Mental Health Tribunal

Annual Report 2023-2024

Protecting the rights and dignity of people with mental illness

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30 August 2024

The Honourable Ingrid Stitt MP
Minister for Mental Health
50 Lonsdale Street
Melbourne Vic 3000

Dear Minister

I am pleased to present the Mental Health Tribunal's annual report of its operations for the period 1 July 2023 to 30 June 2024.

Yours sincerely

Matthew Carroll
President

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Accessibility

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President's Message

This year saw the culmination of complex and intense preparatory work across the mental health sector for the commencement of the *Mental Health and Wellbeing Act 2022* on 1 September 2023. While the new Act made no changes to the criteria governing compulsory treatment or electroconvulsive treatment under the previous *Mental Health Act 2014*, and similar functions were vested in the Mental Health Tribunal, the new Act still meant significant changes for the Tribunal.

Most importantly, the Mental Health and Wellbeing Act has changed the nature of the Tribunal's obligation relating to the mental health and wellbeing principles. Along with all other entities working under the new Act, the Tribunal is now required to give *proper consideration* to the mental health and wellbeing principles. Under the previous Mental Health Act, the Tribunal was required to *have regard* to the mental health principles. This is more than a change of phrase. It is intended to elevate the principles and requires more robust engagement with their possible implications for decisions being made. Supporting and equipping members and staff of the Tribunal to meet this obligation was a key focus of our preparatory work.

While the functions vested in the Tribunal are similar, in some instances the statutory formulation of these functions have changed. Given these highly technical changes did not impact on the parties' experience of Tribunal hearings, the work that was undertaken to incorporate these reforms largely occurred behind the scenes. This included the development of an entirely new hearings management system, which also provided an opportunity to implement a range of procedural improvements. This was a complex undertaking and at times extremely challenging, but the Tribunal and the Department of Health's Information and Digital Systems team worked together very effectively. A new system was built and implemented, and we are continuing to explore its potential to enhance our operations.

Two key changes remain works in progress. The Tribunal welcomed the expansion of Independent Mental Health Advocacy (IMHA) to become an opt-out service for people receiving, or at risk of receiving, compulsory treatment. The Mental Health and Wellbeing Act places an obligation on the Tribunal to notify IMHA when a hearing is listed, and of hearing outcomes. Over the 10 months of this year since the Act came into force, this necessitated more than 29,000 notifications from the Tribunal to IMHA. The Tribunal has met its obligation to notify since the Act commenced, but the process needs refinement to make it more useful for IMHA and streamlined for the Tribunal. This work will continue next year.

One entirely new function was vested in the Tribunal – determining applications for intensive monitored supervision orders. As we flagged in last year's annual report, work on the processes to be used for these applications was placed on hold. This is because applications could not be made until facilities were constructed to accommodate a person on such an order. Those facilities are to be located at Thomas Embling Hospital, as intensive monitored supervision orders can only be made for a person who is a patient at Thomas Embling. Work on designing the processes for these hearings will commence early in the new financial year.

Alongside work relating to implementing the Mental Health and Wellbeing Act, the Tribunal has managed unprecedented growth in the number of hearings it is required to conduct. The magnitude of this increase is better understood by examining changes in the Tribunal's caseload over the last two years.

It was always anticipated that in the short to medium term the new Act would increase the number of hearings. This is a consequence of the maximum duration of community treatment orders reducing from 12 to six months. While this is one of the reforms intended to contribute to a reduction in compulsory treatment, it was understood this impact would not be immediate. In that context the new Act would initially mean more hearings as some patients previously on a 12-month community treatment order (and having one hearing) would be on two six-month orders (and having two hearings). The Tribunal planned for this and took the cautious approach of preparing for up to a 16% increase in hearings compared to the previous year. However, the increase over the past two years was higher than anticipated at 19%. This cannot be solely attributed to the reforms the new Act introduced.

The Tribunal has been able to comply with its statutory obligations and meet this level of demand for hearings. However, the Tribunal's capacity is finite, and if hearing numbers continue to increase our ability to conduct all required hearings will become precarious. Importantly, the critical issue here is not the Tribunal's capacity; put simply, the Tribunal's current capacity should, on its face, be enough. While the number of Tribunal hearings is not a sophisticated metric of compulsory treatment, the trend in hearing numbers serves as a basic indicator. That indicator is confirming the pressing need to focus efforts on realising the vision of the Royal Commission into Victoria's Mental Health System to reduce compulsory treatment in Victoria, which is reflected in the provisions of the new Mental Health and Wellbeing Act.

In this context, the Tribunal has been pleased to be involved in the Reducing Compulsory Treatment Project being led by Safer Care Victoria in accordance with recommendation 55 of the final report of the Royal Commission. The new Mental Health and Wellbeing Act also mandates a broader range of entities with an interest and role in relation to compulsory treatment and its reduction. This opens new opportunities not available under the previous Act, and which are important to explore in the future.

In a year where core business has been so consuming I have been in awe of the focus and hard work of Tribunal members and staff. They have managed the Tribunal's increased caseload and the associated increased need for registry, legal and corporate supports, and have also engaged in ongoing exploration of how we can enhance our work. In our preparations for the new Act, members and staff all looked beyond what was essential to be done to find opportunities to do things better. This developmental work has been undertaken in partnership with our Tribunal Advisory Group (TAG). TAG members provide comprehensive and frank advice, including identifying instances where we have gotten something wrong. Our relationship with the TAG is an invaluable asset.

To everyone who has contributed to what is detailed in this report I say an enormous thank you. The year ahead will undoubtedly have its challenges, but it will also bring opportunities to achieve further progress on the implementation of the recommendations of the Royal Commission, and the enlivening of the mental health and wellbeing principles.

Matthew Carroll
President

Membership changes during 2023-24

Over the course of 2023-24, several members retired. We acknowledge the contribution of and say farewell to:

Community Members
Ms Veronica Spillane
Dr Diane Sisely

Legal Members
Ms Alison Murphy
Ms Tamara Hamilton-Noy

Psychiatrist Member
Dr Stephen Joshua

Registered Medical Member
Dr Deborah Owies

This year saw the culmination of complex and intense preparatory work across the mental health sector for the commencement of the *Mental Health and Wellbeing Act 2022* on 1 September 2023.

Introduction to the Mental Health Tribunal

The Mental Health Tribunal (the Tribunal) is an independent statutory tribunal established under the *Victorian Mental Health and Wellbeing Act 2022* (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 concerning intensive monitored supervision
- 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 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.

Reconciliation Statement

The Tribunal acknowledges the Traditional Owners of the land on which we work. We pay our respects to Elders, past and present. We acknowledge their continuing connection to Country and culture.

We acknowledge that colonisation, racism, discrimination, marginalisation and the compounding impact of intergenerational trauma have had a profound and enduring impact on mental health outcomes for Aboriginal and Torres Strait Islander peoples.

We acknowledge the negative experiences of Aboriginal and Torres Strait Islander peoples with our legal system has contributed to mistrust and a lack of confidence in those decision making bodies and legal processes. As a consequence, there is a need to build relationships, respect and trust between the Tribunal and Aboriginal and Torres Strait Islander peoples.

The mental health and wellbeing principles enshrined in the Act require that when decisions are being made under the Act, proper consideration must be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country, and water.

We commit to listening, learning, and working with Aboriginal and Torres Strait Islander peoples in Victoria to improve access to our services across the state. Our vision is for a Tribunal that is culturally aware, sensitive, inclusive, and safe. Recognition and inclusion of Aboriginal and Torres Strait Islander peoples in the Tribunal and in our hearing processes is paramount to this vision.

Our Reflect Reconciliation Action Plan (RAP) was formally endorsed by Reconciliation Australia in November 2022, and we formally commenced implementing the plan in March 2023. Our RAP is available on our website: MHT Reflect RAP

Our strategic priorities

Mental Health Tribunal

Strategic Plan 2021-2024

Our Vision

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

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Our Strategic Priorities

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

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

1.1 The Tribunal's functions under the Mental Health and Wellbeing Act 2022[1]

The functions of the Tribunal as set out in s332 of the Act are to hear and determine the following:

- a matter in relation to whether a treatment order should be made
- an application to revoke a temporary treatment order or a treatment order
- an application to review the transfer of a patient to another designated mental health service
- an application to perform electroconvulsive treatment on an adult who does not have capacity to give informed consent
- an application to perform electroconvulsive treatment on 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 a grant 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
- applications for an intensive monitored supervision order
- an application by a patient or on a patient's behalf for a revocation of the patient's intensive monitored supervision order, and
- to perform any other function which is conferred on the Tribunal under the Act, any other Act, the regulations or the rules under the Act or any other Act.

1 This Part provides a high-level summary of the Tribunal's functions, procedures and operations under the *Mental Health and Wellbeing Act 2022* (the Act) because this was the legislation in operation for most of the 2023-24 financial year (namely from 1 September 2023).

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 compulsory treatment criteria to make a treatment order are met.

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

- the person has mental illness and
- 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 and
- if the person is made subject to a treatment order the immediate treatment will be provided to the person and
- there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

When the Tribunal makes or confirms 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. If the Tribunal is *making* a treatment order it also determines the duration of a treatment order. The maximum duration of an order for adult patients is six months. Where the patient is under 18 years of age, the maximum duration of any treatment order is three months. If the Tribunal is *confirming* a treatment order the expiry date of that order remains the same and cannot be changed by the Tribunal.

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.

The patient's treating team is required to regularly reconsider both the need for an order (i.e. if the compulsory 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).

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 decision of the Tribunal must be to either revoke the order or confirm the order.

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. 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. Under 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 make an interstate transfer order if satisfied of the statutory test or refuse to make an interstate transfer order if not so satisfied.

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 in writing 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 the young person's medical treatment decision maker must 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, to prevent serious damage to the person's health, or to prevent the person from suffering or continuing to suffer 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 a lesion is created in a person's brain for the purpose of treatment; or
- the use of intracerebral electrodes to create a lesion in a person's brain for the purpose of treatment; or
- the use of intracerebral electrodes to stimulate a person's brain without creating a lesion 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.

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 neurosurgery 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.

1.1.4 Intensive monitored supervision orders

An order to allow intensive monitored supervision can only be made for a compulsory, security or forensic patient detained at Thomas Embling Hospital. To make an intensive monitored supervision order the Tribunal must be satisfied that the person poses an ongoing, unacceptable risk of seriously endangering the safety of another person; and requires an immediate period of supervision in a space that limits contact with others to mitigate the risk. The Tribunal must also be satisfied that all less restrictive options have been tried and found ineffective and that the person will be able to receive treatment or therapeutic interventions if the order is made.

The Tribunal must list and complete the hearing of an application for an intensive monitored supervision order as soon as practicable and within five business days after receiving the application. Intensive monitored supervision orders have a maximum duration of 28 days. Patients subject to an intensive monitored supervision order (or a person on their behalf) can apply to revoke the order and in such cases the Tribunal must hold a hearing as soon as practicable after the application is made.

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 by 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 and mode of hearings

Since February 2022, almost all hearings have been conducted remotely via online video using Microsoft Teams. However, in a small number of cases, where it is identified that an online hearing is not suitable, a hybrid hearing can be requested. A hybrid hearing involves at least one Tribunal member attending the health service in person. The process for requesting a hybrid hearing is available on our website.

The Tribunal conducts its hearings for patients across 57 hospitals and clinical services known as venues. To assist in the effective coordination of hearings, the Tribunal conducts hearings regularly at each venue, generally on a weekly or fortnightly basis

For more information about our hearings see section 1.3.

1.2.3 Notice of hearing

A notice of a hearing is provided to the person who is the subject of the proceeding, the patient's treating psychiatrist and the following, if applicable:

- the nominated support person of the person who is the subject of the proceeding
- if the person who is the subject of the proceeding is under 16, the person's parent
- 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 primary non-legal mental health advocacy service provider
- if the person who is the subject of the proceeding is a security patient, whoever had custody of the person before the person became a security patient
- the Secretary to the Department of Families, Fairness and Housing, if that Secretary has parental responsibility for the person who is the subject of the proceeding under a relevant child protection order
- in certain matters the person's medical treatment decision maker and support person
- any other person or body joined as a party to 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 one to two days 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.

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 identified 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 specified individuals 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.

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 persons. 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, Independent Mental Health Advocacy (IMHA) and the Mental Health and Wellbeing Commission.

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, NMI or the provision of intensive monitored supervision. 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 ECT, NMI or the provision of intensive monitored supervision. Each special division is made up of a legal member, a psychiatrist member and a community member. The legal member is the presiding member.

The Act does allow some procedural matters relating to adjournments and withdrawals to be handled by a single-member division in certain circumstances.

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 also attend – something the Tribunal strongly encourages. 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:

- 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
- 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 mental health and wellbeing principles and be responsive to the needs of particular consumers.
- 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 Act.

Alongside these resources, professional development opportunities for members are provided during the year including forums, twilight seminars and practice reflection groups.

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 Decisions and orders

The Tribunal delivers its decision orally at the conclusion of the hearing. On the same day, the Tribunal registry prepares a written order. The order is sent to the health service by email, and also to the patient, either electronically via the health service if they are an inpatient, or by post if they are in the community. Any additional person who was notified of a hearing in accordance with the Act (see above at 1.2.3) 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 outcomes and will attend a hearing if requested to do so by VCAT.

1.3.6 Statements of reasons

Parties to a 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 must 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 of reasons produced is distributed to the patient, their legal representative (if any), the authorised psychiatrist or psychiatrist of the relevant mental health service and any party joined by the Tribunal.

Publication of statements of reasons

The Act stipulates that in the performance of a function or duty, or in the exercise of a power under the Act, the Tribunal must ensure that decision making processes are transparent. In line with this obligation, the Tribunal de-identifies and publishes a selection of its statements of reasons on the AustLII website: www.austlii.edu.au.

The Tribunal publishes selected 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 and wellbeing 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 four practice notes. Practice notes deal with:

- the form of applications, clinical reports and attendance requirements
- applications to perform neurosurgery for mental illness
- 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.

The Tribunal must ensure that decision making processes are transparent. In line with this obligation, the Tribunal de-identifies and publishes a selection of its statements of reasons on the AustLII website

1.4 Membership of the Tribunal

The membership of the Tribunal comprises community members, legal members, psychiatrist members and registered medical practitioner members. Members of the Tribunal are appointed by the Governor in Council for terms of up to five years; members can 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's Member Performance Feedback Framework has been in place since 2018. It is well-embedded in the Tribunal's operations and underpinned by the Tribunal's Competency Framework and Principles of Conduct for members. As part of the feedback 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 support and training needs, both 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 the various member training opportunities which occur throughout the year. As part of the ongoing professional development opportunities for members, the Tribunal holds forums, twilight seminars and practice reflection groups.

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.

Independent Mental Health Advocacy

Independent Mental Health Advocacy (IMHA) is the primary non-legal mental health advocacy service provider under the Act. The Act requires the Tribunal to notify IMHA of all hearings and orders. The Tribunal meets on a regular basis with IMHA to discuss issues of common interest and maintain effective communication and 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 facilitates a Tribunal Working Group (TWG) to consult and engage with Area Mental Health Services (AMHS) about key administrative practices. The group includes representatives from each AMHS, providing the Tribunal with a valuable opportunity to improve our engagement with these services. The TWG meets every two months.

During 2023-24, the TWG has worked with the Tribunal to:

- implement the *Mental Health and Wellbeing Act 2022*
- implement the Tribunal's new hearing management system (HeMS)
- consolidate the process for requesting hybrid hearings
- deliver the Tribunal's updated report template for hearings about ECT
- improve communication with patients and their support people by improving the quality of data the Tribunal receives from health services
- improve the documents and information provided at hearings
- refine the Tribunal's health service liaison model.

Alongside the broad agenda and communication that occurs through the TWG, Tribunal Registry staff are in regular contact with each AMHS to respond to localised issues that are identified by either or both the Tribunal or a service.

Other engagement activities

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

- Department of Health
- Victorian Mental Illness Awareness Council (VMIAC)
- Tandem
- Mental Health and Wellbeing Commission
- Office of the Chief Psychiatrist
- Health Information Management Association Australia (Victoria branch) Mental Health Advisory Group (MHAG).

1.5.2 Quarterly Activity Report

In previous financial years Quarterly Activity Reports with data about the decisions we make were published at the end of quarters one, two and three and are available on our website.

During 2023-24, the Tribunal has not produced these reports as resources were redirected to prepare for the implementation of the Act. We anticipate resuming production of Quarterly Activity Reports in 2024-25.

1.5.3 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 by email, letter or phone or by completing an online form via the website.

During 2023-24 the Tribunal received 23 complaints^* and nine pieces of feedback. These related to:

	Complaints	Feedback
Clarification of procedures	3	3
Conduct of hearings	11	2
Procedural fairness	2	1
Technical or administrative difficulty or error	7	1
Customer service	0	2
Total	23	9

^ *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 may not match the count of complaint or feedback types as each contact can raise multiple concerns.*

Case Study

Capacity to give informed consent for ECT

The Mental Health Tribunal (Tribunal) must conduct ECT hearings within five business days of receiving an ECT application. In ECT hearings, the first criterion the Tribunal must decide is whether the person has capacity to give informed consent.

Section 87 of the *Mental Health and Wellbeing Act 2022* states that a person has capacity to give informed consent if the person:

a. *is able to understand the information they are given for the purpose of deciding whether or not to consent; and*

b. *is able to remember that information; and*

c. *is able to use or weigh that information in deciding whether or not to consent; and*

d. *is able to communicate the decision the person makes by speech, gestures or any other means.*

In many hearings, the Tribunal's decision focuses on section 87(c) of the Act; that is whether the person is able to use or weigh information in deciding whether or not to consent to ECT. This was the case in two recent hearings – one involving BDV and the other involving GJR.

In *BDV* [2024] VMHT 8, BDV had been admitted to hospital after experiencing a three-month deterioration in her mental health. She was discharged from hospital but was then readmitted to hospital a short time later. BDV was not eating or drinking in the lead up to the ECT hearing because she believed the treating team was poisoning her food and she questioned the credentials of members of the treating team.

The treating team had made many attempts to explain and discuss ECT with BDV. However, she had been unable to engage in those discussions because of the symptoms of her illness, specifically the delusions about members of the treating team seeking to harm her.

BDV told the Tribunal she did not want any treatment as she did not believe she was experiencing symptoms of a mental illness. BDV wanted to be discharged from hospital and didn't believe she needed to take any medication. In BDV's view, she had been readmitted to hospital because members of her family were setting her up so they could access her house and her bank accounts. BDV also told the Tribunal that the community mental health services were abusive, mistreated her and overmedicated her. BDV wanted an opportunity to show the treating team she could live well in the community without any medication.

The Tribunal accepted BDV's lawyer's submission that a person did not necessarily need to have insight into their diagnosis to have capacity. However, in this case BDV's strong delusional beliefs, including the belief the treating team was trying to poison her and that her family conspired against her to have her admitted to hospital, prevented her from being able to give any consideration to the risks and benefits of ECT, the need for any treatment or to think about whether there may be alternative treatments available to her. The Tribunal was therefore satisfied that BDV did not have the ability to use or weigh information relevant to the decision and did not have capacity to give informed consent to ECT.

The Tribunal's decision in *GJR* [2023] VMHT 23 also focused on whether GJR had the ability to use or weigh information in deciding whether or not to consent to ECT. GJR's preference was to remain in seclusion and continue with antipsychotic medication under the supervision of the treating team. GJR believed his mental state was slowly improving as a result of the antipsychotic medication. In GJR's view, ECT was the most restrictive form of treatment. GJR told the Tribunal he was unable to recognise when he was unwell and only realised he had experienced a relapse and needed treatment once his mental state started to improve. GJR acknowledged that when unwell he becomes aggressive and has outbursts which can scare other people. GJR had been in seclusion for an extended time. GJR said he wanted to recover from his relapse and that he would comply with treatment. GJR acknowledged the treating team recommended ECT because they did not believe antipsychotic medication had been effective in treating his symptoms. GJR also understood the treating team wanted to speed up his recovery because he had been in seclusion for an extended time and they described ECT as the best treatment option.

However, both GJR and his family were concerned about the impact ECT had on GJR's memory and functioning in the past. Although GJR acknowledged that his previous experience of ECT had a calming effect on him and resolved his symptoms to a degree, he said the trauma associated with ECT outweighed the benefits. ECT caused GJR to become slow and droopy, he felt 'zombied-out' for the day following each session and spent a lot of time in bed. He also lost the ability to recall memories and it took him a year to recover his memory following the previous course of ECT. GJR's brother agreed with GJR that he needed to continue to receive antipsychotic medication which was preferable to ECT.

The Tribunal acknowledged GJR understood what ECT was, could remember information relevant to the decision and could communicate his decision. The Tribunal accepted GJR's answers to questions in the hearing demonstrated he had a good understanding about his illness including an awareness of what treatments work best to resolve a serious relapse in his mental health. He demonstrated that he had thought about his treatment needs and recognised that continuing with antipsychotic medication had its risks and may mean he had a slower recovery that was likely to mean he would continue to be contained in seclusion.

The Tribunal had regard to GJR's statement that ECT helped to resolve the symptoms last time, but that he considered the improvement in his mental state was outweighed by the significant side effects that ECT had on his memory and functioning.

The Tribunal accepted GJR's answers to the Tribunal's questions demonstrated that he was able to weigh up the advantages and disadvantages of ECT. GJR was able to explain why he did not accept the treating team's advice to try ECT again and recognised the treating team proposed a form of ECT that would have fewer risks associated with memory loss because of his concerns and experiences when he had ECT in the past. For these reasons, the Tribunal was satisfied that GJR had the ability to use or weigh information relevant to the decision about whether to have ECT.

Part Two:
Hearing statistics for 2023-24

In this year's Annual Report, the Tribunal is presenting much of the data in three parts – the year as a whole, then broken down into two periods, 1 July 2023 to 31 August 2023 and 1 September 2023 to 30 June 2024. The split separates data between the *Mental Health Act 2014* and the *Mental Health and Wellbeing Act 2022*.

Key statistics at a glance*

	2021-22^	2022-23^	**2023-24**	July & Aug. 2023	Sept. 2023 to June 2024
Hearings listed ‡	13,642	14,377	**15,776**	**2,576**	**13,200**
Hearings conducted	9,346	10,042	**11,129**	**1,746**	**9,383**
Hearings determined	7,925	8,629	**9,398**	**1,464**	**7,934**
Hearings adjourned	1,421	1,413	**1,731**	**282**	**1,449**
Treatment orders made/confirmed	6,569	7,239	**8,350**	**1,212**	**7,138**
Temporary treatment orders / Treatment orders revoked	449	479	**617**	**78**	**539**
ECT orders made	507	530	**507**	**86**	**421**
ECT applications refused	67	60	**77**	**10**	**67**
NMI hearings conducted	4	3	**4**	**3**	**1**
Statement of reasons requested	217	239	**348**	**75**	**273**
Applications to VCAT	36	25	**34**		

Attendance at hearings

	2021-22	2022-23	**2023-24**	July & Aug. 2023	Sept. 2023 to June 2024
Patients	5,744	6,251	**6,851**	**1,095**	**5,756**
Carers and family members	1,978	2,266	**2,385**	**390**	**1,995**
Nominated support persons	266	236	**269**	**23**	**246**
Guardians	39	48	**60**	**7**	**53**
Medical treatment decision makers	24	39	**27**	**6**	**21**
Support persons	396	491	**857**	**175**	**682**
Interpreters	462	574	**613**	**76**	**537**
Legal representatives	1,167	1,411	**1,902**	**298**	**1,604**

** The figures in Parts 2.1 – 2.10 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 2021-22 and 2022-23 may vary from figures published in previous Annual Reports due to improved reporting methodology.

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 another treatment order, an application by a patient seeking revocation of an order and an application to perform ECT 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 submissions from the patient's lawyer 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 which gives rise to a second case type. Wherever practicable, the Tribunal Registry will list the two case types to one hearing at the same time. For the purpose of recording statistics, this scenario is counted as one hearing and two decisions.

2.1 Treatment orders

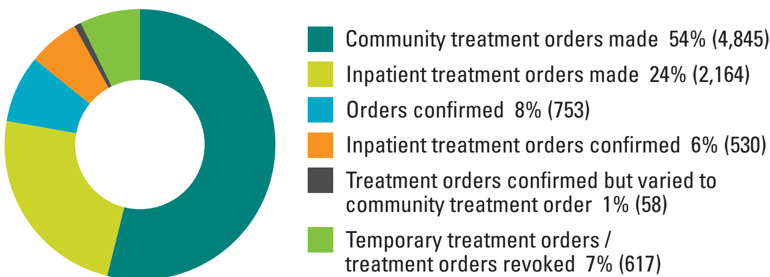
2.1.1 Outcomes of hearings regarding treatment orders (all case types)

In 2023-24, the Tribunal made a total of 7,009 treatment orders, confirmed 1,341 treatment orders and revoked 617 temporary treatment orders and treatment orders. There were 17 matters where the Tribunal found it did not have jurisdiction to conduct a hearing and 118 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.

Table 1: Determinations regarding treatment orders

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
Community treatment orders made	61% (4,295)	61% (4,663)	**54% (4,845)**	60% (777)	53% (4,068)
Inpatient treatment orders made	33% (2,274)	33% (2,576)	**24% (2,164)**	34% (435)	22% (1,729)
Orders confirmed	—	—	**8% (753)**	—	10% (753)
Inpatient treatment orders confirmed	—	—	**6% (530)**	—	7% (530)
Treatment orders confirmed but varied to community treatment order	—	—	**1% (58)**	—	1% (58)
Temporary treatment orders / treatment orders revoked	6% (449)	6% (479)	**7% (617)**	6% (78)	7% (539)
Total	100% (7,018)	100% (7,718)	**100% (8,967)**	100% (1,290)	100% (7,677)

Figure 1: Determinations regarding treatment orders



2.2 Treatment order hearing outcomes by case type

2.2.1 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. If making a treatment order, the Tribunal must also decide whether it is an inpatient or community treatment order and the duration of the treatment order.

Table 2: Outcomes of 28-day hearings

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
Community treatment orders made	46% (1,423)	48% (1,624)	**45% (1,569)**	44% (249)	46% (1,320)
Inpatient treatment orders made	46% (1,438)	45% (1,544)	**47% (1,619)**	50% (282)	46% (1,337)
Temporary treatment orders revoked	8% (261)	7% (254)	**8% (276)**	6% (35)	8% (241)
Total	100% (3,122)	100% (3,422)	**100% (3,464)**	100% (566)	100% (2,898)

Figure 2: Outcomes of 28-day hearings in 2023-24

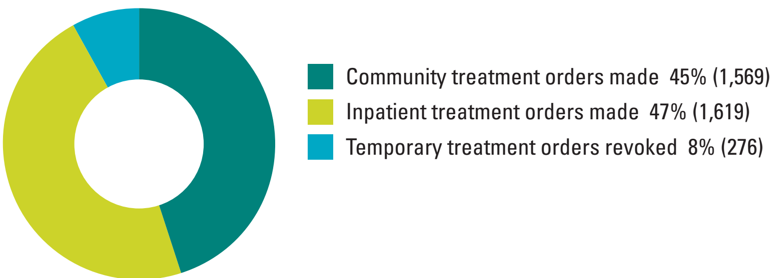


Table 3: Duration of community treatment orders made in 28-day hearings

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
1–11 weeks	7% (106)	6% (99)	**7% (104)**	6% (16)	6% (88)
12 weeks	16% (232)	16% (262)	**14% (226)**	18% (45)	14% (181)
13–25 weeks	10% (149)	12% (194)	**15% (239)**	13% (31)	16% (208)
26 weeks	52% (735)	53% (859)	**62% (974)**	53% (131)	64% (843)
27–51 weeks	1% (9)	1% (11)	**< 1% (1)**	< 1% (1)	—
52 weeks	14% (192)	12% (199)	**2% (25)**	10% (25)	—
Total	100% (1,423)	100% (1,624)	**100% (1,569)**	100% (249)	100% (1,320)

Figure 3: Duration of community treatment orders made in 28-day hearings in 2023-24

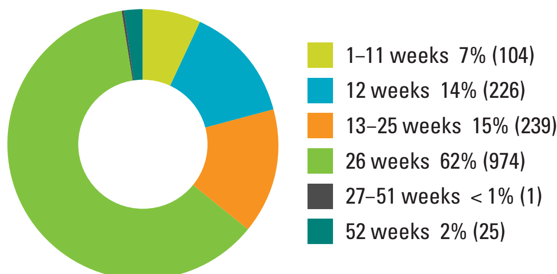
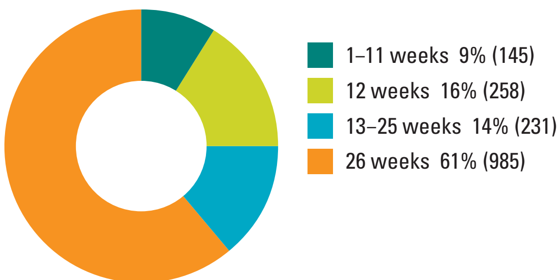


Table 4: Duration of inpatient treatment orders made in 28-day hearings

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
1–11 weeks	11% (156)	9% (134)	**9% (145)**	9% (26)	9% (119)
12 weeks	17% (244)	17% (267)	**16% (258)**	18% (49)	15% (209)
13–25 weeks	10% (151)	10% (157)	**14% (231)**	12% (34)	15% (197)
26 weeks	62% (887)	64% (986)	**61% (985)**	61% (173)	61% (812)
Total	100% (1,438)	100% (1,544)	**100% (1,619)**	100% (282)	100% (1,337)

Figure 4: Duration of inpatient treatment orders made in 28-day hearings in 2023-24



The Tribunal revokes a temporary treatment order when one or more of the criteria for treatment in s143 of the Act is not met. The reasons for revocation of a temporary treatment order were as follows:

*Table 5: Reasons the Tribunal revoked temporary treatment orders in 28-day hearings**

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
The person did not have a mental illness	2%	2%	**3%**	5%	4%
Immediate treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	4%	3%	**7%**	7%	7%
Immediate treatment was not able to be provided	8%	9%	**12%**	20%	10%
Immediate treatment was able to be provided in a less restrictive manner	86%	86%	**78%**	68%	79%
Total	100%	100%	**100%**	100%	100%

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

2.2.2 Applications for a further 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. After conducting the hearing, the Tribunal must either make a new treatment order or revoke the current treatment order. If making a treatment order, the Tribunal must also decide whether it is an inpatient or community treatment order and the duration of the treatment order.

Table 6: Outcomes of authorised psychiatrist application hearings

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
Community treatment orders made	84% (2,609)	82% (2,724)	**83% (3,216)**	84% (468)	83% (2,748)
Inpatient treatment orders made	12% (356)	13% (433)	**12% (452)**	11% (60)	12% (392)
Treatment orders revoked	4% (128)	5% (156)	**5% (204)**	5% (30)	5% (174)
Total	100% (3,093)	100% (3,313)	**100% (3,872)**	100% (558)	100% (3,314)

Figure 5: Outcomes of authorised psychiatrist application hearings in 2023-24

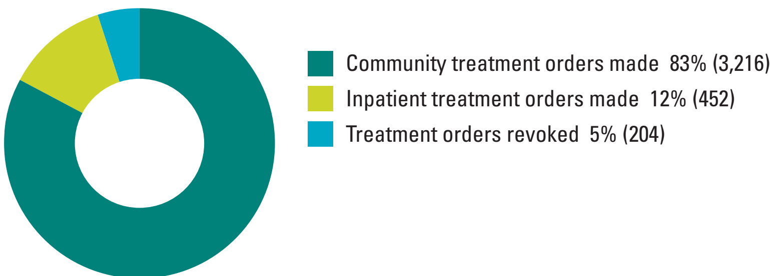


Table 7: Duration of community treatment orders made in authorised psychiatrist application hearings

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
1–11 weeks	2% (43)	1% (35)	**2% (45)**	1% (6)	2% (39)
12 weeks	5% (138)	5% (142)	**6% (194)**	6% (29)	6% (165)
13–25 weeks	5% (128)	5% (134)	**6% (195)**	5% (23)	6% (172)
26 weeks	37% (959)	45% (1,225)	**81% (2,614)**	52% (242)	86% (2,372)
27–51 weeks	1% (34)	2% (42)	**< 1% (6)**	1% (6)	-
52 weeks	50% (1,307)	42% (1,146)	**5% (162)**	35% (162)	-
Total	100% (2,609)	100% (2,724)	**100% (3,216)**	100% (468)	100% (2,748)

Figure 6: Duration of community treatment orders made in authorised psychiatrist application hearings in 2023-24

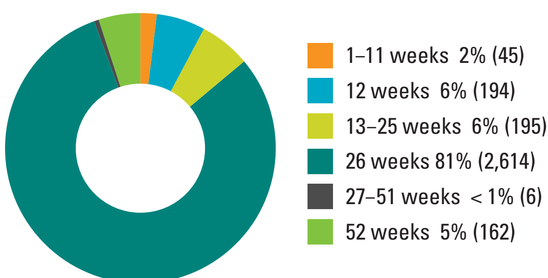
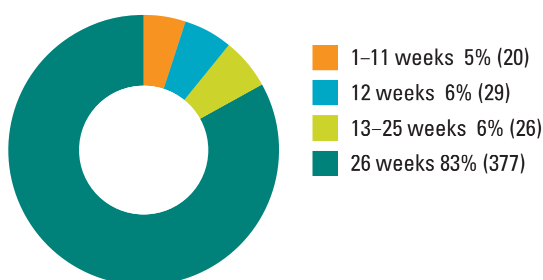


Table 8: Duration of inpatient treatment orders made in authorised psychiatrist application hearings

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
1–11 weeks	5% (17)	8% (35)	**5% (20)**	10% (6)	3% (14)
12 weeks	8% (28)	9% (37)	**6% (29)**	5% (3)	7% (26)
13–25 weeks	6% (21)	5% (22)	**6% (26)**	7% (4)	6% (22)
26 weeks	81% (290)	78% (339)	**83% (377)**	78% (47)	84% (330)
Total	100% (356)	100% (433)	**100% (452)**	100% (60)	100% (392)

Figure 7: Duration of inpatient treatment orders made in authorised psychiatrist application hearings in 2023-24



As with temporary treatment orders, the Tribunal revokes a treatment order when one or more of the criteria for treatment in s143 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 9: Reasons the Tribunal revoked treatment orders in authorised psychiatrist application hearings**

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
The person did not have a mental illness	6%	2%	**3%**	6%	2%
Immediate treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	6%	5%	**6%**	6%	6%
Immediate treatment was not able to be provided	9%	9%	**13%**	12%	14%
Immediate treatment was able to be provided in a less restrictive manner	79%	84%	**78%**	76%	78%
Total	100%	100%	**100%**	100%	100%

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

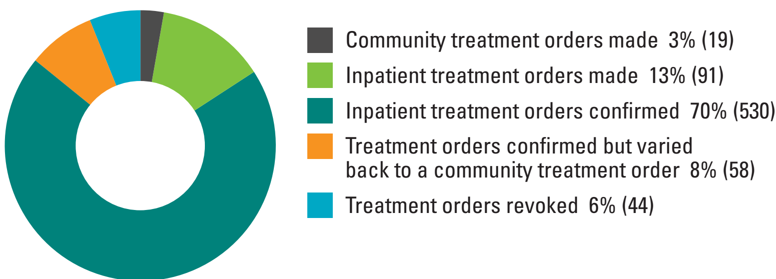
2.2.3 Patients whose community treatment order was varied to an inpatient treatment order

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 confirm or revoke the treatment order, and if confirming the treatment order whether it should be for inpatient or community treatment. If confirming the treatment order, the Tribunal does not decide on a new duration, the confirmed treatment order's expiry date will be unchanged.

Table 10: Outcomes of variation hearings

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
Community treatment orders made	15% (95)	10% (77)	**3% (19)**	16% (19)	—
Inpatient treatment orders made	79% (501)	85% (625)	**13% (91)**	78% (91)	—
Inpatient treatment orders confirmed	—	—	**70% (530)**	—	85% (530)
Treatment orders confirmed but varied back to a community treatment order	—	—	**8% (58)**	—	9% (58)
Treatment orders revoked	6% (37)	5% (39)	**6% (44)**	6% (7)	6% (37)
Total	100% (633)	100% (741)	**100% (742)**	100% (117)	100% (625)

Figure 8: Outcomes of variation hearings in 2023-24



The reasons for revocation of the treatment order in hearings triggered by variations were:

*Table 11: Reasons the Tribunal revoked treatment orders in variation hearings**

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
The person did not have a mental illness	0%	0%	**0%**	0%	0%
Immediate 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%	0%	**0%**	0%	0%
Immediate treatment was not able to be provided	68%	85%	**73%**	71%	74%
Immediate treatment was able to be provided in a less restrictive manner	29%	15%	**27%**	29%	26%
Total	100%	100%	**100%**	100%	100%

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

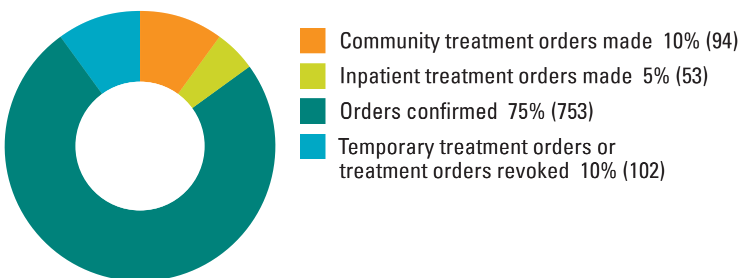
2.2.4 Applications for revocation by the patient

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. After conducting the hearing, the Tribunal must either confirm the order or revoke the treatment order or temporary treatment order. If the patient's application concerns a treatment order, and the Tribunal decides to confirm the treatment order, it must also decide whether it is for inpatient or community treatment. If confirming the treatment order, the Tribunal does not decide on a new duration, the confirmed treatment order's expiry date will be unchanged.

Table 12: Outcomes of revocation hearings

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
Community treatment orders made	57% (429)	55% (496)	**10% (94)**	58% (94)	—
Inpatient treatment orders made	33% (249)	35% (316)	**5% (53)**	33% (53)	—
Orders confirmed	—	—	**75% (753)**	—	90% (753)
Temporary treatment orders or treatment orders revoked	10% (71)	10% (87)	**10% (102)**	9% (15)	10% (87)
Total	100% (749)	100% (899)	**100% (1,002)**	100% (162)	100% (840)

Figure 9: Outcomes of revocation hearings in 2023-24



The reasons for revoking a temporary treatment order or treatment order in proceedings initiated by the patient were as follows:

*Table 13: Reasons the Tribunal revoked temporary treatment orders / treatment orders in revocation hearings**

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
The person did not have a mental illness	10%	1%	**3%**	0%	3%
Immediate treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	12%	10%	**13%**	13%	13%
Immediate treatment was not able to be provided	7%	5%	**5%**	7%	5%
Immediate treatment was able to be provided in a less restrictive manner	71%	84%	**79%**	80%	79%
Total	100%	100%	**100%**	100%	100%

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

2.3 ECT order applications related to adults

2.3.1 Outcomes of applications for an ECT order

In 2023-24, the Tribunal made decisions about 581 applications for an electroconvulsive treatment (ECT) order for an adult. ECT orders were made in 440 hearings for adult patients and 74 applications were refused. ECT orders were made in 64 hearings for adults being treated as voluntary patients and 3 applications were refused. When the Tribunal decides to make an ECT order it must also decide on the duration of the order and the authorised number of treatments.

Table 14: Outcomes of applications for an ECT order

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
ECT orders made					
Adult patients	461	475	**440**	77	363
Adults not a patient	44	51	**64**	9	55
ECT applications refused					
Adult patients	64	58	**74**	10	64
Adults not a patient	2	1	**3**	0	3
Total	571	585	**581**	96	485

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

Figure 10: Determinations regarding applications for an ECT order

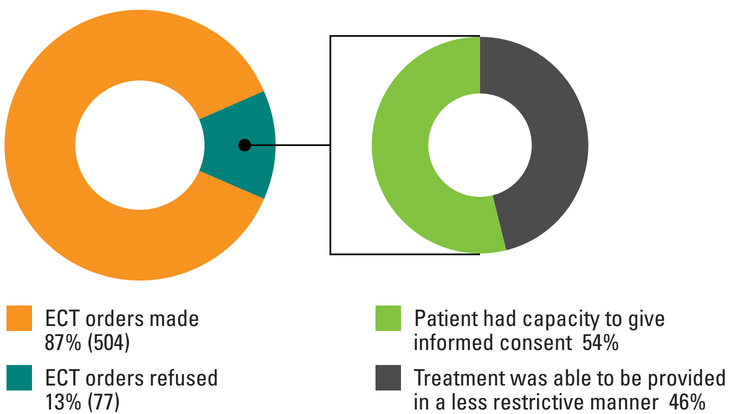


Table 15: Determinations regarding applications for an ECT order

	2021–22*	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
ECT orders made	88% (505)	90% (526)	**87% (504)**	90% (86)	86% (418)
ECT applications refused	12% (66)	10% (59)	**13% (77)**	10% (10)	14% (67)
Total	100% (571)	100% (585)	**100% (581)**	100% (96)	100% (485)

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

Table 16: Duration of ECT orders made

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
1–11 weeks	48% (243)	46% (239)	**45% (225)**	36% (31)	46% (194)
12 weeks	14% (73)	16% (86)	**17% (85)**	15% (13)	17% (72)
13–25 weeks	11% (54)	10% (53)	**6% (33)**	6% (5)	7% (28)
26 weeks	27% (135)	28% (148)	**32% (161)**	43% (37)	30% (124)
Total	100% (505)	100% (526)	**100% (504)**	100% (86)	100% (418)

Figure 11: Duration of ECT orders made in 2023-24

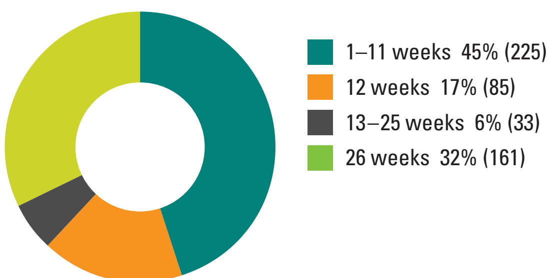


Table 17: Number of ECT treatments authorised

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
1–11 treatments	12% (59)	8% (42)	**7% (34)**	7% (6)	7% (28)
12 treatments	88% (446)	92% (484)	**93% (470)**	93% (80)	93% (390)
Total	100% (505)	100% (526)	**100% (504)**	100% (86)	100% (418)

Figure 12: Number of ECT treatments authorised in 2023-24

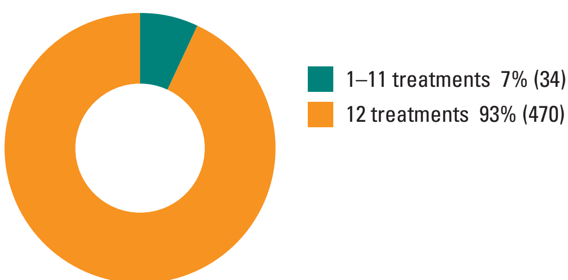


*Table 18: Reasons applications for an ECT order were refused**

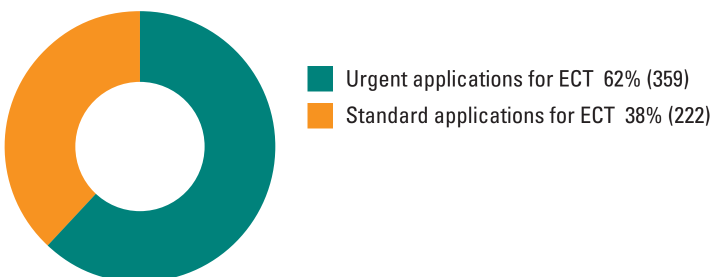
	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
Patient had the capacity to give informed consent	57%	50%	**54%**	55%	54%
Treatment was able to be provided in a less restrictive manner	40%	49%	**46%**	45%	46%
No instructional directive or written consent by the medical treatment decision maker	3%	1%	**0%**	0%	0%
Total	100%	100%	**100%**	100%	100%

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

Table 19: Proportion of applications for ECT orders which were urgent

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
Urgent applications for ECT	60% (344)	66% (387)	**62% (359)**	61% (59)	62% (300)
Standard applications for ECT	40% (227)	34% (198)	**38% (222)**	39% (37)	38% (185)
Total	100% (571)	100% (585)	**100% (581)**	100% (96)	100% (485)

Figure 13: Proportion of applications for ECT orders which were urgent in 2023-24



2.3.2 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. In 2023-24 the Tribunal heard two urgent after-hours ECT applications. One application was granted and one was refused.

2.3.3 Elapsed time from receipt of ECT applications to hearing

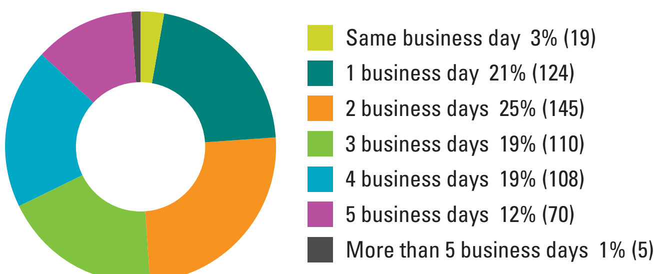
The Tribunal's Registry has detailed procedures that apply to the listing of ECT applications, including urgent applications. The Tribunal's listing processes consider patient participation in, and procedural fairness of, hearings, as well as the urgency of the application. Particular caution is taken 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.

Table 20: Elapsed time from receipt of ECT applications to hearing

	2021–22	2022–23	**2023–24**	July & Aug. 2023	Sept. 2023 to June 2024
Same business day	6% (32)	8% (48)	**3% (19)**	4% (4)	3% (15)
1 business day	22% (125)	24% (138)	**21% (124)**	26% (25)	20% (99)
2 business days	26% (151)	26% (153)	**25% (145)**	26% (25)	25% (120)
3 business days	21% (119)	18% (103)	**19% (110)**	10% (10)	21% (100)
4 business days	14% (82)	14% (84)	**19% (108)**	19% (18)	18% (90)
5 business days	11% (62)	10% (58)	**12% (70)**	14% (13)	12% (57)
More than 5 business days	0% (0)	< 1% (1)	**1% (5)**	1% (1)	1% (4)
Total	100% (571)	100% (585)	**100% (581)**	100% (96)	100% (485)

Figure 14: Elapsed time from receipt of ECT applications to hearing in 2023-24



2.4 ECT order applications related to a young person under 18 years

Compulsory patients

During 2023-24, there were three applications received in relation to a compulsory patient under 18 years of age. All three applications were granted.

Voluntary patients

The Tribunal also determines whether ECT can be performed on a voluntary patient under the age of 18. During 2023-24, the Tribunal did not receive any applications concerning voluntary patients under 18 years old.

Table 21: Determinations of ECT applications related to a young person

	2021–22	2022–23	**2023–24**
Compulsory patients – ECT orders made			
Patient's age: 15	2	0	1
Patient's age: 16	0	4	0
Patient's age: 17	0	0	2
Compulsory patients – ECT applications refused			
Patient's age: 16	0	1	0
Patient's age: 17	1	0	0
Total	3	5	3

2.5 Neurosurgery for mental illness

In 2023-24, the Tribunal received four applications to perform neurosurgery for mental illness (NMI). All applications were granted.

Table 22: 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 Centre	Obsessive-compulsive disorder	Deep brain stimulation	WA	Granted
2	Royal Melbourne Hospital, Neurosurgery Centre	Obsessive-compulsive disorder	Deep brain stimulation	VIC	Granted
3	Royal Melbourne Hospital, Neurosurgery Centre	Obsessive-compulsive disorder	Deep brain stimulation	NSW	Granted
4	Royal Melbourne Hospital, Neurosurgery Centre	Obsessive-compulsive disorder	Deep brain stimulation	VIC	Granted

Case Study

Adjournment with order extension – meaning of 'exceptional circumstances'

The Tribunal has limited adjournment powers. Section 374 of the *Mental Health and Wellbeing Act 2022* states:

1. *If a person who is the subject of a proceeding is subject to a temporary treatment order or a treatment order, the Mental Health Tribunal must not adjourn the hearing to a date that is after the order expires unless the Tribunal is satisfied that* ***exceptional circumstances*** *exist.*
2. *If a hearing is adjourned under subsection (1), the Mental Health Tribunal may extend the duration of the temporary treatment order or treatment order to which the person is subject for a period not exceeding 10 business days.*
3. *The Mental Health Tribunal must not extend the duration of a temporary treatment order or treatment order more than once.*

What constitutes 'exceptional circumstances' is a matter of fact and degree and will depend on the particular circumstances of the case. In *TPS* [2024] VMHT 6, the Tribunal considered the meaning of 'exceptional circumstances'. TPS was initially placed onto an inpatient temporary treatment order. TPS's mental health improved and the order was varied to a community treatment order about two weeks after he was admitted to hospital. However, less than a week later, and three days before the hearing, TPS's order was varied back to an inpatient temporary treatment order. The variation order stated TPS could not receive treatment in the community because he was experiencing a relapse of his symptoms, was non-adherent with his medication, was at risk of harm to himself and others and was unwilling to engage with the community treating team.

Before the hearing, the inpatient treating team wrote to the Tribunal to advise they would be asking for an adjournment because they had not had enough time to prepare a report. TPS was legally represented. TPS's lawyer stated TPS was opposed to the adjournment. TPS wanted the hearing to proceed so he could be discharged to receive treatment in the community.

TPS's lawyer submitted there had been ample time for the treating team to prepare the report and the treating team's failure to provide a report should not result in TPS's continued detention in hospital. She submitted the threshold for 'exceptional circumstances' should be high as TPS's liberty and freedom of movement was at stake.

The Tribunal noted 'exceptional circumstances' is not defined in the *Mental Health and Wellbeing Act 2022* and a plain language definition of 'exceptional' includes unusual, not typical, not following a general rule. The Tribunal considered the purpose of section 373 of the Mental Health and Wellbeing Act is to ensure procedural fairness for the patient. Section 373 of the Act places an obligation on the treating team to give TPS access to documents it intends to rely on at least two business days before the hearing. Section 373 ensures the person knows before the hearing what the treating team is going to say, and has time to respond to any issues they disagree with as well as time to prepare what they want to say and to be legally represented.

The Tribunal also considered Rules 14, 15 and 16 of the *Mental Health Tribunal Rules 2023* (the Rules) which relate to the provision and content of hearing reports.

Rule 14 states that a hearing report must be provided to the Tribunal at least two business days before the hearing. The Tribunal considered that one of the purposes of this rule is to make sure that Tribunal members can properly prepare for the hearing, so they can focus on relevant questions and hearings are run efficiently.

In TPS's case, the provisions in the Act and the Rules had not been complied with. The Tribunal acknowledged this was unfortunate, but the Tribunal accepted the treating team's view they had not had sufficient time to comply with the Act and the Rules. In this case, the Tribunal concluded it would have been very difficult for the treating team to prepare a report with an updated assessment and recommendation and for TPS to have time to consider the report within the required timeframe.

The Tribunal also balanced TPS's expressed wishes and right to freedom with his right to a fair hearing, to know what was being said about him and for the Tribunal to have sufficient information to make an informed decision.

In this case, the Tribunal was satisfied the lack of a report constituted exceptional circumstances and adjourned the hearing and extended the duration of the temporary treatment order by 10 business days.

2.6 Security patients

During 2023-24, the Tribunal made 96 determinations in relation to security patients. The types of hearings and outcomes are detailed below.

Table 23: Determinations made in relation to security patients

	2021–22	2022–23	**2023–24**
28-day review			
Remain a security patient	80	76	**88**
Discharge as security patient	4	2	**3**
6 month review			
Remain a security patient	3	1	**0**
Discharge as security patient	0	0	**0**
Application for revocation by the patient			
Remain a security patient	2	1	**2**
Discharge as security patient	0	0	**3**
Application by a security patient regarding leave			
Application granted	0	0	**0**
Application refused	0	0	**0**
Total	89	80	**96**

2.7 Applications to review the transfer of a treatment patient to another service

During 2023-24, the Tribunal received 11 applications to review the transfer of a patient to another health service.

Table 24: Determinations made in relation to applications to review transfer of treatment patient to another service

	2021–22	2022–23	**2023–24**
Directed to remain subject to order as varied	3	4	**8**
Directed treatment by original treating service	2	0	**3**
Total	5	4	**11**

2.8 Applications to transfer a treatment patient interstate

During 2023-24, the Tribunal received one application to transfer a patient interstate.

Table 25: Determinations made in relation to applications to transfer a treatment patient interstate

	2021–22	2022–23	**2023–24**
Directed to remain subject to order as varied	0	0	**1**
Directed treatment by original treating service	0	0	**0**
Total	0	0	**1**

2.9 Applications to deny access to documents

During 2023-24, the Tribunal received 204 applications to deny access to documents.

Table 26: Determination made in relation to applications to deny access to documents

	2021–22	2022–23	2023–24
Applications granted	106	124	**192**
Applications refused	7	15	**12**
Total	113	139	**204**

2.10 Applications for review by VCAT

During 2023-24, 34 applications were made to VCAT for a review of a Tribunal decision.

Table 27: Applications to VCAT and their status

	2021–22	2022–23	2023–24
Applications made	36	25	**34**
Applications withdrawn	9	11	**12**
Applications struck out	0	1	**0**
Applications dismissed	5	4	**4**
Hearings vacated	8	7	**1**
Decision set aside by consent	0	0	**0**
No jurisdiction	1	2	**1**
Applications proceeded to full hearing and determination	19	12	**11**
Applications pending at 30 June	6	1	**5**

Table 28: Outcomes of applications determined by VCAT

	2021–22	2022–23	2023–24
Decisions affirmed	17	9	**9**
Decisions varied	0	0	**0**
Decisions set aside and another decision made in substitution	0	3	**2**
Orders revoked	1	0	**0**

2.11 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 broad 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. A matter may also be adjourned if the Tribunal is unable to constitute a three-member division.

Table 29: Hearings adjourned

	2021–22	2022–23	**2023–24**
Hearings adjourned without extending the order	20% (279)	16% (233)	**17% (301)**
Hearings adjourned with order extended	80% (1,142)	84% (1,180)	**83% (1,430)**
Total	100% (1,421)	100% (1,413)	**100% (1,731)**
Hearings adjourned as a percentage of total hearings conducted	15%	14%	**16%**

Figure 15: Hearings adjourned in 2023-24

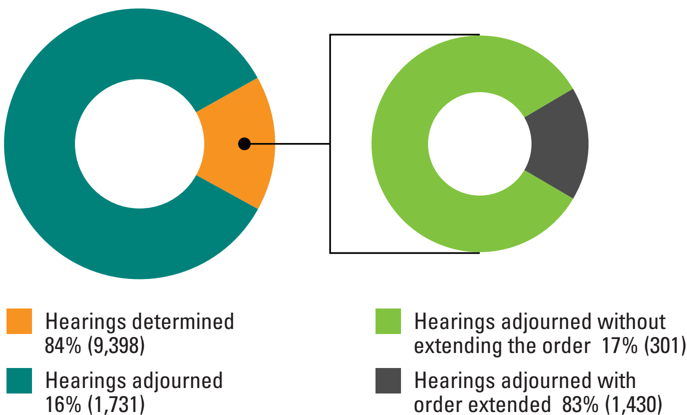
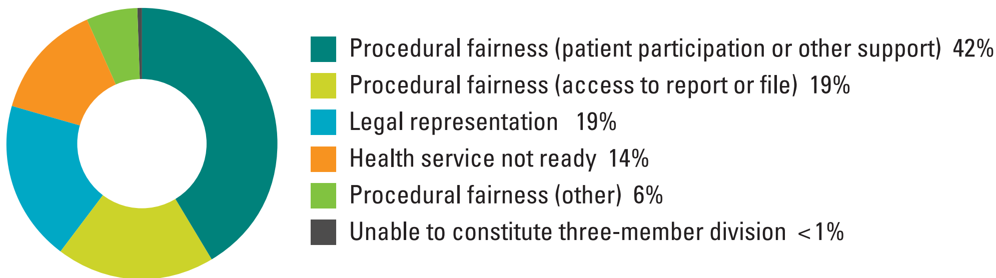


Table 30: Reasons for adjournments with extension of order

	2021–22	2022–23	**2023–24**
Procedural fairness (patient participation or other support)	44%	47%	**42%**
Procedural fairness (access to report or file)	18%	18%	**19%**
Legal representation	16%	17%	**19%**
Health service not ready	17%	16%	**14%**
Procedural fairness (other)	4%	2%	**6%**
Unable to constitute three-member division	1%	< 1%	**< 1%**
Total	100%	100%	**100%**

Figure 16: Reasons for adjournments with extension of order in 2023-24



2.12 Hearings conducted by a single member division of the Tribunal

For a very limited range of procedural matters the Tribunal can be constituted by a single legal member. This requires the written approval of the President, and the Tribunal must report on the use of single member divisions in its annual report.

In 2023-24, there were no hearings conducted by a single member division of the Tribunal.

2.13 Attendance and legal representation at hearings

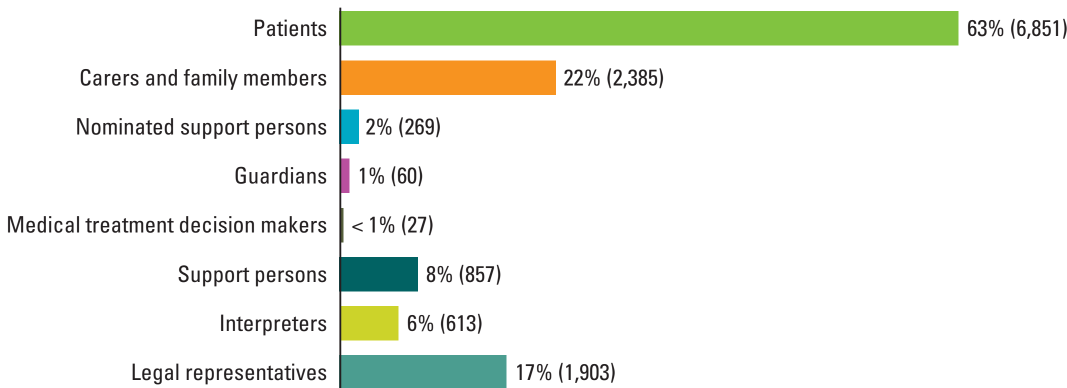
2.13.1 Attendance at hearings

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. The Tribunal strongly encourages the attendance of patients and those who support them at all hearings.

Table 31: Number and percentage of hearings with patients and support persons in attendance

	2021–22	2022–23	**2023–24**
Patients	62% (5,744)	63% (6,251)	**63% (6,851)**
Carers and family members	21% (1,978)	23% (2,266)	**22% (2,385)**
Nominated support persons	3% (266)	2% (236)	**2% (269)**
Guardians	< 1% (39)	< 1% (48)	**1% (60)**
Medical treatment decision makers	< 1% (24)	< 1% (39)	**< 1% (27)**
Support persons	4% (396)	5% (491)	**8% (857)**
Interpreters	5% (462)	6% (574)	**6% (613)**
Legal representatives	12% (1,167)	14% (1,411)	**17% (1,903)**

Figure 17: Number and percentage of hearings with patients and support persons in attendance in 2023-24



2.13.2 Legal representation at hearings

As noted in Part 1, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. In 2023-24, patients were legally represented in 1,903 (17%) hearings. The following table provides a more detailed breakdown of legal representation.

Table 32: Legal representation at hearings

	2021-22	2022-23	**2023-24**
Victoria Legal Aid	10% (956)	10% (1,020)	**12% (1,281)**
Mental Health Legal Centre	2% (161)	4% (322)	**5% (518)**
Victorian Aboriginal Legal Service	– –	< 1% (27)	**< 1% (54)**
Private Lawyer	< 1% (39)	< 1% (29)	**< 1% (35)**
Other Legal Aid	< 1% (11)	< 1% (13)	**< 1% (15)**
Total hearings conducted	9,346	10,042	**11,129**

2.14 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 timeframes specified in the Act. In a small number of matters, statutory deadlines are missed.

Table 33: Hearings not conducted within statutory deadlines

	2023–24
Hearings unable to proceed because the patient's treatment order had expired	0
Hearings adjourned by the Tribunal to be heard out of time *	21
Hearings conducted out of time ^	7
Total	28

**Occasionally the Tribunal will adjourn a matter to a date that is after the relevant statutory deadlines; 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: five arose because of an error on the part of a health service and two because of an error by the Tribunal.

2.15 Customer service

The Tribunal's service standards are published on our website and outline 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 2023-24, both service standards were met, with all email and website enquiries responded to in accordance with the service targets, and 90% of phone calls were answered within 30 seconds.

Case Study

Power to set the duration of an order

Under the previous *Mental Health Act 2014*, if the Tribunal was satisfied that the treatment criteria were met, it had the power to decide the duration (and setting) of the order regardless of the hearing trigger/s that had led to the hearing being scheduled.

Under the *Mental Health and Wellbeing Act 2022*, the Tribunal only has the power to decide the duration of an order if the hearing trigger is, or involves, a 28-day temporary treatment order hearing or an application for another treatment order by an authorised psychiatrist. If the Tribunal has one of these hearing triggers before it, and the Tribunal is satisfied the compulsory treatment criteria in section 143 of the Mental Health and Wellbeing Act are met, the Tribunal must make a treatment order and determine the setting (inpatient or community) and duration of the order.

If the only hearing trigger (or combination of hearing triggers) before the Tribunal is an application for revocation and/or a variation from community treatment order to inpatient treatment order, and the Tribunal is satisfied the compulsory treatment criteria are met, the Tribunal only has the power to confirm the order and determine the setting of the order. However, the Tribunal does not have the power to set a new duration for the order under the Mental Health and Wellbeing Act, as it did under the previous Act. Instead, the Mental Health and Wellbeing Act sets the duration of the order as the time remaining on the order at the time of the hearing. This means the duration of the order is unchanged.

Section 193 of the Act sets a maximum duration for treatment orders. However, unlike the previous Mental Health Act which set a maximum duration for adult patients of 12 months for community treatment orders and six months for inpatient treatment orders, section 193 of the new Act sets a maximum duration of six months for adult patients. The maximum duration for patients under the age of 18 has not changed and is still three months.

Although the Mental Health and Wellbeing Act provides a maximum duration for treatment orders, the duration of the treatment order must reflect the particular circumstances of the case including the proposed treatment and proper consideration of the mental health and wellbeing principles. The following cases illustrate some of the considerations the Tribunal may have regard to when deciding the duration of a treatment order.

In *DQD* [2023] VMHT 21, DQD was subject to an inpatient temporary treatment order at the time of the hearing. DQD did not think he needed any psychiatric treatment and in his view, he had experienced a drug-induced psychosis that had resolved at the time of the hearing. The treating team said that DQD had experienced two recent hospital admissions and was experiencing bizarre ideas about his family which caused him to become highly and uncharacteristically agitated and aggressive towards his family and the treating team. The treating team said that DQD had not smoked cannabis between his two hospital admissions which suggested he had an underlying mental illness, rather than drug-induced psychosis. The Tribunal was satisfied the compulsory treatment criteria were met and made a treatment order.

As the hearing was triggered by DQD being placed on a 28-day temporary treatment order the Tribunal had the power to decide the duration of the treatment order. DQD's treating team requested a 26-week treatment order. However, the Tribunal placed considerable weight on the fact it was DQD's first experience with mental health services and his diagnosis was evolving. In the circumstances the Tribunal decided to make a shorter 12-week order which would enable the treating team to clarify DQD's diagnosis and work with him towards voluntary treatment. It would also enable DQD to obtain a second psychiatric opinion report if that was something he wanted to pursue.

Similarly, in *EFN* [2023] VMHT 18, the Tribunal only had one hearing trigger before it, namely a 28-day temporary treatment order hearing. In that case, EFN did not believe she had experienced psychosis or that she needed treatment for her mental health. In EFN's view, she wanted to leave hospital and return home. EFN said she was experiencing serious side effects from the medication and wanted to stop the medication. The Tribunal was satisfied the compulsory treatment criteria were met and made an order.

In the treating team's view, EFN required a 26-week order. However, the Tribunal had regard to the mental health and wellbeing principles in the new Act and decided to make a shorter 12-week order. Even though EFN said she wanted to stop the medication, the Tribunal considered that a shorter period of compulsory treatment would enable a reassessment of EFN's medication and any adverse side effects.

Part Three: Implementing the Mental Health and Wellbeing Act

The defining event of this reporting period was the commencement of the *Mental Health and Wellbeing Act 2022*. This part of the Annual Report describes key initiatives undertaken to implement the Act and the impact of the Act on our work. It describes the Tribunal's focus on strengthening the involvement of people with lived experience and how the mental health and wellbeing principles inform and underpin the work of the Tribunal across the organisation.

3.1 Embedding the mental health and wellbeing principles in Tribunal practice

The new Mental Health and Wellbeing Act contains the following mental health and wellbeing principles:

- Dignity and autonomy principle (section 16)
- Diversity of care principle (section 17)
- Least restrictive principle (section 18)
- Supported decision making principle (section 19)
- Family and carers principle (section 20)
- Lived experience principle (section 21)
- Health needs principle (section 22)
- Dignity of risk principle (section 23)
- Wellbeing of young people principle (section 24)
- Diversity principle (section 25)
- Gender safety principle (section 26)
- Cultural safety principle (section 27)
- Wellbeing of dependents principle (section 28).

Under section 333 of the Act, the Tribunal must in the performance of a function or duty, or the exercise of a power under the Act:

- give proper consideration to the mental health and wellbeing principles
- ensure that decision making processes are transparent
- consider ways to promote good mental health and wellbeing.

The Act imposes a higher standard of consideration and accountability than the previous *Mental Health Act 2014* by replacing the obligation to 'have regard to' the principles, with the obligation to give them 'proper consideration.' To discharge this obligation, the Tribunal must seriously turn its mind to the possible impact of the principles on the decision and the implications on the person affected. In addition, section 10 of the new Act states that in interpreting the Act, a construction that would promote the mental health and wellbeing principles is to be preferred to a construction that would not promote those principles.

A key component of the member training day in preparation for the new Act was a presentation on the mental health and wellbeing principles and exploring their implications for decision making and the conduct of hearings. Training conducted for Tribunal Registry staff also highlighted the new mental health and wellbeing principles and how the principles can be applied to the work of the registry team.

Training also included how Tribunal Registry staff can help ensure the Tribunal's decision making processes are transparent. This included providing notices of hearings and orders to all parties in a format that is accessible and understandable, along with ensuring open communication between parties and the Tribunal where appropriate (such as sharing any submissions with all parties prior to the hearing; ensuring parties are aware of their right to request a statement of reasons), and providing consumers and their carers with accurate information about the Tribunal's functions and procedures. While these are longstanding features of registry procedures, the implementation of the new Act was an opportunity to refresh and refocus our efforts.

In response to our obligation to ensure the decision making processes of the Tribunal are transparent, a selection of statements of reasons are published on the AustLII website at: www.austlii.edu.au

3.2 Tribunal Advisory Group

The Tribunal Advisory Group (TAG) consists of consumers, carers and lived experience workforce members, together 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 2023-24, the TAG farewelled Mary Eckel and Peter McDonald. Sadly, TAG member Brittany McVeagh passed away in November 2023. Brittany commenced on the TAG in June 2022 and was a committed advocate for the rights of people experiencing mental illness and used her own lived experience in the work she did. Brittany is greatly missed by the TAG and the Tribunal. We thank all our outgoing TAG members for their significant contributions to the work of the Tribunal.

In 2023-24, we welcomed several new TAG members:

Semonti Modak *Consumer*
Roger Moulton *Carer Workforce*
Nicolas Bloom *Carer*
Francesca Macauley *Consumer Workforce*
Jonathon Evans *Consumer Workforce*.

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 comprehensive strategy and proactive framework around how the Tribunal values lived experience
- review of the wording and instructions provided in the Microsoft Teams invitations sent to patients and carers for hearings
- advice on the information we provide to patients and carers in preparation for electroconvulsive treatment (ECT) hearings, and how we might rethink our approach
- developing the Tribunal's next Strategic Plan.

3.3 Elevating and embedding lived experience

Principle 21 of the new Act is the 'lived experience' principle. It states that 'the lived experience of a person with mental illness or psychological distress and their carers, families and supporters is to be recognised and valued as experience that makes them valuable leaders and active partners in the mental health and wellbeing service system'.

In 2023, the Tribunal decided that an overarching framework for how we value lived experience in a positive and supportive way was required and a project was endorsed through Governance for the work to begin. Members and staff were surveyed to help understand what the Tribunal does well, and also to highlight what opportunities exist to make positive changes. The first co-design workshop was held in 2024 with Tribunal members, senior management and staff. This work will continue into the next strategic planning period and will inform a framework, policy and procedure, and an education strategy around valuing lived experience.

The framework will also support our previously established and integrated inclusion of lived experience expertise in the Tribunal's governance and service design as discussed in previous Annual Reports.

In addition to our own work to elevate lived experience expertise, during 2023–24 the Tribunal supported the work of the peak consumer and carer organisations. We sponsored the VMIAC Unconference which was attended by the Tribunal CEO, Principal Registrar and the Senior Adviser Lived Experience, and the Tandem Carers Awards which was attended by the Tribunal President and the Senior Adviser Lived Experience. These events were opportunities to meet and discuss the work of the Tribunal with consumers and carers.

3.4 Improving documentation and resources for hearings

Updated report templates

Treating teams provide a report for each Tribunal hearing. These reports help consumers and Tribunal members to understand the treating team's perspective. This makes it easier for patients to participate in hearings and respond to what the treating team provides as the rationale for a treatment order.

The Tribunal has continually worked to transform its report templates to make them user-friendly for patients, health services and Tribunal members. Most recently the Tribunal collaborated with the TAG, Tribunal members and consulted health services to re-design report templates for hearings about ECT. Those templates were released on 1 September 2023 along with report templates for uncommon types of hearings such as applications related to security patients and transfers between health services.

'What I want to tell the Tribunal' online form

In May 2024 the Tribunal published an online version of its 'What I want to tell the Tribunal' Form. Patients and their support people can use this form to plan what they want to say at their hearing and can submit the form to the Tribunal if they want to. An online version of the form makes it easier and more accessible for patients to complete and submit the form, without the need to print and post, or scan and email the form to the Tribunal.

Specified documents review

While the provision of clinical documents for hearings has always involved challenges, paperless processes make it difficult for some services to provide clinical documents in an accessible format, which in turn means Tribunal members encounter difficulties reviewing these documents prior to hearings. To address this issue, the Tribunal has collaborated with health services through its TWG to understand health services capabilities and limitations related to providing documents for hearings. This work has informed a pending update to the list of documents the Tribunal requires for hearings to reduce the documents provided. Reducing the volume of documents and focusing on those most directly relevant will make it easier for members to access information and reduce the burden on health services. It can also assist in making it easier for patients to access relevant documents prior to a hearing.

Additional resources for the commencement of the Act

Additional resources developed for the commencement of the Mental Health and Wellbeing Act included updated general information products for patients, carers and health services. We also fully revised the extensive suite of hearing resources for members with a particular focus on the new mental health and wellbeing principles.

3.5 Statements of reasons

As part of the work for preparing for the Mental Health and Wellbeing Act, the Tribunal also made significant changes to its statement of reasons templates. As well as placing more emphasis on explaining the mental health and wellbeing principles that were most relevant to the decision, the template also requires the Tribunal to explain exactly how the Tribunal had regard to the patient's views and preferences as well as the views of carers and guardians. The new template also reduces the summary of evidence, instead highlighting the evidence that the Tribunal relied on to make its decision, making the overall statement shorter and more accessible. In combination, these changes make the explanation of a decision more transparent and make more explicit the way in which the Tribunal has met its obligations under the Act, the Charter and broader administrative law principles.

3.6 Reflect Reconciliation Action Plan

In March 2023, the Tribunal formally commenced the Reflect Reconciliation Action Plan (RAP), endorsed by Reconciliation Australia. Our RAP is available on our website.

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.

Over the past twelve months, the Tribunal has sought to develop relationships with Aboriginal and Torres Strait Islander stakeholders and to explore our sphere of influence. This foundational work reflecting on our practices and building relationships will prepare the Tribunal for reconciliation initiatives in the future.

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. The work undertaken in accordance with our RAP also seeks to promote the principles in the Act that recognise the distinct needs and unique culture of Aboriginal and Torres Strait Islander peoples.

The Tribunal's Reflect RAP represents our commitment and contribution to Australia's journey of reconciliation. Our vision is for a Tribunal that is culturally aware, sensitive, inclusive, and safe.

Case Study

Voluntary treatment or compelled under an order

When the Tribunal conducts treatment order hearings, it must apply the compulsory treatment criteria set out in section 143 of the *Mental Health and Wellbeing Act 2022*. Section 143(d) of the Act requires the Tribunal to consider whether 'there are no less restrictive means reasonably available to enable the person to receive the immediate treatment'. This criterion is a question of whether the person can be treated on a voluntary basis or whether they need to be compelled to have treatment while subject to a treatment order. The Tribunal must consider the particular circumstances of the case. The following decisions illustrate some of the considerations the Tribunal may have regard to when deciding whether or not this criterion is met.

In *AFU* [2024] VMHT 3, AFU was subject to an inpatient temporary treatment order at the time of the hearing. In the lead up to AFU's hospital admission, she had become depressed at home. She was very isolated and was not leaving her home or eating much food. She was admitted to hospital for about two months at the end of 2023. However, she was readmitted to hospital about two weeks after she was discharged because she was worried and fearful that her neighbours wanted to kill her and was not leaving her house or eating any food. During the initial stages of AFU's hospital admission, she refused to leave her room because she was frightened that her neighbours and other patients wanted to kill her.

During the hearing, AFU and her lawyer submitted that her mental state had improved significantly and she was ready to return home. AFU said it was no longer therapeutic for her to remain in hospital. AFU's legal representative referred to the principles in the Act and submitted that AFU should be treated on a voluntary basis because her mental state had improved significantly and she would continue to take the medication as prescribed by the treating team.

Although AFU's treating team acknowledged that her mental state had improved a lot during her hospital admission because she was receiving consistent medication, they did not believe she would receive the treatment she required if she was a voluntary patient. The treating team noted AFU experienced a cognitive impairment and required regular prompting and reminders about medication and other self-care needs during her hospital admission. The treating team also noted AFU had a history of stopping medication.

The Tribunal weighed AFU's preferences against her recent history of treatment and the information provided by the treating team. In this case, the Tribunal was not satisfied that AFU could be treated on a voluntary basis.

In *RYV* [2024] VMHT 2, RYV's treating team had applied for another treatment order. RYV was supported in the hearing by her friend, who had known her for more than 20 years. RYV wanted to receive treatment on a voluntary basis. She was willing to take the medication prescribed by the treating team. But she was experiencing significant side effects from the medication, and she wanted to transition back to a combination of medication she was previously on which she tolerated better. In the hearing, RYV said if she was no longer a compulsory patient, she would gradually stop the mood stabiliser medication and return to the previous antidepressant she had taken in the past but would continue to take the antipsychotic medication. RYV's parents were supportive of her receiving treatment on a voluntary basis.

The treating team submitted that a treatment order was necessary due to the risk of RYV disengaging from treatment if given the choice. In their view, a treatment order would enable RYV to continue to receive assertive management from the community treating team who could monitor RYV's mental state and adherence to treatment.

The treating team acknowledged that RYV had been receiving treatment at the community clinic for about two years on a voluntary basis before she was admitted to hospital in mid-2023. However, in the treating team's view RYV had not been adequately treated when she was a voluntary patient because she did not agree to an increase in one of her medications. The treating team believed this led to her experiencing a relapse which resulted in the hospital admission in mid-2023. Following that hospital admission, RYV's mood continued to fluctuate and she made a significant suicide attempt in late 2023. The treating team had been trying to accommodate RYV's treatment preferences but there were significant differences of opinion about the type of treatment RYV needed. In the treating team's view, RYV required a mood stabiliser in addition to an antipsychotic medication, whereas RYV wanted to stop the mood stabiliser and replace it with an antidepressant medication. In the treating team's view this would undermine RYV's recovery and could result in a deterioration in her mental health.

RYV's case manager acknowledged that RYV was well engaged with the treating team in early 2023, but that she stopped taking her medications after returning from overseas and asked to be referred back to her GP before the treating team could refer her to a private psychiatrist.

In the hearing, RYV acknowledged that she had stopped her medication in 2023 and that led to her experiencing a relapse. She explained she had stopped taking the medication because she was concerned about how it might impact her health, but she now understood that her health and circumstances had changed and that she needed to remain on the medication. RYV explained the attempted suicide was in large part because of the oppressive feeling of being a compulsory patient and having her rights taken away.

RYV also said she would continue to engage with the community clinic on a voluntary basis until she had been transferred to the care of a private psychiatrist, which was her preferred mode of treatment and she had previously engaged with the community clinic under a shared care arrangement with her previous private psychiatrist.

RYV's friend said it was very important for RYV to feel in control of her treatment and that when her rights are taken away from her it amplifies the symptoms of post-traumatic stress disorder and has a profoundly negative impact on her. He thought the overseas trip in 2023 had been particularly stressful for RYV and had disrupted her sleep patterns. He acknowledged RYV was not yet at her baseline, but she was improving and in his view the negatives of a treatment order outweighed the potential benefits.

The Tribunal acknowledged the concerns outlined by the treating team and agreed that RYV's plan to stop the mood stabiliser medication increased the risk of her becoming unwell again. The Tribunal also acknowledged that the longitudinal pattern of RYV's illness indicated that her hospital admissions appeared to be becoming more frequent. However, the Tribunal also recognised that RYV had generally shown positive engagement with treatment for her mental health, had been under the care of a private psychiatrist for many years, and was open to receiving support from the treating team to reengage with a private psychiatrist. RYV was also clear that she would not stop the mood stabiliser abruptly, but would do so gradually, under the supervision of the community treating team. The Tribunal accepted RYV had good support in the community including from her parents, NDIS support workers and her friend.

The Tribunal accepted RYV and her friend's evidence that a treatment order had a profoundly negative impact on RYV's sense of autonomy and dignity and that it exacerbated the impact of previous trauma. The Tribunal also accepted that RYV's parents felt the treatment order was counter-therapeutic and shared RYV's concerns about the significant side effects RYV was experiencing.

The Tribunal noted that RYV's recent serious suicide attempt occurred at a time when she was receiving compulsory treatment which indicated that a treatment order was not a guarantee against this occurring again. The Tribunal also noted RYV's evidence that the treatment order contributed to her low mood at that time and was a significant contributing factor in that suicide attempt.

The Tribunal had regard to the dignity of risk principle and notwithstanding the risks associated with RYV's preferred treatment, the Tribunal was satisfied that there was dignity of risk in allowing RYV to be treated as a voluntary patient. In RYV's case, the Tribunal felt that continuing with the treatment order, whilst potentially enabling RYV to receive a more optimal balance of treatment, was ultimately not reasonable or justifiable in all of the circumstances. The Tribunal therefore revoked RYV's treatment order.

Appendix A: Financial data

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

	2023-24	2022-23	2021-22
TOTAL	**13,041,551**	$10,927,231	$10,363,022

Expenditure

Full and part-time member salaries	**$1,615,577**	$1,595,575	$1,817,052
Sessional member salaries	**$5,849,324**	$4,919,676	$4,873,544
Staff Salaries (includes contractors)	**$3,036,272**	$2,477,300	$2,541,333
Total Salaries	**$10,501,173**	$8,992,552	$9,231,929
Salary On costs	**$2,060,593**	$1,643,213	$1,598,950
Operating Expenses	**$818,825**	$640,587	$472,353
TOTAL	**$13,380,591**	$11,276,351	$11,303,233
Balance	**-$339,040**	$349,120	-$940,211*

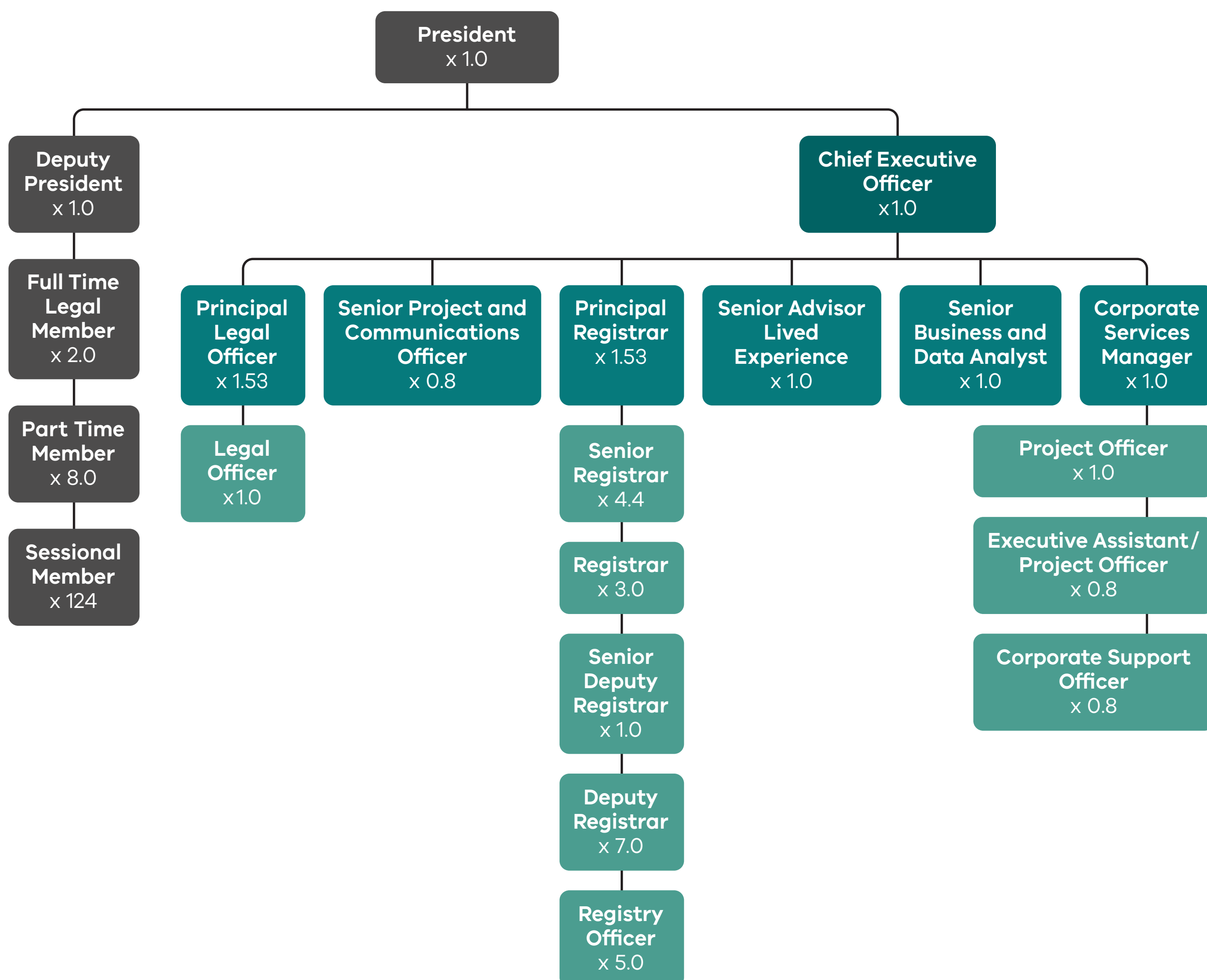
* *The 2021-22 budget deficit is impacted by accrual related anomalies totalling $502,348. Accounting for these anomalies, the Tribunal's adjusted deficit is estimated at $437,863*

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: Organisation chart

Figures represent available FTE, including vacancies, at 30 June 2024.



Appendix C: Membership list

The composition of the Tribunal on 30 June 2024 includes 77 female and 55 male members, made up of four full-time members (the President, Deputy President and two Senior Legal Members), six part-time members and 122 sessional members across all categories (legal, psychiatrist, registered medical practitioner and community).

Full-time members	Total period of appointment
President	
Mr Matthew Carroll *Appointed to current position 23 May 2010*	1 June 2003 – 1 June 2025
Deputy President	
Ms Emma Montgomery *Appointed to current position 10 June 2023*	25 Aug 2014 – 9 June 2028
Senior Legal Member	
Mr Tony Lupton *Appointed to current position 15 March 2017*	25 Feb 2016 – 1 Sept 2025
Senior Legal Member	
Ms Camille Woodward *Appointed to current position 10 June 2023*	10 June 2023 – 9 June 2028

Part-time members	Total period of appointment
Legal Member	
Mr Robert Daly *Appointed to current position 15 September 2020*	10 June 2013 – 9 June 2028
Psychiatrist Members	
Dr Michael McCausland *Appointed to current position 15 September 2020*	10 June 2018 – 9 June 2028
Dr Philip Price *Appointed to current position 10 June 2023*	10 June 2018 - 9 June 2028
Community Members	
Mr Ashley Dickinson *Appointed to current position 1 June 2014*	25 Feb 2011 – 1 Sept 2025
Dr Kylie McShane *Appointed to current position 10 June 2023*	29 June 1999 – 9 June 2028
Ms Helen Walters *Appointed to current position 1 June 2014*	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
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
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 Kim Magnussen *Transitioned to sessional membership August 2023*	25 Feb 2011 – 1 Sept 2025
Ms Jo-Anne Mazzeo	10 June 2013 – 9 June 2028
Ms Robyn Mills	10 June 2023 – 9 June 2028
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 Septr 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 Sept 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 Spiridoula Katsenos	9 Oct 2012 – 1 Sept 2025
Dr Diana Korevaar	25 Feb 2021 – 1 Sept 2025
Dr Jenny Lawrence	9 Octr 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 September 2025
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 Feb2016 – 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 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
Prof Penelope Weller	10 June 2013 – 9 June 2028
Mr Kenton Winsley	10 June 2023 – 9 June 2028

Appendix D: Compliance reports

In 2023-24, 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 22 requests for access to documents. In 11 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 required a formal response. Six of the requests were not proceeded with or were withdrawn, no documents were found in relation to one request and one request was transferred to the treating mental health service. No requests were 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 2023-24 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
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www.mht.vic.gov.au

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