoked	**100% (899)**	100% (749)	100% (926)

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**

	2022-23	2021-22	2020-21
Treatment was able to be provided in a less restrictive manner	**84%**	71%	71%
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	**10%**	12%	13%
Immediate treatment was not able to be provided	**5%**	7%	4%
The person did not have a mental illness	**1%**	10%	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

	2022-23	2021-22	2020-21
Community Treatment Orders made	**10% (77)**	15% (95)	16% (100)
Inpatient Treatment Orders made	**85% (626)**	79% (501)	77% (483)
Temporary Treatment Orders / Treatment Orders revoked	**5% (39)**	6% (37)	7% (47)
Total Orders made or revoked	**100% (742)**	100% (633)	100% (630)

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**

	2022-23	2021-22	2020-21
Treatment was able to be provided in a less restrictive manner	**15%**	29%	19%
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	**0%**	3%	2%
Immediate treatment was not able to be provided	**85%**	68%	79%
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 2022-23 the Tribunal heard a total of 585 applications for an electroconvulsive treatment (ECT) Order in relation to an adult. ECT Orders were made in 475 hearings for adult compulsory patients and 51 applications were refused. ECT Orders were made in 58 hearings for adults being treated as voluntary patients and one application was refused.

Table 12: Outcomes of applications for an ECT Order

	2022-23	2021-22	2020-21
ECT Orders made			
Compulsory adult ECT	**475**	461	482
Voluntary adult ECT	**51**	44	50
ECT applications refused			
Compulsory adult ECT	**58**	64	77
Voluntary adult ECT	**1**	2	3
Total ECT Orders made and applications refused	**585**	571	612

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

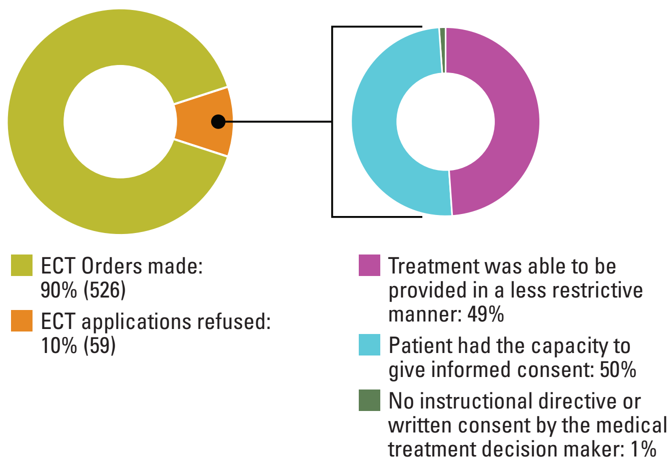


Table 13: Determinations regarding ECT applications

	2022-23	2021-22*	2020-21
ECT Orders made	**90% (526)**	88% (505)	87% (532)
ECT applications refused	**10% (59)**	12% (66)	13% (80)
Total ECT Orders made or applications refused	**100% (585)**	100% (571)	100% (612)

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

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

	2022-23	2021-22	2020-21
Treatment was able to be provided in a less restrictive manner	**49%**	40%	41%
Patient had the capacity to give informed consent	**50%**	57%	58%
No instructional directive or written consent by the medical treatment decision maker (voluntary adult)	**1%**	3%	1%
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

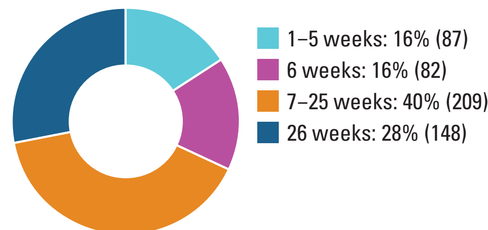


Table 15: Duration of ECT Orders

	2022-23	2021-22	2020-21
1-5 weeks	**16% (87)**	22% (110)	19% (99)
6 weeks	**16% (82)**	15% (77)	12% (63)
7-25 weeks	**40% (209)**	36% (183)	33% (177)
26 weeks	**28% (148)**	27% (135)	36% (193)
Total	**100% (526)**	100% (505)	100% (532)

Figure 6: Number of ECT treatments authorised

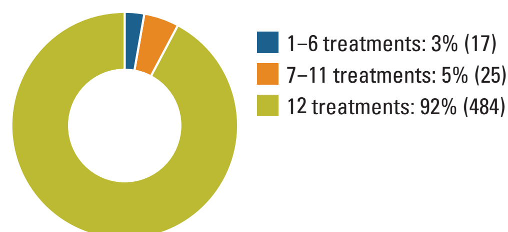


Table 16: Number of ECT treatments authorised

	2022-23	2021-22	2020-21
1-6 treatments	**3% (17)**	4% (20)	5% (27)
7-11 treatments	**5% (25)**	8% (39)	6% (33)
12 treatments	**92% (484)**	88% (446)	89% (472)
Total	**100% (526)**	100% (505)	100% (532)

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

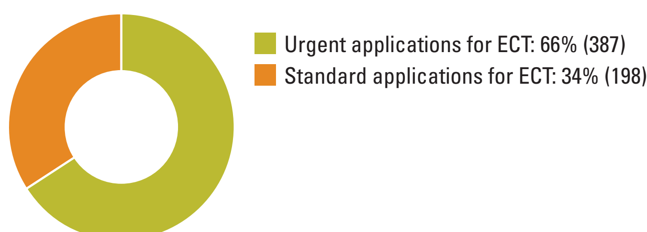


Table 17: Proportion of applications for ECT Orders that were urgent

	2022-23	2021-22	2020-21
Urgent applications for ECT	**66% (387)**	60% (344)	53% (326)
Standard applications for ECT	**34% (198)**	40% (227)	47% (286)
Total ECT applications	**100% (585)**	100% (571)	100% (612)

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. This year processes were designed to enable urgent after-hours ECT hearings to be conducted on-line using MS Teams (previously they had been conducted as a teleconference).

In 2022-23, the Tribunal heard 15 urgent after-hours ECT applications. 13 applications were granted and two were refused.

2.2.3 Elapsed time from receipt of ECT applications to hearing

The Tribunal's registry has detailed procedures that apply to the listing of ECT applications, including urgent applications. The Tribunal's listing processes consider patient participation in, and procedural fairness of, 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

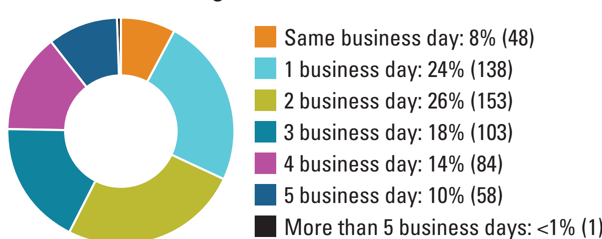


Table 18: Elapsed time from receipt of ECT applications to hearing

	2022-23	2021-22	2020-21
Same day	**8% (48)**	6% (32)	4% (25)
1 business day	**24% (138)**	22% (125)	24% (147)
2 business days	**26% (153)**	26% (151)	28% (171)
3 business days	**18% (103)**	21% (119)	18% (111)
4 business days	**14% (84)**	14% (82)	14% (82)
5 business days	**10% (58)**	11% (62)	12% (75)
More than 5 business days	**<1% (1)**	0% (0)	<1% (1)
Total	**100% (534)**	100% (571)	100% (612)

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

Compulsory patients

During 2022-23, five applications for an ECT Order were received relating to a compulsory patient under 18 years of age. Four 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 2022-23, the Tribunal did not receive any applications concerning voluntary patients under 18 years old.

Table 19: Determinations regarding young person ECT applications

	2022-23	2021-22	2020-21
Compulsory patients – ECT Orders made			
Patient's age: 15	**0**	2	1
Patient's age: 16	**4**	0	2
Patient's age: 17	**0**	0	2
Compulsory patients – ECT applications refused			
Patient's age: 16	**1**	0	0
Patient's age: 17	**0**	1	0
Voluntary patients – ECT Orders made			
Patient's age: 16	**0**	0	1
Patient's age: 17	**0**	0	1
Total	**5**	3	7

2.4 Neurosurgery for mental illness

During 2022-23, the Tribunal received three 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	Western Australia	Granted
2	Royal Melbourne Hospital, Neurosurgery Unit	Obsessive compulsive disorder	Deep brain stimulation	Victoria	Granted
3	Royal Melbourne Hospital, Neurosurgery Unit	Obsessive compulsive disorder	Deep brain stimulation	Victoria	Granted

2.5 Security patients

During 2022-23, the Tribunal made 80 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

	2022-23	2021-22	2020-21
Hearings for a security patient			
28 day review			
Remain a security patient	**76**	80	110
Discharge as a security patient	**2**	4	5
6 month review			
Remain a security patient	**1**	3	10
Discharge as a security patient	**0**	0	0
Application for revocation by or on behalf of the patient			
Remain a security patient	**1**	2	2
Discharge as a security patient	**0**	0	1
Total	**80**	89	128
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 2022-23, 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

	2022-23	2021-22	2020-21
Applications granted	**0**	2	1
Applications refused	**4**	3	3
Applications struck out	**1**	0	0
Total	**5**	5	4

2.7 Applications to transfer a patient interstate

During 2022-23 there were no applications received by the Tribunal to transfer a patient interstate.

2.8 Applications to deny access to documents

During 2022-23, the Tribunal received 139 applications to deny access to documents.

Table 23: Number and outcomes of applications to deny access to documents

	2022-23	2021-22	2020-21
Applications granted	**124**	106	99
Applications refused	**15**	7	10
Applications struck out	**0**	1	6
No jurisdiction	**0**	1	0
Total	**139**	115	115

2.9 Applications for review by VCAT

During 2022-23, 25 applications were made to VCAT for a review of a Tribunal decision.

Table 24: Applications to VCAT and their status

	2022-23	2021-22	2020-21
Applications made	**25**	36	26
Applications withdrawn	**11**	9	9
Applications struck out	**1**	0	0
Applications dismissed	**4**	5	3
Hearings vacated	**7**	8	2
Decision set aside by consent	**0**	0	0
No jurisdiction	**2**	1	0
Applications proceeded to full hearing and determination	**12**	19	10
Applications pending at 30 June	**1**	6	4

Table 25: Outcomes of applications determined by VCAT

	2022-23	2021-22	2020-21
Decisions affirmed	**9**	17	9
Decisions varied	**0**	0	1
Decision set aside and another decision made in substitution	**3**	0	0
Orders revoked	**0**	1	0
Other*	**0**	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. add sentence after 'hearing'. It is extremely rare, but a matter may be adjourned if the Tribunal is unable to constitute a three-member division.

Figure 9: Hearings adjourned

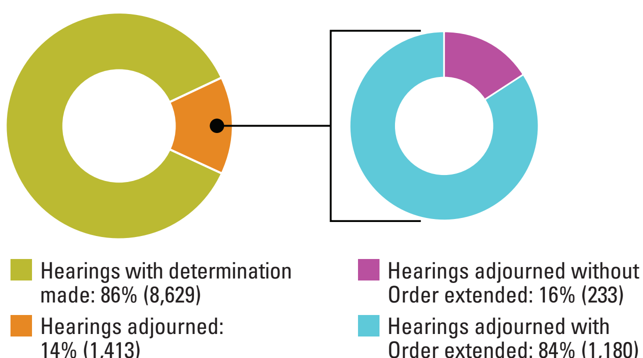


Table 26: Hearings adjourned

	2022-23	2021-22	2020-21
Hearings adjourned without Order extended	**16% (233)**	20% (279)	19% (259)
Hearings adjourned with Order extended	**84% (1,180)**	80% (1,142)	81% (1,072)
Total	**100% (1,413)**	100% (1,421)	100% (1,331)
Hearings adjourned as a percentage of total hearings conducted	**14%**	15%	14%

Figure 10: Reasons for adjournments with extension of Order

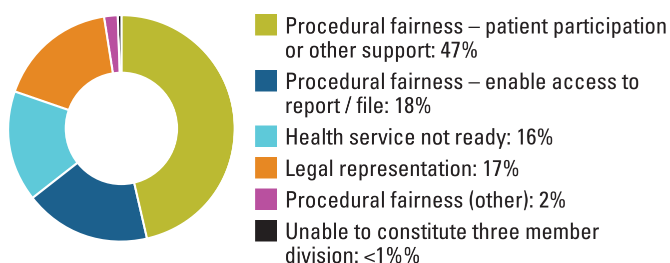


Table 27: Reasons for adjournments with extension of Order

	2022-23	2021-22	2020-21
Procedural fairness – patient participation or other support	**47%**	45%	38%
Procedural fairness – enable access to report/file	**18%**	18%	16%
Health service not ready	**16%**	17%	18%
Legal representation	**17%**	16%	21%
Procedural fairness (other)	**2%**	4%	7%
Unable to constitute three member division	**<1%**	<1%	0%
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 28: Number and percentage of hearings with the patients and support people in attendance

	2022-23	2021-22	2020-21
Patient	**62% (6,244)**	61% (5,744)	62% (5,957)
Carer / family member	**7% (739)**	7% (641)	7% (659)
Nominated person	**2% (233)**	3% (266)	3% (250)
Medical treatment decision-maker	**<1% (37)**	<1% (24)	<1% (26)
Support person	**<1% (3)**	<1% (4)	<1% (1)
Interpreter	**6% (574)**	5% (462)	5% (456)
Legal representative	**14% (1,411)**	12% (1,167)	13% (1,257)

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. In 2022-23 1,411 patients were legally represented in 14% of hearings. The following table shows patients who were legally represented at a hearing in 2022-23.

Table 29: Legal representation at hearings

	2022-23	2021-22	2020-21
Victoria Legal Aid	**72% (1,020)**	82% (956)	86% (1,078)
Mental Health Legal Centre	**23% (322)**	14% (161)	10% (128)
Private Lawyer	**2% (29)**	3% (39)	3% (31)
Victorian Aboriginal Legal Service	**2% (27)**	– –	– –
Other Community Legal Centre	**1% (13)**	1% (11)	1% (18)
Total legal representation	**100% (1,411)**	100% (1,167)	100% (1,255)

2.12 Mode of conducting hearings

Since 29 November 2021 all hearings have been conducted online using MS Teams, giving participants the choice to participate online. See Part One for further details.

Table 30: Hearings conducted by mode

	2022-23	2021-22	2020-21
In-person*	**0% (0)**	0% (0)	0% (0)
Online	**100% (9,253)**	61% (6,087)	-
Teleconference	**0% (0)**	39% (3,837)	100% (9,544)
Total hearings conducted	**100% (9,253)**	100% (9,924)	100% (9,544)

**Complete data about the number of hearings conducted in person in 2022-23 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 31: Hearings not conducted within statutory deadlines

	2022-23
Hearing unable to proceed because the patient's Treatment Order had expired #	3
Hearings adjourned by the Tribunal to be heard out of time*	41
Hearing conducted out of time ^	11
Total	55

 # Three hearings 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; eight arose because of an error on the part of a health service and three 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 30 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 2022-23, both Service Charter standards were met, with all email and website enquiries in accordance service targets, and 90% of phone calls were answered within 30 seconds.

The Tribunal's Registry aims to send Treatment Orders and ECT Orders to relevant parties on the day of hearing. In 2022-23, the Tribunal achieved this target 100% of the time.

Table 32: Sending Treatment and ECT Orders to relevant parties

	2022-23	2021-22	2020-21
Percentage of Orders sent to parties within five working days of a hearing	**100%**	100%	99%
Average number of days to send Orders to parties	**Same day**	Same day	Same day

The Tribunal's Service Charter standards include that 90% of phone calls will be answered within 30 seconds, and email enquiries will be respond to within two business days, unless the enquiry is complex and/or requires investigation.

Legal Case Study 2

Capacity to give informed consent to ECT: How the Tribunal decides a person has the ability to use or weigh information relevant to their decision.

One criterion the Tribunal must be satisfied of to grant an application for an Electroconvulsive Treatment (ECT) Order for an adult patient is that the patient does not have the capacity to give informed consent. A person has capacity to give informed consent if they understand the information they have been given that is relevant to making a decision about ECT, and they are able to remember and use or weigh information that is relevant to the decision. A person also needs to be able to communicate their decision by speech, gestures or any other means.

The Victorian Supreme Court decision in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (PBU & NJE) continues to guide Mental Health Tribunal determinations about whether a person has capacity to give informed consent to ECT. The Supreme Court confirmed, among other things, that the capacity test is a functional one in that a person must understand information relevant to the decision but only have an ability to remember, use or weigh information relevant to the decision and communicate it; they do not need to have actually done so.

The focus is on the process of making a decision rather than the content of it: a person does not lack capacity to give informed consent simply by making a decision that others consider to be unwise. Moreover, having insight, or demonstrating agreement, acceptance or appreciation of a diagnosis or having mental illness is not required for a person to have capacity; these factors may be relevant but are not determinative. Importantly, when assessing the presence or absence of each of the domains of capacity, the threshold is relatively low. This reflects the principles of self-determination, to be free of non-consensual medical treatment, personal inviolability and the dignity of the person.

In many hearings, the main issue is whether the person has the ability to use or weigh information relevant to the decision. This was the case in the hearing involving XNC (XNC [2023] VMHT 1).

XNC told the Tribunal that he didn't want ECT. He believed his previous ECT had not helped. He told the Tribunal he preferred to go back onto the medications he was on before he was admitted to hospital. He told the Tribunal he was concerned that ECT may cause brain damage as he was aware of a person on his ward who had brain damage which he believed was caused by ECT. XNC's lawyer told the Tribunal the fact XNC didn't want ECT didn't mean he couldn't weigh the information relevant to the decision. For example, he said XNC was aware he would be in hospital for a longer period if he didn't have ECT.

The treating team told the Tribunal that XNC did not have enough insight into the seriousness of his current relapse and that he believed the treating team intended to harm him with ECT. They pointed out that, despite having been given all the relevant information about ECT, XNC had refused it. However, the treating team and XNC's family members also acknowledged that XNC's mental state and level of functioning, despite some fluctuations, had significantly improved since the start of his admission.

The Tribunal accepted that XNC understood the relevant information about ECT and was also able to remember it and communicate his decision. However, the Tribunal disagreed with the treating team's view that XNC was not able to use or weigh the information relevant to his decision. It based its decision on a number of factors including that XNC:

- could describe his concerns about having further ECT and the reasons he didn't want it, including what he had observed of the effects of ECT on other patients
- appreciated that if he did not have further ECT, he may have a longer hospital stay and he had considered what his preferences would be if he took medication only.

The Tribunal referred to the presumption in the Act that a person has the capacity to give informed consent unless this presumption is displaced. It also had regard to the PBU & NJE decision, noting that the threshold for the domains of capacity, including the ability to use and weigh information about ECT, is relatively low. It also had regard to the overall improvement in XNC's mental state.

For these reasons, the Tribunal was satisfied on the day of the hearing that XNC was able to use and weigh information about ECT and that, given the other domains of capacity were not impaired, XNC had the capacity to give informed consent. This meant the Tribunal refused the treating service's application for ECT, and XNC was free to make his own decision about whether to have it.

Part Three

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.[1]

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.

The Royal Commission's recommendations have continued to be an important guide for the work of the Tribunal. Our Strategic Plan for 2021–2024 includes a strategic priority 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.[2] 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 the focus on strengthening the involvement of people with lived experience, and how the mental health principles inform and underpin the work of the Tribunal across the whole organisation.

1 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.

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

The mental health principles

Section 11(1) of the Mental Health Act 2014 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 about their assessment, treatment and recovery and 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.**

3.1 Tribunal Advisory Group

The Tribunal Advisory Group (TAG) consists of consumers, carers and lived experience workforce members, along with a Senior Legal member, the Chief Executive Officer, and the Senior Adviser Lived Experience 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 our TAG membership every two years to maintain a balance of experienced TAG member and new member perspectives.

In 2022–23, the TAG farewelled Elvis Martin and Tracey Taylor. We thank both for their significant contributions to the work of the Tribunal. We welcomed Susie Alvarez-Vasquez as a new consumer TAG member. We look forward to continuing to learn from the expertise our TAG members bring to the work of the Tribunal.

This year the TAG undertook or advised on several strategic activities, including:

- developing a more comprehensive and pro-active framework to work with and support members who bring lived experience expertise to their role
- developing a more accessible and consumer-focused template for reports for hearings concerning applications for an Electroconvulsive Treatment (ECT) Order
- updating our website pages and communication materials in preparation for the commencement of the *Mental Health and Wellbeing Act 2022* on 1 September 2023
- review of the TAG Code of Conduct and Terms of Reference.

As a result of our preparations for the Mental Health and Wellbeing Act, the TAG has deferred planning for a future consumer and carer forum until after the Act commences.

3.2 Elevating and embedding lived experience

The Royal Commission called for the elevation of lived experience expertise. Alongside our well-established TAG, the Tribunal has made ongoing, structural changes so that lived experience expertise is part of the 'bricks and mortar' of organisational governance, operations, and decision making. Ways the Tribunal delivered on this in 2022-23 included:

- the membership of the Tribunal's Governance Group includes two Tribunal members with lived experience (one with lived experience as a consumer and one with lived experience as a carer) and the Tribunal's Senior Adviser – Lived Experience
- the Tribunal's Senior Adviser Lived Experience is also a member of the CEO's Leadership Team
- continuation of the Tribunal Members Lived Experience Working Group to provide strategic advice on how we support, value and work with Tribunal members with lived experience as consumers
- continuation of the Lived Experience Network for Tribunal Members to provide support to Members with lived experience as carers
- all the selection panels for the appointment of new Tribunal Members included at least one panel member with lived experience, and in most instances the majority of panel members had lived experience
- inclusion of the Senior Adviser Lived Experience in the recruitment of senior staff positions at the Tribunal.

Where possible, the Tribunal endeavours to include presentations based on lived experience expertise when we conduct member education seminars on specific subjects. The Tribunal's ongoing efforts to elevate and embed lived experience expertise was also featured as part of the induction program for newly appointed Tribunal Members.

> The Tribunal has made ongoing, structural changes so that lived experience expertise is part of the 'bricks and mortar' of organisational governance, operations, and decision making.

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 innovate our hearing processes with a focus on operating flexibly to respond to individual needs and improving our environmental sustainability

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

3.3 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.

For several years now, under the direction of the TAG and with broad consultation, the Tribunal has developed new report templates designed to assist in the preparation of clear and concise reports that are directed to the consumer as the primary audience. During 2022–23, the focus was on developing a new template for reports concerning applications for Electroconvulsive Treatment (ECT) Orders. This work is close to completion and the new template is expected to be released in the later part of 2023.

For several years now, under the direction of the TAG and with broad consultation, the Tribunal has developed new report templates designed to assist in the preparation of clear and concise reports.

3.4 Preparation for the Mental Health and Wellbeing Act 2022

The Tribunal spent much of 2022-23 preparing for the commencement of the Mental Health and Wellbeing Act on 1 September 2023. This has been a significant program of work that will continue into the next financial year and includes:

- a new hearing management system (HeMS)
- Registry change management
- design and implementation of new procedures for Intensive Monitored Supervision Orders (this was paused until late 2023 given applications for these orders will not be possible until 2024)
- updating communications to patients and carers
- updating communications and information for health services
- updating guides for members with a particular focus on the new mental health and wellbeing principles
- updating MHT Rules
- training for members about the new Act including early exploration of how to comply with the obligation to give proper consideration to the mental health and wellbeing principles
- ensuring the Tribunal is adequately resourced to implement the new Act.

In addition to our key activities, the Tribunal has engaged and participated in a range of activities with other key stakeholders, including:

- Department of Health Mental Health and Wellbeing division
- Safer Care Victoria
- Independent Mental Health Advocacy service
- legal service providers
- mental health and wellbeing services
- Office of the Chief Psychiatrist.

3.5 *Reflect* Reconciliation Action Plan

In November 2022, the Mental Health Tribunal's *Reflect* Reconciliation Action Plan (RAP) was formally endorsed by Reconciliation Australia. The Tribunal is excited to embark on the first year of our RAP journey. Our RAP is available on our website at MHT Reflect RAP.

The Tribunal's *Reflect* RAP represents our commitment and contribution to Australia's journey of reconciliation. This includes acknowledging the deep pain, disparity, inequality, and injustices that Aboriginal and Torres Strait Islander peoples have experienced, and its ongoing impact, and the need to build relationships, respect and trust between the wider Australian community and Aboriginal and Torres Strait Islander peoples. The Tribunal's *Reflect* RAP also represents our commitment to the recognition, inclusion and voice of Aboriginal and Torres Strait Islander people in our organisation.

Our *Reflect* RAP formally commenced on 1 March 2023 and will conclude on 31 March 2024. During this time, the Tribunal will scope, reach out and seek to develop relationships with Aboriginal and Torres Strait Islander stakeholders and explore our sphere of influence. This foundational work will prepare the Tribunal for reconciliation initiatives in future RAPs.

Our vision is for a Tribunal that is culturally aware, sensitive, inclusive and safe. Recognition and inclusion of Aboriginal and Torres Strait Islander people in the Tribunal and in our hearing processes are paramount to this vision. Through implementing this and future RAPs the Tribunal also seeks to promote the principles in the current Mental Health Act, and the new Mental Health and Wellbeing Act that recognise the distinct needs and unique culture of Aboriginal and Torres Strait Islander peoples.

3.6 Implementing a process for ad hoc hybrid hearings

Since December 2022, the Tribunal has been developing a process for managing ad hoc requests for hybrid hearings. Hybrid hearings are those conducted with at least one Tribunal member attending the hearing venue in person while the other member/s attend by online video. A consumer, treating team, legal advocate/representative or a Tribunal member can ask for a hybrid hearing. The aim is to support the participation of consumers with needs that require a face-to-face hearing, such as difficulties with hearing or speech.

We sought feedback from health services through the Tribunal-Area Mental Health Service Working Group (TWG). We also provided all stakeholders, including Victorian Legal Aid, Mental Health Legal Centre, Victorian Aboriginal Legal Service, and the Independent Mental Health Advocate with guidance on how to ask for a hybrid hearing in March 2023. This is available on our website.

One reason the Tribunal cannot simply 'switch back' to how we conducted in-person hearings before the Covid-19 pandemic is that technology now plays a critical role in providing access to hearing materials and enabling participation by parties. Technology is also essential to enabling the Tribunal to conduct its caseload. A key part of planning a hybrid hearing is therefore testing arrangements with the relevant service so the hearing giving rise to the request can be conducted effectively, and that the hybrid division can operate effectively across the entire day (which will most likely involve conducting hearings for consumers at a number of other services).

During 2022-23, the Tribunal conducted four hybrid hearings. In some instances, after the request was made and planning was underway for a hybrid hearing, the hearing became unnecessary because the consumer was no longer a compulsory patient. The hearings that did proceed provided a valuable opportunity to learn and refine the necessary logistics and provided a more accessible process for the consumer.

We hope to further refine our processes and conduct hybrid hearings across more hearing venues next year. This will continue on an ad-hoc basis, although once the Tribunal and services have capacity, we aim to work through these issues systematically to settle on arrangements that allow for straightforward flexibility and responsiveness.

3.7 Advocacy and legal representation at the Tribunal

Our previous 2021–22 Annual Report provided information on an Advocacy Project, which was a collaborative undertaking of the Tribunal, the Mental Health Legal Centre, and Victoria Legal Aid. The aim of the Advocacy Project was to promote and enhance the quality of Tribunal hearings where legal representatives appear.

The Royal Commission recommended that access to legal representation for consumers who appear before the Tribunal be increased, particularly when consecutive compulsory treatment orders in the community are sought (Recommendation 56(3)). As a result, a co-design process to design a legal service model was launched. Victoria Legal Aid, the Mental Health Legal Centre, and the Victorian Aboriginal Legal Service are facilitating the co-design process, which aims to increase and improve legal services for consumers who have a Tribunal hearing. The Tribunal is part of the co-design group. As a result, we have paused the Advocacy Project to contribute to that process. When future arrangements for the delivery of legal representation services are confirmed, we will consult with our project partners to assess whether to recommence this project.

The Royal Commission recommended that access to legal representation for consumers who appear before the Tribunal be increased, particularly when consecutive compulsory treatment orders in the community are sought.

Legal Case Study 3

Mental Health Principle 11(1)(h) of the MHA and section 5(d) determining whether there is a less restrictive way to treat the person.

The mental health principles in section 11(1) of the Act have a bearing on the Tribunal's decision making and application of the criteria relevant to a hearing.

A small number of the Tribunal's hearings involve consumers who identify as Aboriginal or Torres Strait Islander. When making decisions in hearings involving Aboriginal or Torres Strait Islander patients, the Tribunal must recognise and respond to an Aboriginal person's 'distinct culture and identity…' (section 11(1)(h) of the Act). In some hearings, access by Aboriginal consumers is supported by culturally-specific services such as the Victorian Aboriginal Legal Service (VALS) or community-based organisations. The Tribunal welcomes these representatives and support people in hearings.

Amy is an Aboriginal woman who had recently re-connected with her culture and community. She resided with her 20-year-old daughter, with whom she has a close relationship. Amy had a good relationship with one of her brothers, Rob, whom she identified as an important support in her life. Amy had a NDIS support worker.

Amy attended the Tribunal hearing together with her daughter and Rob, and her NDIS support worker.

At the time of the hearing, Amy had been on a Community Treatment Order (CTO) for three months. This followed a hospital admission which occurred in the context of substance use and not taking medication. Amy applied to the Tribunal to have her CTO revoked.

Amy described experiencing substantial losses and trauma in her life. Her parents both had major mental illnesses and died early in her life. Amy was exposed to significant family violence during childhood and experienced violence from previous partners.

Amy had several hospital admissions, as well as periods of being supported by a community treatment team on a CTO as well as on a voluntary basis. She had difficulty accepting the treating team's diagnosis of a relapse of psychosis leading up to her last admission. Amy acknowledged that previously she had suffered from drug-induced psychosis and been diagnosed with Post Traumatic Stress Disorder. In her Advance Statement, Amy stated she did not wish to have injectable medication as she had previously experienced agitation and other physical health side effects.

Amy's treating team recommended the Tribunal make a 16-week CTO. The treating team stated that Amy would continue to receive injectable medication with a planned dosage reduction. The team noted that Amy's mental state had improved significantly in recent weeks. However, they said that in the past, Amy had become unwell when ceasing medication and in the context of substance use, and expressed concern this may reoccur.

Amy said she would like to have better balance in her mood and wanted to restore damaged familial relationships and to return to work. She expressed a preference for natural remedies and involvement with an Aboriginal healing service which she identified as a safe place to receive support, including addressing her substance use. Amy also planned to resume regular appointments with her psychologist.

Rob expressed concern that in the past his sister's treatment was almost entirely focused on medicines. He was pleased that Amy was embracing other forms of treatment which were culturally appropriate. Amy's daughter emphasised the importance that her mother remained well and stated that she would immediately contact the treating team if her mother developed early warning symptoms.

Amy said that she would take oral antipsychotic medication if she was treated on a voluntary basis. Amy found being on a compulsory Order and receiving depot medication to be intrusive. Amy said being on an Order diminished her sense of control and autonomy and rekindled memories of past trauma when she felt powerless over her life.

The Tribunal acknowledged the concerns raised by the treating team about Amy's history of stopping medication and using substances. However, the Tribunal had regard to Amy's commitment to reliably take her medication and work with the treating team on a voluntary basis. The Tribunal also considered Amy's active engagement with support services, particularly with culturally appropriate supports. The Tribunal had regard to her daughter's awareness of early warning signs of deterioration in Amy's mental health and assurance that she would contact the treating team with any concerns about her mother's health. The Tribunal also had regard to the value Rob placed on the cultural supports that Amy was receiving. The Tribunal concluded that Amy could be treated on a voluntary basis and did not make an Order.

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

	2022-23	2021-22	2020-21
TOTAL	**$10,927,231**	$10,363,022	$10,331,839

Expenditure

Full and part-time member salaries	**$1,595,575**	$1,817,052	$1,875,462
Sessional member salaries	**$4,919,676**	$4,873,544	$4,202,829
Staff Salaries (includes contractors)	**$2,477,300**	$2,541,333	$2,415,542
Sub-total Salaries	**$8,992,552**	$9,231,929	$8,493,833
Salary On costs	**$1,643,213**	$1,598,950	$1,526,654
Operating Expenses	**$640,587**	$472,353	$583,100
TOTAL	**$11,276,351**	$11,303,233	$10,603,587
Balance	**-$349,120**	-$940,211*	-$271,748

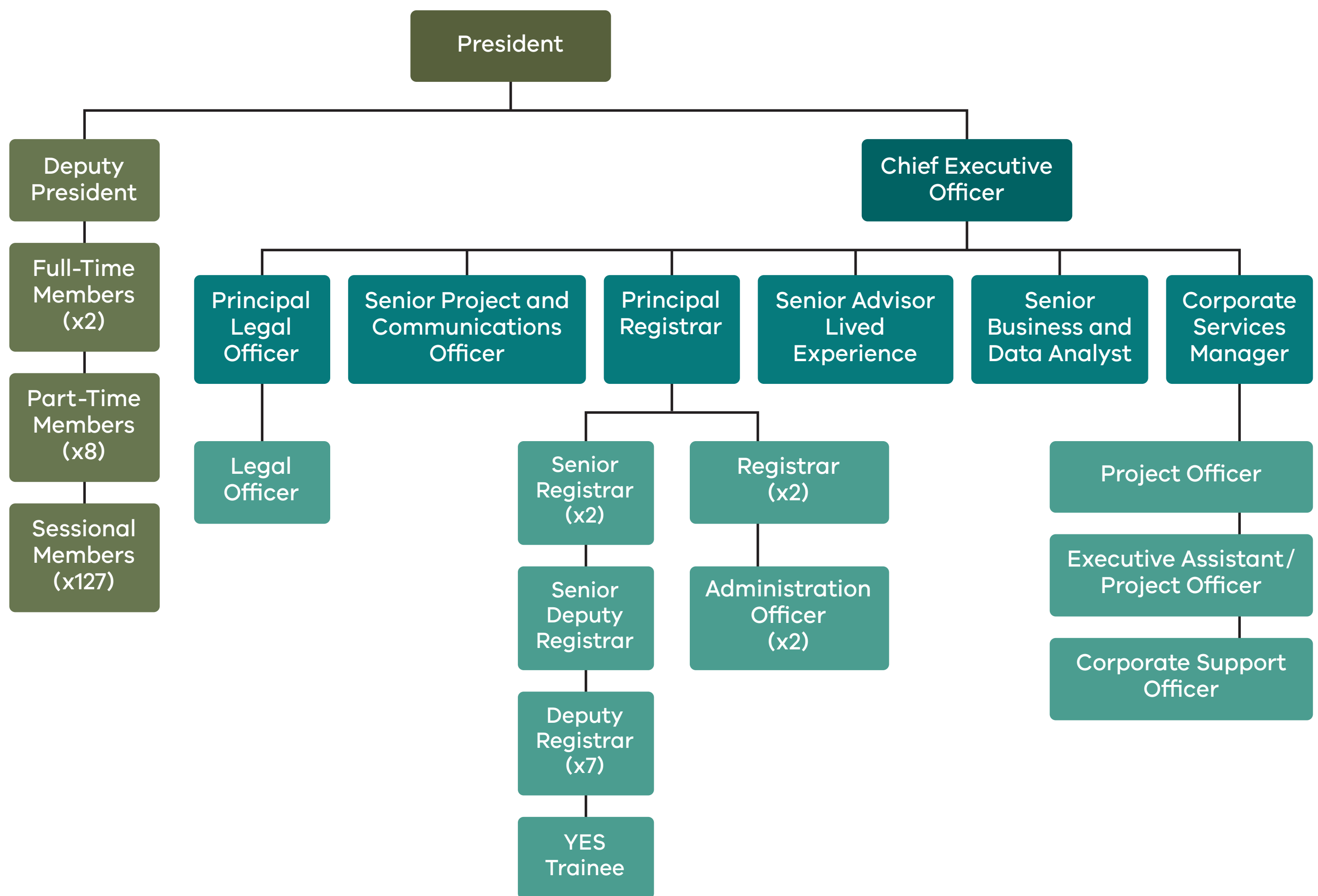
** The 2021-22 budget deficit is impacted by accrual related anomalies totalling $502,348. Accounting for these anomalies, the Tribunal's adjusted deficit is estimated at $437,863.*

Financial Reporting Direction 24:
Reporting of environmental data by government entities

The Mental Health Tribunal utilises central government contracts for the provision of all its services including electricity provision, fleet and office fit outs. Relevant environmental data pertaining to Tribunal business activity under FRD24 is captured and reported in the whole of Victorian Government reporting.

Appendix B

Organisational Chart as at 30 June 2023



Appendix C

Membership List on 30 June 2023

The composition of the Tribunal includes 83 female and 56 male members, made up of four full-time members (the President, Deputy President and two Senior Legal Members), eight part-time members and 127 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 Emma Montgomery	25 Aug 2014 - 9 June 2028
Appointed Deputy President 10 June 2023	
Senior Legal Members (Full-time)	
Mr Tony Lupton	25 Feb 2016 – 1 Sept 2025
Appointed Senior Legal Member 15 March 2017	
Ms Camille Woodward	10 June 2023 – 9 June 2028

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 Michael McCausland	10 June 2018 – 9 June 2028
Appointed Part-time Psychiatrist Member 15 September 2020	
Dr Philip Price	10 June 2018 – 9 June 2028
Appointed Part-time Psychiatrist Member 10 June 2023	
Community Members	
Mr Ashley Dickinson	25 Feb 2011 – 1 Sept 2025
Dr Kylie McShane	29 June 1999 – 9 June 2028
Appointed Part-time Community Member 10 June 2023	
Dr Diane Sisely	25 Feb 2006 - 1 Sept 2025
Ms Helen Walters	10 June 2013 – 9 June 2028

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 Troy Barty	1 June 2003 – 9 June 2028
Ms Wendy Boddison	7 Sept 2004 – 9 June 2028
Ms Venetia Bombas	10 June 2013 – 9 June 2028
Ms Melissa Bray	25 Feb 2021 – 1 Sept 2025
Ms Jodie Burns	10 June 2023 – 9 June 2028
Ms Katherine Byrne	10 June 2023 – 9 June 2028
Mr Jeremy Cass	25 Feb 2021 - 1 Sept 2025
Mr Peter Cutting	10 June 2023 – 9 June 2028
Ms Arna Delle-Vergini	10 June 2018 – 9 June 2028
Ms Jennifer Ellis	25 Feb 2016 - 1 Sept 2025
Ms Tamara Hamilton-Noy	25 Feb 2016 – 1 Sept 2025
Mr Brook Hely	25 Feb 2011 – 1 Sept 2025
Ms Amanda Hurst	10 June 2013 – 9 June 2028
Mr Gregory Levine	10 June 2023 – 9 June 2028
Ms Jo-Anne Mazzeo	10 June 2013 – 9 June 2028
Ms Robyn Mills	10 June 2023 – 9 June 2028
Ms Alison Murphy	25 Feb 2016 – 1 Sept 2025
Ms Carrie O'Shea	10 June 2023 – 9 June 2028
Ms Fotini Panagiotidis	25 Feb 2021 - 1 Sept 2025
Ms Penelope Ralston	10 June 2023 – 9 June 2028
Ms Natalie Sheridan-Smith	10 June 2023 – 9 June 2028
Ms Sue Tait	10 June 2013 – 9 June 2028
Dr Michelle Taylor-Sands	10 June 2013 – 9 June 2028
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 2028
Dr Bethia Wilson	10 June 2013 – 9 June 2028
Ms Tania Wolff	10 June 2018 – 9 June 2028
Ms Magdalena Wysocka	25 Feb 2021 – 1 Sept 2025

Sessional Members	Period of Appointment
Psychiatrist Members	
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 Abhilash Balakrishnan	10 June 2023 – 9 June 2028
Dr Anthony Barnes	10 June 2018 – 9 June 2028
Dr David Baron	22 Jan 2003 – 1 Sept 2025
Dr Ruth Borenstein	10 June 2018 – 9 June 2028
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 2028
Dr Peter Burnett	10 June 2018 – 9 June 2028
Dr Sue Carey	25 Feb 2011 – 1 Septr 2025
Dr Robert Chazan	25 Feb 2016 – 1 Sept 2025
Dr Peter Churven	10 June 2018 – 9 June 2028
Dr Eamonn Cooke	14 July 2009 – 9 June 2028
Dr Blair Currie	9 Oct 2012 – 1 Sept 2025
Dr Stanley Gold	10 June 2008 – 9 June 2028
Dr Fintan Harte	13 Feb 2007 – 1 Sept 2025
Dr Harold Hecht	9 Oct 2012 – 1 Sept 2025
Dr Graham Hocking	10 June 2023 – 9 June 2028
Dr Jill Hosking	10 June 2023 – 9 June 2028
Dr Stephen Joshua	27 July 2010 – 1 Sept 2025
Dr Spiridoula Katsenos	9 Oct 2012 – 1 Sept 2025
Dr Diana Korevaar	25 Feb 2021 – 1 Sept 2025
Dr Jenny Lawrence	9 Oct 2012 – 1 Sept 2025
Dr Melissa Lowe	10 June 2023 – 9 June 2028
Dr Barbara Matheson	9 Oct 2012 – 1 Sept 2025
Dr Kristine Mercuri	10 June 2023 – 9 June 2028
Dr Peter Millington	30 Oct 2001 – 9 June 2028
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 2028
Dr Philip Roy	9 Oct 2012 – 1 Sept 2025
Dr Amanda Rynie	25 Feb 2016 – 1 Sept 2025
Dr Jo Selman	11 March 2014 – 9 June 2028
Dr John Serry	14 July 2009 – 9 June 2028
Dr Anthony Sheehan	10 June 2008 – 9 June 2028
Dr Robert Shields	10 June 2018 – 9 June 2028
Dr Kieran Sinnott	10 June 2023 – 9 June 2028
Dr Oladipo Sorungbe	10 June 2023 – 9 June 2028
Assoc Prof Dean Stevenson	25 Feb 2021 – 1 Sept 2025
Dr Jennifer Torr	11 March 2014 – 9 June 2028
Dr Maria Triglia	25 Feb 2011 – 1 Sept 2025
Dr Ruth Vine	9 Oct 2012 – 1 Sept 2025
Dr Sue Weigall	10 June 2018 – 9 June 2028
Dr Ria Zergiotis	10 June 2023 – 9 June 2028
Dr Nina Zimmerman	10 June 2023 - 9 June 2028

Sessional Members	Period of Appointment
Registered Medical Practitioner Members	
Dr Adeola Akadiri	25 Feb 2021 – 1 Sept 2025
Assoc Prof Anthony Cross	10 June 2023 – 9 June 2028
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 2028
Dr John Hodgson	1 July 2014 – 9 June 2028
Dr Marija Kirjanenko	10 June 2023 – 9 June 2028
Dr Helen McKenzie	1 July 2014 – 9 June 2028
Dr Sandra Neate	25 Feb 2016 – 1 Sept 2025
Dr Debbie Owies	1 July 2014 – 9 June 2028
Dr Stathis Papaioannou	1 July 2014 – 9 June 2028
Dr Maxine Waycott	10 June 2023 – 9 June 2028

Sessional Members	Period of Appointment
Community Members	
Dr Nadja Berberovic	25 Feb 2021 – 1 Sept 2025
Dr Lisa Brophy	10 June 2008 – 9 June 2028
Dr Leslie Cannold	10 June 2013 – 9 June 2028
Ms Katrina Clarke	10 June 2018 – 9 June 2028
Mr Christian Cosma	10 June 2023 – 9 June 2028
Ms Paula Davey	29 Oct 2014 – 9 June 2028
Ms Robyn Duff	25 Feb 2011 – 1 Sept 2025
Ms Angela Eeles	10 June 2018 – 9 June 2028
Dr Josh Fergeus	25 Feb 2021 – 1 Sept 2025
Mr Harry Gelber	25 Feb 2021 – 1 Sept 2025
Ms Katherine George	10 June 2023 – 9 June 2028
Mr John Griffin	25 Feb 2011 – 1 Sept 2025
Prof Margaret Hamilton	25 Feb 2016 – 1 Sept 2025
Ms Renee Harrison	10 June 2023 – 9 June 2028
Ms Philippa Hemus	25 Feb 2021 – 1 Sept 2025
Mr Ben Ilsley	10 June 2013 – 9 June 2028
Ms Erandathie Jayakody	10 June 2018 – 9 June 2028
Mr Jie (George) Jiang	25 Feb 2021 – 1 Sept 2025
Mr John King	1 June 2003 – 1 Sept 2025
Ms Fiona Knapp	10 June 2023 – 9 June 2028
Ms Danielle Le Brocq	10 June 2013 – 9 June 2028
Mr John Leatherland	25 Feb 2011 – 1 Sept 2025
Ms Anne Mahon	10 June 2013 – 9 June 2028
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 2028
Mr Graham Rodda	10 June 2018 – 9 June 2028
Ms Lynne Ruggiero	10 June 2013 – 9 June 2028
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 2028
Ms Tracey Taylor	10 June 2023 – 9 June 2028
Ms Zara van Twest Smith	25 Feb 2021 – 1 Sept 2025
Dr Penny Webster	25 Feb 2006 – 1 Sept 2025
Assoc Prof Penelope Weller	10 June 2013 – 9 June 2028
Mr Kenton Winsley	10 June 2023 – 9 June 2028

Appendix D

Compliance reports

In 2022-23, 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 19 requests for access to documents and completed one request that was not finalised in the previous financial year. In 15 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. Three of the requests were not proceeded with or were withdrawn, no documents were found in relation to one request and one request was handled as a formal FOI request which was the subject of a review by the Office of the Victorian Information Commissioner.

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 2022-23 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:

Public Interest Disclosures Coordinator, Integrity, Prevention and Detection Unit
Department of Health
50 Lonsdale Street
Melbourne VIC 3000
Phone: 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
In person at IBAC's office:
North Tower, Level 1, 459 Collins Street
Melbourne VIC 3000
Phone: 1300 735 135
Email: info@ibac.vic.gov.au
Online using IBAC's online complaint form:
www.ibac.vic.gov.au/report

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

Level 30, 570 Bourke Street
Melbourne Victoria 3000

Phone: (03) 9032 3200
Email: mht@mht.vic.gov.au
www.mht.vic.gov.au

Fax: (03) 9032 3223
Vic Toll Free: 1800 242 703

ISSN 2206-544X (Print)
ISSN 2206-5458 (Online)