2014 / **2015** ANNUAL REPORT

Mental Health Tribunal

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4 August 2015

The Honourable Martin Foley MP
Minister for Mental Health
Level 22, 50 Lonsdale Street
MELBOURNE VIC 3000

Dear Minister

I am pleased to present the Mental Health Tribunal's first annual report of its operations for the period 1 July 2014 to 30 June 2015.

Yours sincerely

Matthew Carroll
President

Contents

Terminology in this Annual Report

There is continuing debate about the most desirable or acceptable terminology to use when referring to people who have a mental illness and who receive compulsory treatment. Diverse views on terminology are acknowledged. In this report, the terms 'patient', 'compulsory patient' and 'security patient' are used when the context concerns the specific statutory functions of the Tribunal. This accords with the terminology used in the provisions of the *Mental Health Act 2014*, which defines and uses the term 'patient' in relation to the functions of the Tribunal. The term 'consumer' is used in parts of the report concerning the Tribunal's broader initiatives relating to engagement and participation.

President's Message

The commencement of the *Mental Health Act 2014* (the Act) represented the culmination of years of consultation about, and reflection upon, the framework that should govern situations when people experiencing severe mental illness are treated on a compulsory basis. The Act reaffirms the principle of least restrictive treatment and asserts that voluntary treatment must be preferred. It emphasises the right of people receiving treatment to be involved in all aspects of decision making and acknowledges that such a right includes the latitude to make decisions involving a degree of risk. The critical role of carers is also explicitly recognised, including the right of carers to be respected and supported.

One of the key reforms of the Act was the replacement of the former Mental Health Review Board (the Board) by the Mental Health Tribunal (the Tribunal). As I foreshadowed in previous annual reports of the Board, in all our preparations for the commencement of the Act, we have been very clear that the Tribunal is not simply the Board with a new name. We have worked from the premise that, while exercising a range of recognisable but at the same time very different functions, the Tribunal will reflect the contemporary principles of the new Act.

The new Act is very much about cultural change, which is something that occurs over time and can only be fully measured and assessed on a longitudinal basis. But often the process of cultural change is 'jump-started' by immediate practical reforms, especially when legislative reform is a key catalyst. In this context, from 1 July 2014 far-reaching procedural reforms took immediate effect and demanded a totally different approach to decision making regarding orders permitting compulsory treatment for people with severe mental illness.

Compared to the Board, the Tribunal is involved much sooner after the commencement of compulsory treatment for an individual (no more than 28 days, rather than eight weeks). The Tribunal makes Orders, rather than reviews them, which means far more detailed reasons must be provided in Tribunal hearings to support an Order being made. Orders also have strict expiry dates, meaning Tribunal hearings generally must proceed on the day they are scheduled and cannot be deferred repeatedly, as was often the case with Board hearings. The Tribunal is also vested with an entirely new jurisdiction in relation to ECT and must now determine whether ECT can be performed on a compulsory patient unable to consent to this treatment and for any person under 18 years of age. There is also a requirement for the Tribunal to handle all ECT matters expeditiously.

It is difficult to overstate the magnitude of these changes and I am especially delighted to report that these reforms commenced smoothly and are operating effectively. Two years of comprehensive preparatory work, that included exceptional levels of collaboration between the Board, mental health services, the then Department of Health (now Health and Human Services) and peak consumer and carer bodies, meant that comprehensive systems and processes were in place from the beginning of the Tribunal's operation.

In addition, the Act's inclusion of full and part-time member roles in the structure of the Tribunal, along with a framework to underpin a contemporary registry, positioned the Tribunal to sustain this collaborative and comprehensive approach to its functions. Full and part-time members play a critical role in maintaining effective working relationships with mental health services, complementing the case listing and case management processes of our Registry. This has enabled the Tribunal to smoothly translate complex changes into operational practices and processes, with widespread acceptance. It also strengthens our ability to adapt and respond almost immediately to emerging issues and growing experience with the Act.

The Tribunal has also taken a number of significant steps in relation to the broader aspects of cultural change envisaged by the Act.

Promoting rights by ensuring the participation of people with mental illness and their carers in decision making is the vision of the Tribunal, and it is woven throughout our first three-year strategic plan. After our first year of operation, the Tribunal has a sense of where we fall short in relation to consumer and carer participation, and we also have ideas for how we can improve. But, in accordance with the principle of 'nothing about us without us', it is not for the Tribunal to define unilaterally either the current gaps or the possible solutions. If we were to take this approach, at best we would achieve only partial improvement. To fully succeed, we must open the Tribunal to direct input from consumers and carers in order to develop a shared understanding of current issues and work jointly on solutions. Accordingly, a critical focus this year has been the establishment of our first Consumer and Carer Advisory Group (CCAG). The CCAG will play a central role in promoting progress towards realising the Tribunal's vision.

A key piece of work undertaken in the lead up to the commencement of the Act was the development of A Guide to Solution-Focused Hearings in the Mental Health Tribunal, which is a first-step in articulating a framework to guide the approach taken by the Tribunal to the performance of its hearing functions. This is not only a resource for members; it also provides participants in hearings with an understanding of the concepts underpinning the Tribunal's practices and procedures. The guide is a dynamic resource that will develop and change over time. In particular, there will be a need to move from a generic framework to one that recognises and responds to the needs of specific groups of consumers. In this context, the Tribunal has developed and released for consultation a discussion paper exploring how hearings might be approached differently and more effectively for patients under the age of 18. This consultation process is ongoing. Work was also undertaken on a similar discussion paper focusing on older persons, which will be released in the first half of 2015/16.

Another initiative that is likely to become part of the ongoing operation and evolution of the Tribunal is our Continuous Improvement Performance Model (CIPM). CIPM is a process by which we review key aspects of our operation to develop a shared understanding and approach across a range of areas and, in doing so, reflect critically on what presently happens and identify improvements. The current focus of CIPM includes member induction and professional development, maximising the effectiveness of multi-disciplinary decision making, our approach to statements of reasons and feedback mechanisms.

This year, it is especially important to acknowledge and say thank you to the extraordinarily committed and skilled group of staff at the Mental Health Tribunal. Throughout this year, and in the years leading up to the Act's commencement, our staff have maintained an unrelenting focus on making the new Act work. The fact that it has worked, and worked very smoothly, has often been due to the Tribunal's dedicated staff working actively to insulate others from complexities, confusion and challenges. For an extended period, the primary concern of Tribunal staff has been to provide what others (including members, services, consumers and carers) need from them. A key initiative in the early part of 2015/16 will be taking the time to consult with our staff to ensure the Tribunal is doing all it can to meet their needs and support them in their demanding roles.

Finally I acknowledge the hard work and commitment of the members of the Tribunal. Much has been asked of these members over our first year of operation. They needed to be familiar with a new and complex piece of legislation, and to be ready to make new types of decisions from day one. Alongside this, members needed to adapt to administrative changes spanning everything from rostering and scheduling to new and a vastly higher number of precedent documents. Members have approached these challenges positively and with a commitment to meeting the expectations of stakeholders that are embodied in the Act.

This report covers a fundamental and significant period in mental health law reform in Victoria. The picture it paints, I believe, is highly positive – but it is also preliminary. As is to be expected in these early days, the deeper penetration of cultural change is just commencing, but there is a decidedly firm foundation from which this process can continue.

Matthew Carroll
President

The new Act is very much about cultural change, which is something that occurs over time and can only be fully measured and assessed on a longitudinal basis.

Overview

Who we are

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

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

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

The Tribunal will also determine:

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

Our vision

Promoting rights by ensuring the participation of people with mental illness and their carers in decision making.

Our values

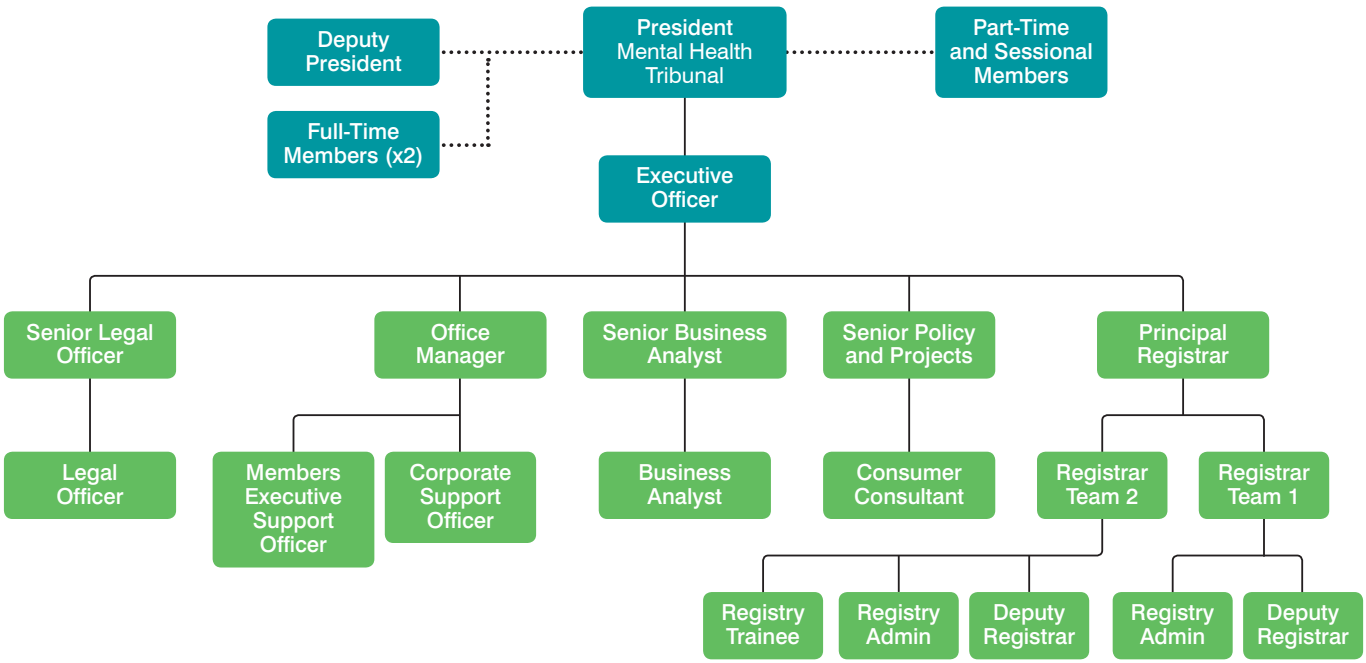
We strive to be:

- Accessible
- Collaborative
- Responsive and solution focused
- Respectful of diversity and individual dignity
- Accountable and professional
- Committed to learning and development.

Our goals

1. **Participation –** maximising opportunities for consumer and carer participation
2. **Excellence in Tribunal practice –** embedding best practice in all aspects of our operation
3. **Building excellence in mental health law –** promoting transparency in decision making and contributing to the implementation and development of the Mental Health Act.

Figure 1: *Mental Health Tribunal organisational chart*



Our obligations under the Charter of Human Rights and Responsibilities

As a public authority under the Victorian *Charter of Human Rights and Responsibilities* (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 *Mental Health Act* (the Act), the Tribunal must do so in a way that is compatible with human rights, provided that to do so is consistent with the purpose of the Act.

Making the transition to the new Mental Health Act

The Tribunal commenced operating on 1 July 2014 when Victoria's new *Mental Health Act 2014* came into effect. The Tribunal replaced the Mental Health Review Board, heralding a significant shift in the legal framework governing compulsory treatment of Victorians with severe mental illness.

In accordance with the transitional provisions of the Act, all members of the former Mental Health Review Board became members of the new Mental Health Tribunal on 1 July 2014. The psychiatrist members of the former Psychosurgery Review Board also became psychiatrist members of the Tribunal. Professors Malcolm Hopwood, Daniel O'Connor and Dennis Velakoulis all continued to sit on Tribunal hearings relating to neurosurgery for mental illness.

With the exception of the President, members' terms of appointment were unchanged. As the President's term of appointment would otherwise have ended in May 2015, his appointment was extended to 1 June 2017.

The structure of the Tribunal membership is far more contemporary than that of the Board. The Board had a 'flat' structure comprising one full time member (the President), with all other members being sessional. To support more effective operation, the Tribunal comprises four full time members, (the President, Deputy President and two Senior Members) eight part time members and a large pool of sessional members.

Ms Dominique Saunders, a sessional legal member of the Board since 2003 was appointed Deputy President and Ms Troy Barty, also a sessional legal member of the Board since 2003, was appointed a Senior Legal Member. Ms Emma Montgomery joined the Tribunal as a Senior Legal Member. Mr Duncan Cameron, Dr Sue Carey, Mr Ashley Dickinson, Mr Brook Hely, Ms Kim Magnussen, Dr Nick Owens, Dr Di Sisely and Ms Helen Walters, all of whom were sessional members of the Board, were appointed as part time members.

The Act also introduced a new category of member: in addition to psychiatrist members, the Tribunal includes registered medical members. Doctors Adeola Akadiri, Patricia Buckeridge, Louise Buckle, Naomi Hayman, Alan Hodgson, David Marsh, Helen McKenzie, Sharon Monagle, Debbie Owies and Stathis Papaioannou were welcomed as the Tribunal's first group of registered medical members. Ms Paula Davey joined the Tribunal as a community member in October.

In September, the Tribunal farewelled Dr Barbara Taylor. Dr Taylor was first appointed as a psychiatrist member when the former Board commenced operation in 1987 and served as a member for 27 years. Dr Taylor made an enormous contribution to the work of the Board and the Tribunal. We were all saddened to be saying good-bye to Dr Taylor, but cannot begrudge her a very well earned retirement.

The Tribunal is an essential safeguard under the Act to protect the rights and dignity of people with mental illness.

Part One

Functions and procedures of the Mental Health Tribunal

The Tribunal's core business is to perform its functions as set out in the Act, in accordance with the Tribunal's obligations as a public authority under the Charter of Human Rights and Responsibilities.

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

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

(i) a matter in relation to whether a Treatment Order should be made;

(ii) an application to revoke a Temporary Treatment Order or Treatment Order;

(iii) a matter in relation to an application involving the transfer of the treatment of a compulsory patient to another designated mental health service;

(iv) an application to perform electroconvulsive treatment on a patient who does not have capacity to give informed consent;

(v) an application to perform electroconvulsive treatment on a person who is under the age of 18 years;

(vi) an application to perform neurosurgery for mental illness;

(vii) an application by a person subject to a Court Secure Treatment Order to determine whether the criteria specified in section 94B(1)(c) of the *Sentencing Act 1991* apply;

(viii) an application by a security patient subject to a Secure Treatment Order to have the Order revoked;

(ix) an application by a security patient in relation to a grant of leave of absence;

(x) an application by a security patient for a review of a direction to be taken to another designated mental health service;

(xi) an application for an interstate transfer Order or an interstate transfer of Treatment Order for a compulsory patient;

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

1.1.1 Treatment Orders

Temporary Treatment Orders and Treatment Orders

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

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

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

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

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

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

In relation to Inpatient Treatment Orders, it is important to distinguish between the duration of the Order and the length of time a patient spends

in hospital. In the vast majority of matters, the former will exceed the latter – meaning the patient will leave hospital when able to be treated in the community, and if that treatment needs to be on a compulsory basis, the Order will operate as a Community Treatment Order for the remainder of its duration.

A person who is subject to a Temporary Treatment Order or Treatment Order (or particular persons on their behalf) may apply at any time while the Order is in force to the Tribunal to have the Order revoked. The determination of the Tribunal must be to either make a Treatment Order (setting the duration and category) or revoke 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 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 Court Secure Treatment Order where the person is found guilty of an offence or pleads guilty to an offence and the criteria in s94B of the *Sentencing Act 1991* are met. The Order cannot exceed the period of imprisonment to which the person would have been sentenced had the Order not been made. Pursuant to s273, the Tribunal is required to conduct a hearing within 28 days after the designated mental health service receives a security patient subject to a Court Secure Treatment Order to determine whether the criteria set out in s94B(1)(c) of the *Sentencing Act 1991* apply to the security patient, and thereafter at six month intervals, and on an application made by the security patient (or by a person on their behalf).

A Secure Treatment Order is an Order made by the Secretary to the Department of Justice and Regulation that enables a person to be transferred from a prison or other place of confinement to a designated mental health service and detained and treated at the designated mental health service. Pursuant to s279, 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 criteria set out in s276(1)(b) of the Mental Health Act apply to the security patient, and thereafter at six month intervals, 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.

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 approved mental health service to another within Victoria. The Tribunal can either grant, or refuse, the application for review.

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

Case Study 1

Is dementia a mental illness under the Act?

Under the Act, the first treatment criterion requires the Tribunal to be satisfied the person has mental illness. 'Mental illness' is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

P had a diagnosis of dementia, with a significant disturbance of thought, mood, and memory. Victoria Legal Aid represented P at the hearing and submitted that dementia and other like conditions, such as brain damage and other permanent neurological conditions, without the presence of an associated psychiatric illness, are not intended to be treated under the Act. In support of this submission, Victoria Legal Aid argued, amongst other things, that these conditions are generally permanent; the person does not suffer from an illness but from a disability; there is limited medical treatment for the underlying cause of the disability; and it is not possible for the person to return to their former level of function.

The Tribunal noted that in exercising its decision-making function, it must primarily have regard to the provisions of the Act itself, which defines mental illness as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. The Act does not exclude symptoms that are attributable only to a brain injury or trauma from that definition, nor does it exclude specific diagnoses.

The Tribunal also did not accept Victoria Legal Aid's submission that the Act only intends to cover those conditions where recovery is possible. The Tribunal found that there is no requirement in the Act that recovery must be possible in order for a person to receive compulsory treatment. The Tribunal noted that some patients have treatment resistant mental illnesses, whose symptoms continue despite prolonged treatment. The focus of the Act remains on what treatment can be given to ameliorate the symptoms. Therefore, treatment resistant conditions are not excluded from the Act.

This decision was not published on AustLII due to the Tribunal being unable to de-identify some of the issues in P's case. Those reasons are unrelated to the Tribunal's decision regarding this criterion.

1.1.2 ECT

The Tribunal will determine whether electroconvulsive treatment (ECT) can be performed on a compulsory patient if they are considered to not have capacity to give informed consent to ECT, or if they are 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 and the number of ECT treatments.

For adult patients, the Tribunal may only approve ECT if it is satisfied that:

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

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

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

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

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

1.1.3 Neurosurgery for mental illness (NMI)

The former Psychosurgery Review Board ceased operation on 30 June 2014 and what had been its 'stand-alone' jurisdiction was vested in the Tribunal. Psychosurgery is now called 'neurosurgery for mental illness' (NMI) and is defined by s3 of the Act to include:

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

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

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

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

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

If the Tribunal grants an application, the applicant psychiatrist must prepare regular reports for the Chief Psychiatrist.

Case Study 2

Treatment is not limited to medication

The second treatment criterion requires the Tribunal to be satisfied that, because of a person's mental illness, the person needs treatment to prevent serious deterioration in their mental or physical health or serious harm to themselves or to another person. 'Treatment' is defined as things done to the person in the course of the exercise of professional skills to remedy the mental illness or to alleviate the symptoms and reduce the ill effects of the mental illness.

P was admitted to an adolescent mental health unit with first episode psychosis. As part of his treatment, he received medication via depot injection* and psycho-education. Victoria Legal Aid represented P at the hearing and submitted that in P's case 'treatment' was limited to the depot medication and that psycho-education could not be considered treatment because it is not a remedy for mental illness.

The treating team submitted that when patients were admitted to this particular adolescent unit, often medication was not used at all. Treatment was a bio-psychosocial approach and psycho-education was essential for recovery to ensure patients understood why it was important to continue to take medication.

The Tribunal agreed that treatment is not limited to medication and included the holistic bio-psychosocial approach provided by the service.

AustLII citation: QMT [2014] VMHT 9

* Depot medication is antipsychotic medication given by injection that is slowly released into the body over several weeks.

1.2 Administrative procedures

1.2.1 Scheduling of hearings

The responsibility for scheduling hearings rests with the Tribunal's Registry, which draws upon information provided from designated mental health services to list matters. Registry will liaise with the medical records staff at each of the mental health services to coordinate and confirm the Tribunal's hearings list.

1.2.2 Location of hearings

The Tribunal conducts hearings at 56 venues on a weekly or fortnightly basis. Some divisions visit more than one mental health service on the same day as part of a circuit. Hearings can be conducted either in-person or via video-conference from the Tribunal's offices.

The Tribunal favours conducting hearings in-person; however, it is not possible for the Tribunal to conduct hearings at the full range of places and times its services are required without the use of video-conference connections. The capacity to conduct video-conference hearings is also critical to the Tribunal being able to hear matters quickly and flexibly. The Tribunal has point-to-point high quality video connections to all venues where it conducts hearings. Statistics regarding the proportion of hearings conducted in-person and via video-conferencing are provided in Part Two.

This year, work commenced on establishing additional connections to remote satellite clinics that are part of some regional and rural mental health services. This will increase access to hearings for rural and regional consumers and their carers and families who may currently face significant costs and long travel times to attend the nearest hearing venue.

1.2.3 Notice

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

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

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

1.2.4 Case management

As the Tribunal conducts over 6,000 hearings per year, it is not possible to 'case manage' all matters. All cases are listed in accordance with the Tribunal's *List Management Policy and Procedure*. Case management is an additional process applied to priority cases to support the participation of patients, carers and nominated persons, and to facilitate the readiness of the matter to proceed on the date of hearing. Categories of matters that are case managed include:

- any matter that has previously been adjourned by a division of the Tribunal
- 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 lengthy period of inpatient treatment
- hearings relating to a patient who has had his or her Treatment Order revoked (meaning they ceased being a compulsory patient) but who is 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 mental health service. The Tribunal recognises that, even where patients have basic English skills, this may not be adequate to ensure they understand the complex legal and clinical issues raised in a hearing. Availability of a competent professional interpreter is important to ensure that patients can fully understand and participate in the hearing process. Statistics on the use of interpreting services are provided in Part Two of this report.

1.2.6 Information products

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

Work has commenced to review some of the Tribunal's information products to make them more accessible and relevant to consumers and their carers. Work has also commenced on a project to translate key information products into languages other than English. A more comprehensive web content review will commence next year. The Tribunal's Consumer and Carer Advisory Group (see Part Three) and other stakeholders will be involved in designing new information products.

Case Study 3

Defining 'serious' deterioration or harm

As part of the second treatment criterion, the Tribunal must decide whether the deterioration or harm that the person would suffer, which the immediate treatment is intended to prevent, is serious. The Act does not define 'serious'.

P was diagnosed with paranoid schizophrenia. P had developed a system of persecutory delusional beliefs about a particular organisation that interfered with her life. At the time of the hearing, those beliefs appeared not to cause P any distress. P had been treated continuously with anti-psychotic medication for several years, which was likely having a significant impact on the intensity of P's delusional beliefs.

Victoria Legal Aid represented P at the hearing and submitted that the deterioration/harm identified by the treating team did not meet the threshold of 'serious'. It was submitted that under the Act, serious should mean 'severe' and that while P had a delusional belief about the organisation, she was not concerned about any person and had never wanted to harm herself or another person.

The Tribunal noted that it should interpret the word 'serious' based on its ordinary meaning and it should favour a construction that would promote the purpose or objects underlying the Act. The Tribunal therefore found the ordinary meaning of 'serious' is defined as, amongst other things, 'important', 'demanding consideration' and 'not slight or negligible'. Harm is defined as, amongst other things, 'hurt', 'injury' or 'damage'. Importantly, what constitutes both seriousness and harm needs to be assessed in the context of an individual patient's life and circumstances.

In P's case, her major symptom was her belief that she had been persecuted by a particular organisation. She had not identified any individual person as being the cause of her problems, and had never shown any indication that she would pursue any person for the perceived wrong. She had never had thoughts of self-harm and despite being continuously treated with anti-psychotic medication, she maintained her delusional belief. The presence of that belief did not appear to cause her any great concern. When not treated, P did become more preoccupied by her belief and occasionally exhibited some distress. However, the distress appeared to be relatively mild. The Tribunal concluded that if P ceased to take her medication, then she would probably again become more preoccupied with her delusional beliefs, somewhat more distressed, experience difficulties with her family and may eventually require a hospital admission. However, in the Tribunal's view, those likely consequences did not amount to serious harm. An admission to hospital would not of itself be a hurt, injury or damage. If this was to occur, then any further deterioration of her mental state would be ameliorated by treatment.

AustLII citation: JMN [2015] VMHT 29

1.3 Conduct of 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 the performance of electroconvulsive treatment or neurosurgery for mental illness. Each division of three is made up of a legal member, a psychiatrist member or registered medical practitioner member, and a community member. The legal member is the presiding member.

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

1.3.2 Hearing procedure

The Act provides a framework for Tribunal procedures, but also allows considerable discretion in determining the manner in which 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.

In-person hearings are usually conducted in a meeting or seminar room of the mental health service where the patient is being treated. Generally, those present at a hearing, other than the Tribunal members, are the patient and the treating doctor who attends as the representative of the authorised psychiatrist. When a person is on a Community Treatment Order their case manager will often attend as well – something the Tribunal encourages strongly. In some cases, friends and relatives of the patient also attend.

Case Study 4

Mental illness leading to deteriorating physical health

One of the limbs of the second treatment criterion requires the Tribunal to consider whether the person, because of their mental illness, needs immediate treatment to prevent serious deterioration in their physical health.

P was diagnosed with schizophrenia. When ill, P suffered from severe thought disorder, thought blocking and tangentiality. He had paranoid delusions regarding the motives of his treating team and the nature of his medications. He was also noted to have poor insight into his illness and poor judgment. P also had another unrelated medical condition, which also required medication.

At the hearing, P's treating team submitted that when P's mental illness deteriorated, he also ceased taking his medication to treat his other medical condition. Recently, this had resulted in him having to be transferred to another hospital for specialist treatment of his medical condition in a medical ward. The treating team submitted that other persons with P's medical treatment had a life expectancy of between 30 to 40 years with optimal treatment. P was in his twenties and the treating team's position was that without treatment his medical condition would progress more rapidly and dramatically reduce his life expectancy.

Victoria Legal Aid represented P at the hearing and submitted that P could not be compulsorily treated for his medical condition, only for his mental illness. The Tribunal agreed with this submission. However, in P's case his mental illness was affecting his ability and judgment to make decisions in relation to his medical care. P believed his medical condition had improved as a result of ceasing anti-psychotic medication. However, the Tribunal found that this was not the case. He had ceased to take some of his medication for his medical condition and had disengaged from treatment. The Tribunal found P's impaired judgment, as a consequence of his mental illness, led him to rejecting medication and treatment for his other medical condition that led to a serious deterioration in his physical health.

AustLII citation: RVQ [2014] VMHT 73

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

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

1.3.3 Legal representation

Some patients are unable to present their cases as well as they might wish because of their illness or they may be reluctant to speak openly at a Tribunal hearing. The presence of an advocate provides support and ensures that the patient's rights are protected appropriately.

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

1.3.4 Determinations and Orders

The Tribunal delivers its decision orally at the conclusion of the hearing and completes a determination reflecting its decision.

If an Order is made, within five working days from the hearing the Tribunal's Registry will process and record the determination and dispatch a formal Order to:

- the patient
- the treating service
- any person who was notified of the hearing – for example, a party to the hearing, a nominated person, a guardian or a carer.

Case Study 5

The need to provide immediate treatment

The third treatment criterion requires the Tribunal to be satisfied that immediate treatment will be provided to the person if the Tribunal makes a Treatment Order.

P had a long history of hospital admissions due to schizophrenia. P also had a history of actively avoiding treatment; at certain times the treating mental health service did not know his whereabouts. At times, P travelled interstate to avoid treatment. P had not received any medication since his last medical review, which was approximately two months before the Tribunal hearing. His whereabouts at the time of the hearing were not known. The treating team had been in contact with P's family, who were concerned that his mental state was deteriorating and supported him remaining on a Treatment Order. The treating team had also made other efforts to locate P, including listing him as a missing person with the police.

The Tribunal was mindful that in the absence of a Treatment Order, efforts to locate P may wane. P's status of being missing while on a Treatment Order may also act as an alert in the event he was located by police carrying out their usual day-to-day duties. The Tribunal noted that the mental health service had made highly commendable efforts to locate P since his last review. However, the Tribunal also noted that each of the treatment criterion is of equal importance and each must be met for the Tribunal to make a Treatment Order. The Tribunal did not have discretion to waive any of the criteria, regardless of how clearly the remaining criteria were met and how persuasive the overall case may be for supporting compulsory treatment.

The Tribunal considered it would not make sense for the Tribunal to make a Treatment Order where the patient required immediate treatment but that treatment was not likely to be provided in the immediate, near or even reasonably foreseeable future. In P's case, the Tribunal decided this criterion was not satisfied as the evidence did not persuade the Tribunal that immediate treatment would be provided if P was subject to a Treatment Order.

AustLII citation: to be confirmed – SOR162/15 – VOA [2015] VMHT 56

1.3.5 Review by VCAT

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

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

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

1.3.6 Statement of reasons

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

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

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

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

Any statement that is produced is distributed to the patient, their legal representative (if any), the authorised psychiatrist of the relevant mental health service and any party joined by the Tribunal. In order to protect the privacy of patients and witnesses, statements of reasons refer to all such persons by their initials only.

During 2014/15, the Tribunal received 228 requests for a statement of reasons. The Tribunal initiated one further statement of reasons.

1.3.7 Rules and Practice Notes

The Tribunal commenced operation in July 2014 with an initial set of Rules governing essential aspects of its operation, accompanied by six Practice Notes. The Practice Notes (all of which are available on the Tribunal's website) deal primarily with the less common types of applications or matters that might come before the Tribunal and provide guidance regarding the information that needs to be provided for the hearing.

The Tribunal has a particularly detailed Practice Note regarding NMI applications. Amongst other things, this note sets out the minimum requirements for information regarding clinical and treatment history and aims to reduce the possibility of applications having to be adjourned while additional information is gathered to enable the Tribunal to make a decision.

Part Two

Hearing statistics for 2014/15

Key statistics at a glance

Hearings listed*	10 305
Hearings conducted	6 619
Hearings adjourned	434
Treatment Orders made	4 912
Treatment Orders revoked	417
ECT Orders made	550
ECT applications refused	68
NMI hearings conducted	3
Patients attending hearing	3 758
Other persons attending hearings**	1 374
Patients with legal representation	1 187
Interpreters at hearing	207
Statements of Reasons produced	229
Applications to VCAT	24

* 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 require a hearing.

** See Section 2.6.3 for discussion of the collection of data in relation to family members and carers attending hearings.

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

A case type can be defined as the 'trigger' for a hearing. For example, an application for a Treatment Order, an application to perform electroconvulsive treatment (ECT) and an application by a patient seeking revocation of an Order are all triggers for a hearing and dealt with as distinct case types. A hearing is the 'event' where the Tribunal hears evidence from the patient, their treating team and, where involved, their carer and advocate to determine whether to make, vary 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 could be where a patient on a Temporary Treatment Order applies to the Tribunal to revoke the Order and the Tribunal is also obliged to initiate a hearing for a Treatment Order before the Temporary Treatment Order expires. Wherever practicable, the Tribunal Registry will list the two case types for hearing at the same time. For the purpose of recording statistics, this scenario will be counted as one hearing and one outcome.

2.1 Treatment Orders

2.1.1 Number and duration of Treatment Orders

In 2014/15, the Tribunal made a total of 4912 Treatment Orders (TOs) and revoked 417 Temporary Treatment Orders (TTOs). The Tribunal also made a small number of other determinations in relation to Temporary Treatment Orders and Treatment Orders. 20 hearings were determined where the Tribunal found it did not have jurisdiction to conduct a hearing. 62 strike out determinations were made. The most common reason for a strike out is where the patient has made an application for revocation and fails to appear at the hearing. The application is struck out but the underlying Treatment Order or Temporary Treatment Order is not affected and continues as if the application for revocation was never made.

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

Figure 2: Determinations regarding Treatment Orders

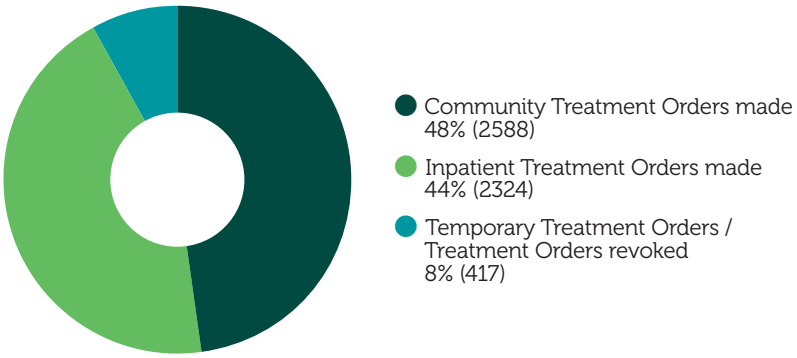


Figure 3: Duration of Community Treatment Orders made

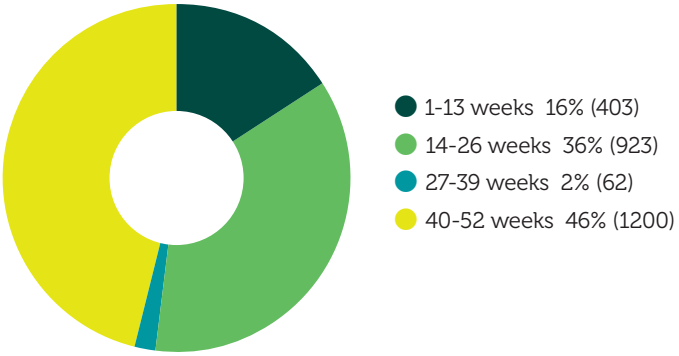
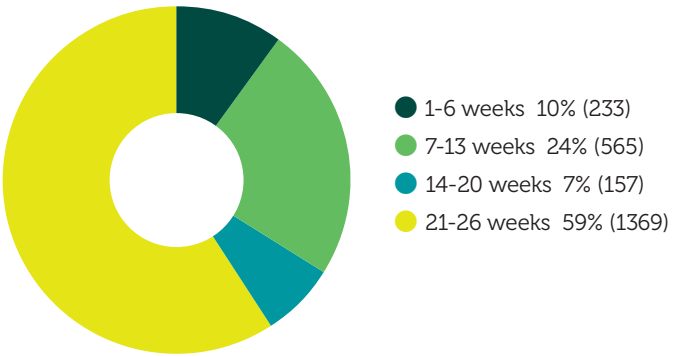


Figure 4: Duration of Inpatient Treatment Orders made



Case Study 6

An assessment of 'less restrictive' treatment

The fourth treatment criterion requires the Tribunal to be satisfied that there are no less restrictive means reasonably available to enable the person to receive immediate treatment.

At the time of the hearing, P was suffering from a severe episode of depression with psychotic symptoms. P's most recent hospital admission was precipitated by her general practitioner observing a deterioration in her mental state over the last six months. While in hospital, P was receiving treatment by way of anti-depressant medication, anti-psychotic medication and assistance with hydration and nutrition. She had also consented to receiving electroconvulsive treatment. P's treating team submitted that she had shown mild improvement but needed further time in hospital; the rationale for this was that P continued to have poor insight into her illness, a depressive thinking pattern and her judgment was affected. P's treating team also submitted that if she was not treated acutely, there was a high risk of deterioration and a risk to P's physical health and life.

Victoria Legal Aid represented P at the hearing and submitted that P wanted to leave hospital and seek treatment from her general practitioner rather than a psychiatrist, which was a less restrictive option for P. P felt that treatment was not working and she had family members who could help her at home. Victoria Legal Aid submitted that the treatment provided under the Treatment Order was medication only and did not include detention and monitoring in hospital. The treating team submitted that P remained significantly depressed with minimal improvement; she received support from the nursing staff at the hospital and medication when needed. If P was not in an acute setting, she would not receive such support.

The Tribunal decided that P's symptoms could not be effectively managed if she was a voluntary patient; she would be at a significant risk if she was not in an inpatient setting where she could receive support from medical and nursing staff to alleviate her distress and to deal with her thoughts of suicide. P's treatment was not limited to medication only; treatment included support, supervision and monitoring. That level of care/immediate treatment would not be available to P as a voluntary patient under the care of a general practitioner.

AustLII citation: KVP [2014] VMHT 31

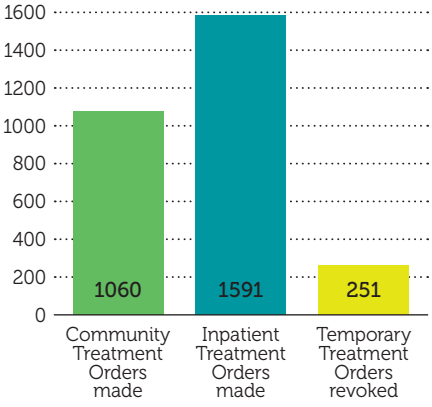
2.1.2 Treatment Orders by initiating case type

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

28 day hearings

The Tribunal must conduct a hearing to determine whether to make a Treatment Order for a person who is subject to a Temporary Treatment Order within 28 days of a compulsory patient being placed on a Temporary Treatment Order. As shown in the graph below, the Tribunal can either make a Treatment Order or revoke the Temporary Treatment Order.

Figure 5: Outcomes of 28 day hearings



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

- Immediate treatment is reasonably available by less restrictive means (i.e. s5(d) did not apply).
- Immediate treatment is not necessary to prevent a serious deterioration in the person's health or to prevent serious harm to the person or another person (i.e. s5(b) did not apply).
- Immediate treatment will not be provided (i.e. s5(c) did not apply).
- The person does not have mental illness (i.e. s5(a) did not apply).

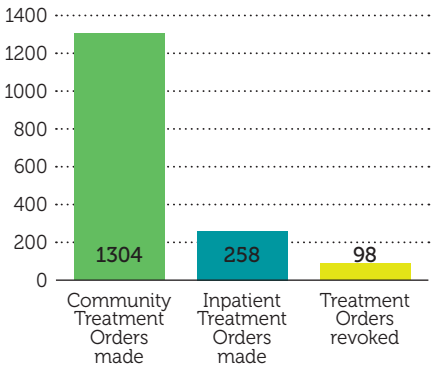
Determinations by the Tribunal are based on a consideration and weighing up of the evidence provided by the patient's treating team to support the making of an Order, alongside the evidence provided by the patient who may oppose an Order, be ambivalent or, in some instances, regard an Order as appropriate.

Very occasionally, the Tribunal forms the view that an Order should be revoked because the information provided by the patient's treating team does not enable meaningful consideration of the criteria for treatment. The Tribunal formed this view in twelve 28 day hearings.

Application for a Treatment Order by the authorised psychiatrist

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

Figure 6: Outcomes of hearings where the authorised psychiatrist has applied for a further Treatment Order



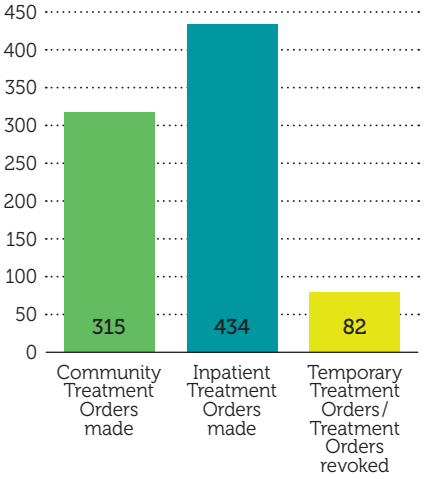
As with Temporary Treatment Orders, the Tribunal revokes a Treatment Order when one or more of the criteria for treatment in s5 of the Act is not met. The most common reasons for revocation of the TO with respect to applications by the authorised psychiatrist were the same as those listed above regarding 28 day hearings.

In relation to two applications by the authorised psychiatrist, the Tribunal formed the view that an Order should be revoked because the information provided by the patient's treating team did not enable meaningful consideration of the criteria for treatment.

Application for revocation by or on behalf of a patient

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

Figure 7: Outcomes of application for revocation hearings



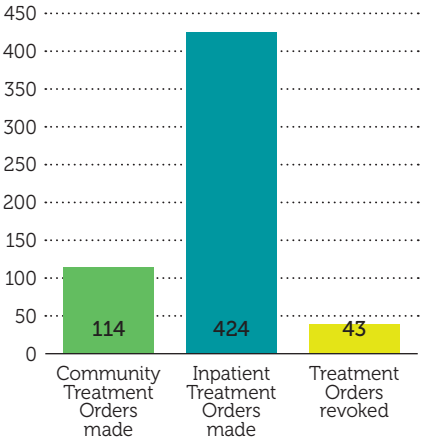
The most common reasons for revoking a Temporary Treatment Order or Treatment Order in proceedings initiated by the patient were the same as those listed on page 18 regarding 28 day hearings.

In relation to three applications for revocation by the patient, the Tribunal formed the view that an Order should be revoked because the information provided by the patient's treating team did not enable meaningful consideration of the criteria for treatment.

Variation hearings

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

Figure 8: Outcomes of variation hearings



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

- Immediate treatment will not be provided (i.e. s5(c) did not apply).
- Immediate treatment is reasonably available by less restrictive means (i.e. s5(d) did not apply).
- Immediate treatment is not necessary to prevent a serious deterioration in the person's health or to prevent serious harm to the person or another person (i.e. s5(b) did not apply).
- The person does not have mental illness (i.e. s5(a) did not apply).

In 10 variation hearings the Tribunal formed the view that an Order should be revoked because the information provided by the patient's treating team did not enable meaningful consideration of the criteria for treatment.

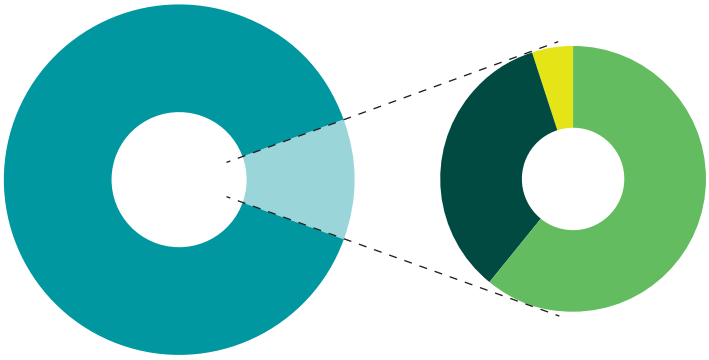
2.2 ECT Orders

2.2.1 Number and duration of ECT Orders

In 2014/15 the MHT heard a total of 621 applications for an ECT Order. 550 Orders were made and 68 applications were refused. In three matters, the Tribunal determined that it did not have jurisdiction to conduct a hearing. The following graphs provide details of the ECT Orders made and refused, the duration of Orders, number of ECT treatments granted, and timelines for the hearing of applications. In one instance the Tribunal heard and determined an application one day late.

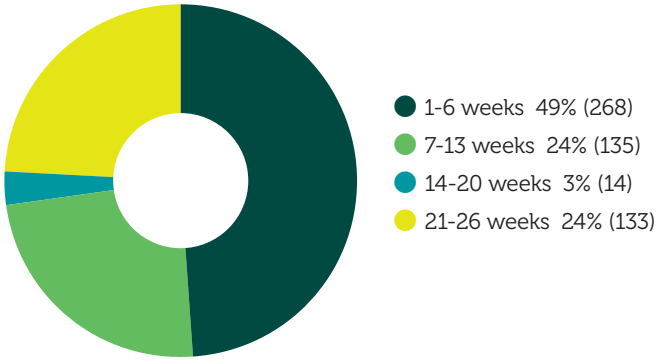
An ECT application concerning an adult patient will be refused if the Tribunal forms the view that the patient has capacity to provide informed consent, or there is a less restrictive way for the patient to be treated. As shown in Figure 9, in most instances where an Order was not made, the Tribunal found that treatment was able to be provided in a less restrictive manner.

Figure 9: Determination of applications for an ECT Order



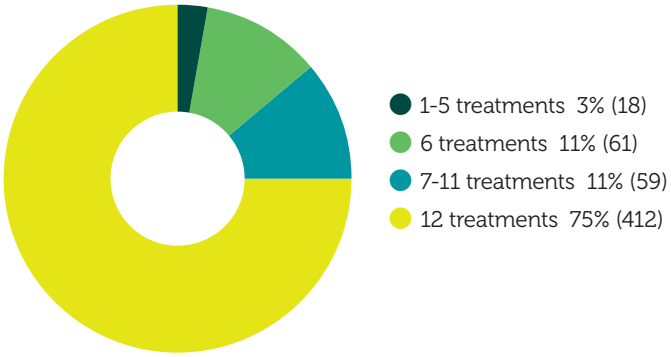
- ECT Orders made 89% (550)
- ECT applications refused 11% (68)
- Treatment is able to be provided in a less restrictive manner 61%
- Person has the capacity to give informed consent 34%
- Tribunal provided with insufficent information to make a decision 5%

Figure 10: Duration of ECT Orders



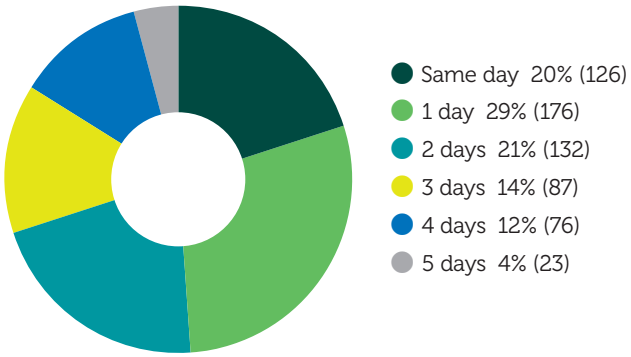
- 1-6 weeks 49% (268)
- 7-13 weeks 24% (135)
- 14-20 weeks 3% (14)
- 21-26 weeks 24% (133)

Figure 11: Number of ECT treatments granted



- 1-5 treatments 3% (18)
- 6 treatments 11% (61)
- 7-11 treatments 11% (59)
- 12 treatments 75% (412)

Figure 12: Elapsed time from receipt of ECT application to hearing

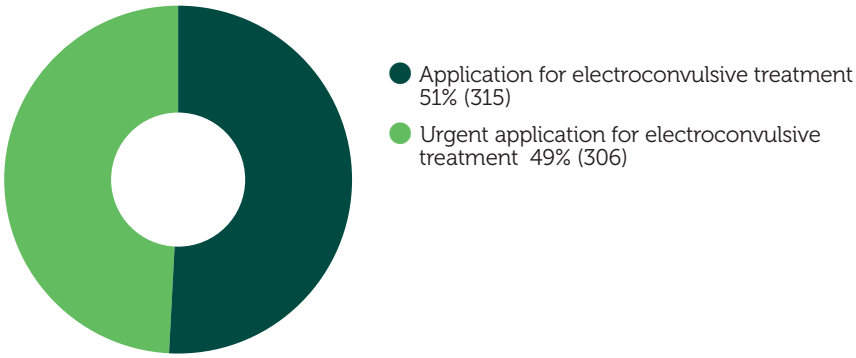


2.2.2 Urgent and emergency applications for ECT Orders

Urgent ECT applications

Urgent applications made up around one half of all applications to the Tribunal for an ECT Order.

Figure 13: Proportion of applications for ECT which were urgent



Emergency after-hours ECT applications

An emergency after-hours application is one that cannot wait for a hearing until the next business day. The Tribunal is committed to making all reasonable efforts to enable emergency applications to be heard on Sundays and public holidays. Authorised psychiatrists must be satisfied that waiting until the next business day to contact the Tribunal will delay treatment and that the treatment is urgent and required immediately. Generally, emergency hearings will be conducted as a telephone conference call.

In 2014/15, the Tribunal heard nine emergency after-hours ECT applications. Eight of the applications were granted and one was refused.

2.2.3 ECT Order applications relating to a young person under 18 years

During 2014/15, three applications relating to a compulsory patient under 18 years of age were received by the Tribunal. In each matter the patient was 17 years old at the time of the hearing. All applications were granted.

The Tribunal did not receive any applications for ECT in relation to a young person being treated as a voluntary patient.

2.3 Neurosurgery for mental illness

During 2014/2015, the Tribunal received and approved three applications to perform neurosurgery for mental illness (NMI), as shown in the table below.

Table 1: *Number, duration and outcome of applications to perform NMI*

Applications	Treating mental health service	Diagnosis	Proposed Treatment	Location of patient	Hearing outcome
1	St Vincent's Hospital	Obsessive-compulsive disorder	Deep brain stimulation	Victoria	Granted
2	Royal Melbourne Hospital	Obsessive-compulsive disorder	Deep brain stimulation	Victoria	Granted
3	Royal Melbourne Hospital	Obsessive-compulsive disorder	Deep brain stimulation	Tasmania	Granted

Case Study 7

Supporting the principle of personal autonomy

In considering the fourth criterion, the Tribunal must make a decision whether the person can receive treatment on a voluntary basis or whether they need to receive that treatment subject to a compulsory Treatment Order.

P was diagnosed with paranoid schizophrenia; she had had several inpatient admissions over the last several years. At the hearing, the treating team submitted that P could not be treated as a voluntary patient due to her history of non-adherence with medication. In the past, deterioration in P's illness had led to dire social and financial circumstances. At the time of the hearing, she was residing in a Community Care Unit.

Victoria Legal Aid represented P at the hearing and submitted that P had been actively pursuing her personal goals of finding private accommodation, enrolling in university and finding part-time work. She was also agreeable to remaining on her current medication and continuing her appointments at the community clinic. She was also open to the Mobile Support Team supervising her medication. Victoria Legal Aid submitted the risks in P's case were low and that in line with the mental health principles in the Act, P should be afforded the autonomy to make her own decisions about treatment.

In making its decision, the Tribunal was mindful of P's history of psychiatric admissions and the concerns raised by the treating team regarding her adherence to medication. However, P had made significant gains in her personal life, including finding private accommodation and enrolling in university. The Tribunal accepted P's willingness to continue to engage in treatment. The Tribunal was particularly mindful of the mental health principles set out in s11 of the Act, especially the principle that persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk. The Tribunal therefore found that P could be treated on a voluntary basis.

AustLII citation: XFH [2015] VMHT 25

2.4 Security patients

During 2014/15, the Tribunal made 105 determinations in relation to security patients. In almost all instances, the Tribunal determined that the person should remain a security patient.

Table 2: *Profile of determinations in relation to security patients*

Determination	2014/15		
	28 day review	Six month review	Application for revocation by or on behalf of the patient
Remain a security patient	82	11	8
Discharge as a security patient	2	0	2

2.5 Applications for review by VCAT

During the year, 24 applications were made to VCAT for a review of the Tribunal's decision. Of these applications,12 were withdrawn and did not proceed, two were struck out and one was dismissed. At 30 June 2015, seven applications had been determined by VCAT. The Tribunal's decision was confirmed in five matters and varied in a further two matters. At the end of the financial year, two matters were pending resolution.

Table 3: *Applications to VCAT and their status*

	2014/15
Applications made	24
Applications withdrawn	12
Applications struck out	2
Applications dismissed	1
Applications proceeded to full hearing and determination	7
Applications pending at 30 June 2015	2

Table 4: *Outcome of applications determined by VCAT*

	2014/15
Decision affirmed	5
Decision varied	2

In the first hearing to proceed to VCAT under the new Act, VCAT reviewed a decision of the Tribunal to grant an Order allowing up to 12 ECT treatments in 21 weeks (to be completed by 1 December 2014). On review, VCAT was satisfied the relevant criteria under the Act were met, but varied the Tribunal's decision so that up to eight treatments were to be completed by 1 December. VCAT did not disagree with the Tribunal's decision to grant up to 12 treatments; rather, if reflected the reality that at the time of the VCAT hearing, it was only possible for the mental health service to administer up to eight treatments before 1 December.

In its second hearing under the new Act, VCAT was satisfied that the patient met all of the treatment criteria. The Tribunal had made a Community Treatment Order for 52 weeks from 8 September 2014. Upon review, VCAT varied the Tribunal's decision so that the 52 weeks started from the time of the VCAT hearing on 24 November 2014.

2.6 Additional statistics

2.6.1 Type of hearings and hearing results

The vast majority of hearings conducted by the Tribunal during the year were in relation to a Treatment Order, followed by applications for an ECT Order.

Table 5: *Total profile of hearings conducted in 2014/15*

Type of hearing	2014/15
Hearing regarding a Treatment Order	5 821
Application for electroconvulsive treatment	324
Urgent Application for electroconvulsive treatment	312
Hearing for a security patient	107
Application to deny access to documents	37
Application to stop transfer to another service	14
Application to transfer a patient interstate	1
Application by security patient regarding leave	0
Application for neurosurgery for mental illness	3
Total	6 619

Case Study 8

Duration of a Treatment Order

If the Tribunal decides that all of the treatment criteria are satisfied, the Tribunal will make a Treatment Order. In making an Order, the Tribunal will decide whether it should be an Inpatient or Community Treatment Order and its duration. The Tribunal may only make an Inpatient Treatment Order if it is satisfied that treatment cannot occur within the community. The Tribunal must also take into account the person's views as well as the views of their support persons as listed in s55(2).

In P's case, the Tribunal was satisfied that all of the treatment criteria were met. Victoria Legal Aid represented P at the hearing and submitted that if the Tribunal decided to make an Inpatient Treatment Order, then the duration of that Order must not be longer than the period for which detention is necessary. It was submitted that, if the Tribunal believed that the patient could receive treatment in the community at a later time, the Tribunal could either: make two Orders, an Inpatient Treatment Order and then a Community Treatment Order; or make a single Treatment Order specifying that the Order be an Inpatient Treatment Order for a specified period before becoming a Community Treatment Order for the remaining duration.

The Tribunal rejected Victoria Legal Aid's submission. The Tribunal found that there was nothing in the Act that allowed the Tribunal to make two separate Treatment Orders or make a single Treatment Order in the way suggested. The category of the Treatment Order is a point in time assessment – that is, at the time of the Tribunal hearing. If the Tribunal makes an Inpatient Treatment Order, the authorised psychiatrist may vary the Order to a Community Treatment Order as soon as the patient is able to be treated in the community and the Order will continue to operate for the unexpired portion of its duration if the patient continues to satisfy the treatment criteria. Accordingly, the duration set by the Tribunal is the duration of compulsory treatment, not the duration of treatment in a particular setting.

AustLII citation: QMT [2014] VMHT 9

The table below shows the result of three types of hearing that have not been discussed in the preceding sections.

Table 6: *Type of hearing and result*

Type of hearing and hearing result	2014/15
Application to deny access to documents	
Application struck out	4
Granted	23
Refused	6
Application to stop transfer to another service	
Application struck out	2
No jurisdiction	3
Granted	4
Refused	5
Application to transfer a patient interstate	
Granted	1

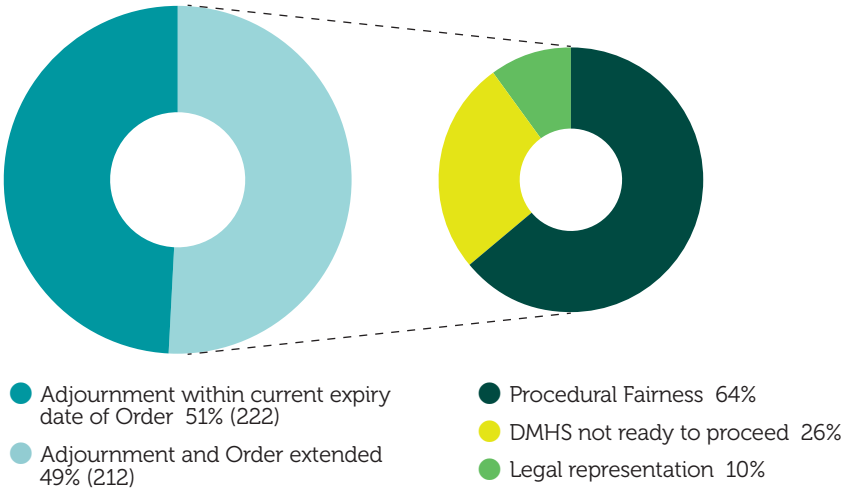
2.6.2 Adjournments

The Act specifies a range of deadlines for the finalisation of hearings by the Tribunal. Generally, hearings are listed in advance of the applicable deadline, which means that if the hearing cannot be finalised, it can be adjourned to a later date ahead of the deadline.

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 adjournment may extend the duration of the patient's Temporary Treatment Order or Treatment Order, but only for a period not exceeding 10 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 have been collated under three categories: procedural fairness (including to enable participation of the patient or other relevant persons in the hearing), to enable legal representation and instances where the designated mental health service was not ready to proceed with the hearing.

***Figure 14:** Adjourned hearings and adjournment categories*



2.6.3 Conduct of hearings

The following tables provide statistics about various aspects of the conduct of hearings by the Tribunal.

In-person hearings and video conferences

As discussed in Part One, while the Tribunal prefers to conduct hearings in-person, it is not always possible to do so. In 2014/15, around one third of hearings were conducted via video conference.

***Table 7:** Hearings conducted in person and via video conference*

Mode of hearing	2014/15
In-person	71%
Video conference	29%

Attendance at hearings

Part Three of this Annual Report highlights the Tribunal's commitment to promoting the participation in hearings of patients and the people who support them. This commitment reflects a similar focus in the Act, which includes a mechanism to expand the Tribunal's notice obligations well beyond those required of the former Board. Pursuant to s189 of the Act, the Tribunal must provide notice of the hearing to the patient (and the patient's parent, if they are under the age of 16), the authorised psychiatrist and certain persons if applicable:

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

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

Carers are often family members and the Tribunal identified some issues with its data collection in the first half of the year where carers were being recorded as 'family' rather than 'carer' in the Tribunal's case management system. These data issues were addressed and carers were recorded correctly from the second half of the year, but the issues could not be rectified in the first half of the year. A more accurate picture of carer participation in hearings is therefore provided by combining the figures for carer and family attendance. The Tribunal's next annual report will clearly differentiate between carer attendance and family attendance at hearings.

Table 8: Profile of attendances at hearings

	2014/15	
	Count	Per cent
Patient	3 758	57%
Carer and family	1 374	21%
Nominated Person	202	3%
Legal Representative	1 187	18%
Interpreter	207	3%

Legal representation at hearings

As noted in Part One, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. The following table shows the organisations that provided legal representation for patients in 2014/15.

Table 9: Legal representation at hearings

	Count	Per cent
Victoria Legal Aid	1 101*	17%
Mental Health Legal Centre	40	< 1%
Private Lawyer	29	< 1%
Other Lawyer	17	< 1%

* figures provided by VLA directly

Two-member divisions

Section 425 of the Act allowed the President to authorise a general division of a Tribunal (i.e. a division that does not hear ECT or NMI matters) to be constituted by a legal member and a community member, if the President is satisfied that a psychiatrist member or a registered medical practitioner member is not available.

Nine two-member divisions conducted a total of 21 hearings in 2014/15.

Section 425 ceased to operate on 30 June 2015.

2.6.4 Patient diagnoses

In preparing their reports for the Tribunal, treating doctors note the primary diagnosis of the patient. The list of diagnoses presented in the table below is an indicative percentage of the primary diagnosis of patients who had Tribunal hearings in 2014/15.

Table 10: Primary diagnoses of patients who have had Tribunal hearings

Primary diagnosis	2014/15
Schizophrenia	51%
Schizo-Affective disorder	21%
Bipolar disorder	12%
Depressive disorders	4%
Delusional disorder	2%
Dementia	1%
No Diagnosis Recorded	< 1%
Other organic disorders	< 1%
Eating disorders	< 1%
Other	7%

2.6.5 Compliance with statutory deadlines

A key element of the Registry's listing procedures is to confirm that a hearing will be conducted within the relevant timeframe specified in the Act. The division conducting a particular hearing also reconfirms that a hearing is within time prior to conducting the hearing.

Where it is identified that a statutory deadline has passed and a patient's Treatment Order has expired, the hearing is unable to proceed. In these situations, the patient's treating team needs to consider making a new Treatment Order; if they do so, the Tribunal then expedites the 28 day hearing for that patient.

Hearings not conducted before an Order expired

In 2014/15, there were 10 matters where a Tribunal error was the cause of a hearing not being conducted before a patient's Order expired. In a further seven matters, a hearing was not conducted because the treating service failed to notify the Tribunal of a person being made a compulsory patient. There were a further two matters where, due to an incorrect application of the Act's transitional provisions, a hearing was not listed and the patient's transitioned Order expired. Finally, there were five matters where the Tribunal failed to apply the Act's transitional provisions correctly due to incorrect information regarding the patient's hearing status under the Mental Health Review Board. In these instances, once the Tribunal identified the errors, the Tribunal contacted the designated mental health service to advise that they would need to re-commence compulsory assessment if they believed compulsory treatment was required.

The Tribunal also undertakes periodic audits of finalised hearings to confirm that no hearing was conducted when a patient's Order had in fact expired. This retrospective audit aims to monitor the Tribunal's performance and identify any gaps or the need for improvements. Critically, even where an audit identifies that a hearing did proceed in circumstances where the patient's Order had expired, neither the hearing nor the determination made in the hearing is rendered invalid.

Section 200(3) of the Act preserves the validity of hearings and determinations where there has been "an accidental or unintentional miscalculation of time". Given the steps undertaken prior to hearings, any mistake made in relation to time/the duration of an Order clearly falls within the scope of s200(3).

In 2014/15, there were nine matters where the hearing proceeded despite the patient's Treatment Order having expired. Each of these instances was scrutinised to identify how the Tribunal might avoid a repetition of these errors. While not diminishing the significance of such errors, it is important to note that in each case the Order had expired one day prior to the hearing.

Late hearings

The Tribunal regards compliance with all statutory timelines as being of vital importance; however, in some instances where a deadline is missed, the patient's Treatment Order continues to operate and the hearing can proceed, albeit late. In particular, the variation hearing that is conducted when a person's Community Treatment Order is varied by the authorised psychiatrist to become an Inpatient Treatment Order must be held within 28 days of the Order being varied; however, if the hearing is not conducted the Treatment Order continues.

During 2014/15, 35 variation hearings were conducted more than 28 days after the variation of the Order. In 22 of these cases, the cause was that the patient's treating team did not advise the Tribunal of the variation to the Treatment Order. In 13 cases, the cause was Tribunal error.

Additionally, where a patient is subject to a Secure Treatment Order, the Tribunal must conduct an initial review and further review every six months. There was 1 matter where the Tribunal did not conduct a review for a security patient within 6 months of the patient's initial review.

Case Study 9

Considering capacity to give consent to ECT

In deciding whether a patient has capacity to give informed consent to electroconvulsive treatment, the Tribunal must consider the four-step test in s68(1).

At the time of hearing, P was suffering a relapse of bipolar affective disorder. The treating team applied to the Tribunal to make an Order allowing electroconvulsive treatment. At the hearing, the treating team submitted P was difficult to engage, lacked insight and was unable to consider treatment options in a meaningful way. P did not want electroconvulsive treatment but was unable to explain why; he was also unable to explain the benefits, risks and consequences regarding electroconvulsive treatment. At the hearing, P confirmed his strong preference was to continue with medication rather than undergo electroconvulsive treatment.

In considering whether a patient has capacity to give informed consent, the Tribunal will not construe the s68(1) test too high or expect from a patient an overly perfect understanding as to the nature, benefits or risks of electroconvulsive treatment. It is also important to differentiate between an impaired mental state and capacity – the former does not preclude the latter.

In P's case the Tribunal had some difficulty extracting a clear understanding from him as to the benefits and risks of electroconvulsive treatment and the reasons for his opposition to it. His understanding of the electroconvulsive treatment process was also rudimentary; his engagement during the hearing fluctuated. However, P's engagement during the hearing was generally good, as was his capacity to discuss most of the issues relevant to the Tribunal's considerations. Despite P's impaired mental state, he was able to adequately understand, remember and use or weigh the information relevant to the decision, and to communicate his decision. The Tribunal therefore decided P had capacity to give informed consent and could make his own decision regarding whether to undergo electroconvulsive treatment.

AustLII citation: QQM [2014] VMHT 58

Part Three

Implementing the Tribunal's broader strategic priorities

In August 2014, the President, Deputy President, full-time members and senior staff undertook a number of facilitated workshops to develop the Tribunal's proposed vision, values, goals and strategies, and to draft the Tribunal's strategic plan. The draft plan was then provided to the wider Tribunal membership and staff for their input. The Tribunal's finalised strategic plan is available on the website.

The Tribunal has three key goals:

- **Participation –** maximising opportunities for consumer and carer participation
- **Excellence in Tribunal practice –** embedding best practice in all aspects of the Tribunal's operation
- **Building excellence in mental health law –** promoting transparency in decision making and contributing to the implementation and development of the *Mental Health Act*.

3.1 Maximising consumer and carer participation

Enhancing consumer and carer engagement and participation was identified as a key priority for the Mental Health Tribunal ahead of its establishment.

The appointment of a consumer consultant was seen as the first opportunity for developing this aspect of the Tribunal's operations. It has been recognised for some time in the mental health sector that consumer consultants contribute to the improvement of services' understanding of, and responsiveness to, consumers' needs through the inclusion of a consumer perspective across all aspects of planning, delivery and evaluation.

The Tribunal's consumer consultant was appointed in November 2014. In December and January, the consumer consultant led a targeted consultation process with key stakeholders from peak bodies and the consumer and carer workforce. This consultation reaffirmed that a consumer and carer advisory group (CCAG) would be an effective and productive mechanism to increase consumer and carer participation at the Tribunal, and that establishing this group should be a priority for the Tribunal. There was consensus that consumers and carers working together would form a stronger, more cohesive voice to influence and improve the operation of the Tribunal.

The CCAG met for the first time in June of this year. The CCAG membership is comprised of:

- two current consumers with recent or current lived experience
- two current carers with current lived experience
- two consumer workers
- two carer workers
- Deputy President – Carer Portfolio Holder
- Senior Member of the Tribunal – Consumer Portfolio Holder
- the Tribunal's Consumer Consultant
- Senior Policy and Projects Officer (ex-officio).

Though the CCAG is still in the process of determining its priorities for 2015/2016, it is expected that key activities will include:

- finalising the CCAG draft terms of reference
- reviewing materials the Tribunal sends to consumers and other compulsory notification persons prior to a hearing to ensure, as far as possible, that the Tribunal's intended message is understood
- reviewing the Tribunal's website content and structure to ensure that it is useful and accessible
- participation in an inaugural Mental Health Tribunal Consumer and Carer Forum where consumers and carers will be invited to join the Tribunal to reflect on the first year of operation of the new Act and discuss future opportunities for engagement with consumers and carers, and the Tribunal.

In the longer term, the Tribunal's approach to consumer and carer engagement will move from the Tribunal simply providing information towards meaningful consultation and evolving ultimately into collaboration with and empowerment of consumers and carers in the co-production of Tribunal strategy and service provision.

3.2 Excellence in Tribunal practice

The Tribunal is committed to continually reviewing and improving its performance to achieve excellence across all aspects of its practice.

3.2.1 Continuous Improvement Performance Model

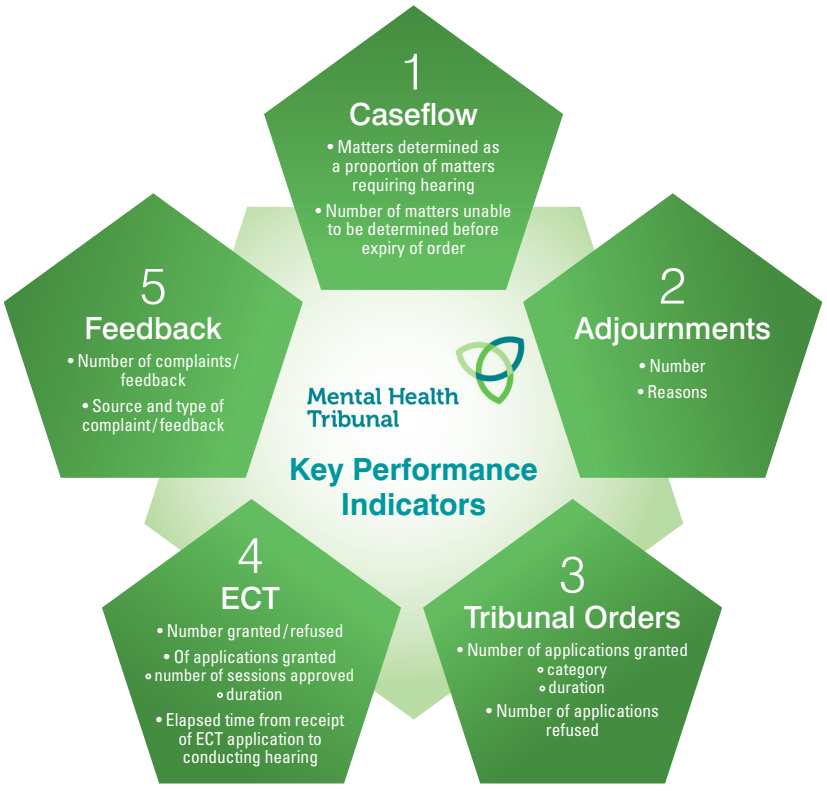
The Tribunal membership has commenced a process of reflecting upon various aspects of their work to develop a shared understanding of their role and approach across a range of areas and practices. This process – known as a Continuous Improvement Performance Model (CIPM) – also focuses on enhancing the Tribunal's capacity to support and encourage all members to develop not only their individual skills, but also their engagement with colleagues. This process has no pre-determined end point; rather, it will become part of the fabric of the organisation as it evolves. As a starting point, a working group of 18 members is reviewing:

- new member orientation and ongoing support and development for all members
- making decisions as a multi-disciplinary panel and promoting a shared understanding of the role of each category of member
- reflecting on practice and providing feedback to colleagues
- the Tribunal's approach to statements of reasons.

3.2.2 Key Performance Indicators

The Tribunal has established Key Performance Indicators and publishes quarterly reports against these KPIs on the Tribunal's website. The Tribunal's Key Performance Indicators will be reviewed in conjunction with the Consumer and Carer Advisory Group.

Figure 15: Mental Health Tribunal KPIs



3.2.3 Service Charter

The Tribunal's Service Charter (available on the Tribunal's website) outlines the services provided by the Tribunal and the service standards the Tribunal aims to deliver. These standards cover matters such as listing hearings within legislative time limits, attending to enquiries promptly and treating enquirers fairly and courteously.

The Tribunal will answer 95% of phone calls within one minute and respond to email enquiries within 2 business days. If the enquiry is complex and/or requires investigation and cannot be fully responded to within 2 business days, the Tribunal will advise of the expected time frame within which a comprehensive response will be finalised.

3.2.4 Feedback

The Tribunal has an established feedback and complaints framework, available on the Tribunal's website. People can contact the Tribunal to provide feedback or make a complaint via email, letter, phone or by completing an online form. The Tribunal's key performance indicator reports (see Section 3.2.2) provide a summary of issues raised in complaints or feedback received by the Tribunal.

The establishment of the Tribunal's Consumer and Carer Advisory Group provides another avenue for the Tribunal to receive feedback about its plans and activities. Additionally, as part of consumer and carer engagement work, the Tribunal will develop further mechanisms to encourage feedback. A key project in this area will be the development of a post-hearing survey of people who attended a Tribunal hearing. This survey will assess the level of consumer and carer satisfaction with the Tribunal and to what extent participants felt informed, engaged and involved with the Tribunal process. It is important to note that this survey will not investigate people's satisfaction with the *outcome* of the hearing, but whether they felt that the *process* provided a fair opportunity to participate and be heard.

3.2.5 Development of the Tribunal's infrastructure

The Tribunal's Case Management System (CMS) continues to fall short of the level of reliability and functionality that is needed to support the work of the Tribunal. While back-up systems and supplementary work practices have succeeded in quarantining hearings from the impact of these deficits, the impact upon Tribunal staff and administrative staff at mental health services is significant. The Tribunal is in the process of developing short, medium and long term strategies to address these issues. As the CMS is closely integrated with the statewide mental health database and Client Management Interface system used by mental health services, the Tribunal will continue to work with the Department of Health and Human Services on the implementation of solutions.

3.2.6 Stakeholder engagement

Victoria Legal Aid (VLA)

VLA is the primary provider of legal services to people having Tribunal hearings in both community and inpatient settings. The Tribunal meets on a regular basis with VLA to discuss issues of common interest and maintain effective working relationships. VLA has also been contracted by the Department of Health and Human Services to design and deliver a (non-legal) Independent Mental Health Advocacy Service and the Tribunal's Deputy President was a member of the expert committee advising VLA on the development of this service.

The Mental Health Legal Centre (MHLC) has also re-established its scheme for the provision of pro-bono legal representation to people on compulsory treatment orders. With this expansion in the providers of legal services, the Tribunal has established a Legal Users Group that includes both VLA and the MHLC.

Case Study 10

Whether ECT is the least restrictive treatment must be considered case-by-case

In regard to approving electroconvulsive treatment for adult patients, the second criterion requires the Tribunal to be satisfied there is no less restrictive way for the patient to be treated.

At the time of hearing, P was suffering from bipolar disorder. At the time of admission, his recorded symptoms included being elevated, grandiose, restless with persecutory ideas and being disinhibited, over-familiar and intrusive with co-patients. As a result, he was being nursed in the Intensive Care Area. At the hearing, the treating team submitted that electroconvulsive treatment would be less restrictive treatment than a prolonged period in the Intensive Care Area with daily injections of anti-psychotic medication. The treating team also submitted that electroconvulsive treatment would facilitate a rapid resolution of P's symptoms, which would enable his transfer to the Low Dependency Unit.

The Tribunal found that the electroconvulsive treatment was the least restrictive treatment whilst P was in the acute phase of his illness. The Tribunal was concerned that the longer P remained acutely unwell without adequate treatment, the greater the risk of continued impairment in his mental state with less chance of recovery and return to normal function. The Tribunal did not accept Victoria Legal Aid's submission that all treatment options needed to be exhausted before electroconvulsive treatment could be administrated. The Act does not define what constitutes less restrictive treatment. Electroconvulsive treatment should not be considered the most restrictive treatment option, or a treatment of last resort, and what constitutes less restrictive treatment should be considered on a case-by-case basis.

AustLII citation: NPP [2015] VMHT 49

Designated mental health services

The Tribunal's full and part time members each have responsibility for a number of mental health services for which they act as the liaison member and where they sit on hearings on a regular basis. The liaison member is a point of continuity for communication and issue management between the Tribunal and services. With a focus on local and informal issue resolution, liaison members are able to facilitate more appropriate and timely responses and localised solutions to emerging issues.

Other engagement activities

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

- Department of Health and Human Services
- Health Information Management Association Australia (Victoria branch) Mental Health Advisory Group
- Mental Health Complaints Commissioner
- Office of the Chief Psychiatrist
- Vicserv.

3.2.7 Educational activities

The Tribunal pursues a range of activities to explain its role and the framework for compulsory treatment established by the Act. This includes papers and presentations delivered by the President and Deputy President (listed at Appendix C), as well as formal and informal presentations to a range of audiences by all of the Tribunal's full and part time members.

During 2014/15, the Tribunal's liaison members undertook a total of 29 formal educational sessions at their liaison mental health services.

3.3 Excellence in mental health law

The Tribunal recognises the importance of its role in the development of a coherent and respected body of mental health law in Victoria. The Tribunal is strongly committed to promoting transparency in decision making, and contributing to the implementation and development of the *Mental Health Act*.

3.3.1 Solution-focused hearings

The former Mental Health Review Board had a long history of adherence to informality, avoidance of legalism and 'patient-centred hearings'. These practices were very positive; however, in the context of the far-reaching reforms embodied in the new Act, it was essential for the Tribunal to articulate a more coherent and comprehensive framework to govern how it will perform its functions and approach its decision-making responsibilities. In doing so, the Tribunal also needed to ensure that its own practices make a meaningful contribution to promoting the objectives and principles of the Act.

As a starting point, the Tribunal developed *A Guide to Solution-Focused Hearings in the Mental Health Tribunal* – a framework that will develop and evolve as we gain more experience with the Act and receive more feedback regarding the expectations of participants in hearings. This evolution is already underway, as our initial focus moves from a generic framework to one that recognises and responds to the fact that different groups of consumers have different needs. During 2014/15, the Tribunal released a discussion paper to explore how the solution-focused approach should be adapted in response to the particular needs of young people who are having a Tribunal hearing. In the second half of 2015, we anticipate releasing a discussion paper to examine the needs of older consumers.

3.3.2 Jurisprudence

The Tribunal is committed to transparency regarding its decision making under the Act. In line with this commitment the vast majority of the Tribunal's statements of reasons for 2014/15 have been de-identified and published on the AustLII website: www.austlii.edu.au. The Tribunal has chosen not to publish certain statements of reasons as the facts of those cases may lead to the identification of persons involved in the proceedings and/or their publication would not be appropriate in the circumstances.

Complementing the publication of statements of reasons on the AustLII website, the Tribunal also publishes selected statements of reasons on its own website. These statements of reasons are from hearings where the particular issues and questions addressed provide examples of the way the Tribunal has interpreted key parts of the Act, which may provide guidance in other matters.

3.3.3 Research and evaluation

Now that the Act is in place, attention will understandably turn to assessing its impact and evaluating its operation (including the operation of the Tribunal). In shifting from a commencement mindset to 'business as usual' approach, the Tribunal needs to be clear about what data and material it can gather and any broader contribution it can make to the accumulated knowledge and research about mental health law, the conduct of hearings involving persons with mental illness and the participation of consumers and carers in decisions about treatment options. This work has not commenced yet, but will be reported in future annual reports.

What are solution-focused hearings?

Solution-focused hearings aim to engage participants as active partners in the decision-making process of a court or tribunal.

A solution-focused approach is not about the Tribunal positioning itself as the source of solutions. Rather, it is based on the premise that the best outcomes in legal processes are achieved when participants in the process are key players in the formulation and implementation of plans to address underlying issues.

Solution-focused hearing techniques complement many of the principles in the new Mental Health Act, including promoting the recovery of individuals, and enabling individuals to fully participate in decisions about their treatment.

A Guide to Solution-Focused Hearings in the Mental Health Tribunal provides specific techniques and processes that can be used by members to promote solution-focused hearings in the mental health context. These include communication skills and listening practices designed to promote a more empathetic, therapeutic interaction with participants in hearings, and strategies to deal with the stresses of this type of intense and often emotionally-charged decision making.

Appendix A

Financial Summary

The table below provides a summary of the Tribunal's funding sources and expenditure for 2014/15. The Tribunal's full audited accounts are published as part of the accounts of the Department of Health and Human Services in its annual report.

Funding sources and expenditure

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

Appropriation	
	2014/15
TOTAL	**$7,6000,000**

Expenditure	
Full and part-time member salaries	$1,586,467
Sessional member salaries	$2,920,188
Staff Salaries (includes contractors)	$1,418,071
Total Salaries	**$5,924,726**
Salary Oncosts	$1,036,571
Operating Expenses	$584,707
Depreciation	$50,409
TOTAL	**$7,596,413**
Balance	$3,587

Appendix B

Membership List

Full-time Members	Period of Appointment
President	
Mr Matthew Carroll	1 June 2003 – 1 June 2017
Deputy President	
Ms Dominique Saunders	1 June 2003 – 9 June 2018
Senior members (full-time)	
Ms Troy Barty	1 June 2003 – 9 June 2018
Ms Emma Montgomery	25 Aug 2014 – 9 June 2018

Part-time Members – Legal	Period of Appointment
Mr Brook Hely	25 Feb 2011 – 24 Feb 2016
Ms Kim Magnussen	25 Feb 2011 – 24 Feb 2016

Part-time Members – Psychiatrist	Period of Appointment
Dr Susan Carey	25 Feb 2011 – 24 Feb 2016
Dr Nicholas Owens	10 June 2013 – 9 June 2018

Part-time Members – Community	Period of Appointment
Mr Duncan Cameron	10 June 2008 – 9 June 2018
Mr Ashley Dickinson	25 Feb 2011 – 24 Feb 2016
Dr Diane Sisely	25 Feb 2006 – 24 Feb 2016
Ms Helen Walters	10 June 2013 – 9 June 2018

Sessional Members – Legal	Period of Appointment
Mr Graeme Bailey	21 Feb 1989 – 24 Feb 2016
Ms Pamela Barrand	3 Sept 1996 – 9 June 2018
Ms Wendy Boddison	7 Sept 2004 – 9 June 2018
Ms Venetia Bombas	10 June 2013 – 9 June 2018
Mr Andrew Carson	3 Sept 1996 – 9 June 2018
Dr Peter Condliffe	10 June 2008 – 9 June 2018
Mr Robert Daly	10 June 2013 – 9 June 2018
Ms Joan Dwyer	25 Feb 2006 – 24 Feb 2016
Mr David Eldridge	10 June 2008 – 9 June 2018
Dr Ian Freckelton	23 July 1996 – 24 Feb 2016
Ms Susan Gribben	5 Sept 2000 – 9 June 2018
Mr Jeremy Harper	10 June 2008 – 9 June 2018
Ms Amanda Hurst	10 June 2013 – 9 June 2018
Ms Kylie Lightman	10 June 2013 – 9 June 2018
Mr Owen Mahoney	10 June 2008 – 9 June 2018
Ms Jo-Anne Mazzeo	10 June 2013 – 9 June 2018
Prof. Bernadette McSherry	5 Sept 2000 – 9 June 2018
Ms Carmel Morfuni	25 Feb 2006 – 24 Feb 2016
Ms Anne O'Shea	8 Sept 1987 – 9 June 2018
Mr Robert Phillips	29 June 1999 – 24 Feb 2016
Mr David Risstrom	25 Feb 2006 – 24 Feb 2016
Mr Nick Sciola	7 Sept 2004 – 9 June 2018
Ms Janice Slattery	25 Feb 2006 – 24 Feb 2016
Ms Susan Tait	10 June 2013 – 9 June 2018
Dr Michelle Taylor-Sands	10 June 2013 – 9 June 2018
Dr Andrea Treble	23 July 1996 – 24 Feb 2016
Ms Helen Versey	10 June 2013 – 9 June 2018
Ms Kara Ward	10 June 2013 – 9 June 2018
Ms Jennifer Williams	7 Sept 2004 – 9 June 2018
Ms Bethia Wilson	10 June 2013 – 9 June 2018
Ms Camille Woodward	25 Feb 2011 – 24 Feb 2016
Prof. Spencer Zifcak	8 Sept 1987 – 24 Feb 2016

Sessional Members – Psychiatrist	Period of Appointment
Dr Robert Athey	9 Oct 2012 – 8 Oct 2017
Dr David Baron	22 Jan 2003 – 24 Feb 2016
Dr Fiona Best	10 June 2013 – 9 June 2018
Dr Joe Black	11 March 2014 – 9 June 2018
Prof. Sidney Bloch	14 July 2009 – 9 June 2018
Dr Pia Brous	10 June 2008 – 9 June 2018
Prof. Thomas Callaly	11 March 2014 – 9 June 2018
Dr Eamonn Cooke	14 July 2009 – 9 June 2018
Dr Blair Currie	9 Oct 2012 – 8 Oct 2017
Dr Elizabeth Delaney	25 Feb 2011 – 24 Feb 2016
Dr Astrid Dunsis	25 Feb 2006 – 24 Feb 2016
Dr Leon Fail	9 Oct 2012 – 8 Oct 2017
Assoc. Prof. John Fielding	11 March 2014 – 9 June 2018
Dr Stanley Gold	10 June 2008 – 9 June 2018
Dr Yvonne Greenberg	11 March 2014 – 9 June 2018
Dr Fintan Harte	13 Feb 2007 – 24 Feb 2016
Assoc. Prof. Anne Hassett	11 March 2014 – 9 June 2018
Dr Harold Hecht	9 Oct 2012 – 8 Oct 2017
Prof. Malcolm Hopwood	5 Sept 2010 – 24 Feb 2016
Dr Sylvia Jones	27 July 2010 – 24 Feb 2016
Dr Stephen Joshua	27 July 2010 – 24 Feb 2016
Dr Spridoula Katsenos	9 Oct 2012 – 8 Oct 2017
Dr Miriam Kuttner	7 Sept 2004 – 9 June 2018
Dr Stella Kwong	29 June 1999 – 24 Feb 2016
Dr Jenny Lawrence	9 Oct 2012 – 8 Oct 2017
Dr Grant Lester	11 March 2014 – 9 June 2018
Dr Samantha Loi	11 March 2014 – 9 June 2018
Dr Margaret Lush	3 Sept 1996 – 9 June 2018
Dr Barbara Matheson	9 Oct 2012 – 8 Oct 2017
Dr Peter McArdle	14 Sept 1993 – 9 June 2018
Dr Cristea Mileshkin	14 July 2009 – 9 June 2018
Dr Robert Millard	14 July 2009 – 9 June 2018
Dr Peter Millington	30 Oct 2001 – 9 June 2018
Dr Frances Minson	30 Oct 2001 – 9 June 2018
Dr Ilana Nayman	9 Oct 2012 – 8 Oct 2017
Prof. Daniel O'Connor	27 June 2010 – 24 Feb 2016
Dr Gunvant Patel	11 March 2014 – 9 June 2018
Dr Tom Peyton	19 May 1998 – 24 Feb 2016
Dr Philip Roy	9 Oct 2012 – 8 Oct 2017
Dr Jo Selman	11 March 2014 – 9 June 2018
Dr John Serry	14 July 2009 – 9 June 2018
Dr Anthony Sheehan	10 June 2008 – 9 June 2018
Dr Frederick Stamp	1 June 2003 – 24 Feb 2016
Dr Jan Steel	27 July 2010 – 24 Feb 2016
Dr Barbara Taylor	4 Nov 1987 – 9 June 2018 *(retired 22/09/2014)*
Dr Jennifer Torr	11 March 2014 – 9 June 2018
Dr Maria Triglia	25 Feb 2011 – 24 Feb 2016
Prof. Dennis Velakoulis	2 Dec 2008 – 24 Feb 2016
Assoc. Prof. Ruth Vine	9 Oct 2012 – 8 Oct 2017

Membership List continued

Sessional Members – Community	Period of Appointment
Dr Lisa Brophy	10 June 2008 – 9 June 2018
Dr Leslie Cannold	10 June 2013 – 9 June 2018
Ms Paula Davey	29 Oct 2014 – 9 June 2018
Ms Robyn Duff	25 Feb 2011 – 24 Feb 2016
Ms Sara Duncan	10 June 2013 – 9 June 2018
Ms Margaret Fowler	25 Feb 2011 – 24 Feb 2016
Ms Liz Gallois	5 Sept 2000 – 9 June 2018
Mr John Griffin	25 Feb 2011 – 24 Feb 2016
Ms Tricia Harper	5 Sept 2000 – 9 June 2018
Adj. Prof. Bill Healy	5 Sept 2000 – 9 June 2018
Mr Ben Ilsley	10 June 2013 – 9 June 2018
Mr John King	1 June 2003 – 24 Feb 2016
Ms Danielle Le Brocq	10 June 2013 – 9 June 2018
Mr John Leatherland	25 Feb 2011 – 24 Feb 2016
Dr Margaret Leggatt	10 June 2013 – 9 June 2018
Ms Fiona Lindsay	5 Sept 2000 – 9 June 2018
Dr David List	25 Feb 2006 – 24 Feb 2016
Ms Anne Mahon	10 June 2013 – 9 June 2018
Mr Gordon Matthews	7 Sept 2004 – 9 June 2018
Assoc. Prof. Marilyn McMahon	19 Dec 1995 – 24 Feb 2016
Dr Kylie McShane	29 June 1999 – 24 Feb 2016
Dr Patricia Mehegan	10 June 2008 – 9 June 2018
Ms Helen Morris	20 April 1993 – 24 Feb 2016
Ms Margaret Morrissey	25 Feb 2011 – 24 Feb 2016
Mr Jack Nalpantidis	23 July 1996 – 24 Feb 2016
Ms Liza Newby	14 Sept 1996 – 9 June 2018
Ms Linda Rainsford	10 June 2013 – 9 June 2018
Ms Lynne Ruggiero	10 June 2013 – 9 June 2018
Mr Fionn Skiotis	25 Feb 2006 – 24 Feb 2016
Dr Jim Sparrow	7 Sept 2004 – 9 June 2018
Ms Veronica Spillane	25 Feb 2011 – 24 Feb 2016
Ms Charlotte Stockwell	10 June 2013 – 9 June 2018
Prof. Trang Thomas	10 June 2013 – 9 June 2018
Dr Penny Webster	25 Feb 2006 – 24 Feb 2016
Dr Penelope Weller	10 June 2013 – 9 June 2018

Registered Medical Members	Period of Appointment
Dr Adeola Akadiri	1 July 2014 – 9 June 2018
Dr Patricia Buckeridge	1 July 2014 – 9 June 2018
Dr Louise Buckle	1 July 2014 – 9 June 2018
Dr Naomi Hayman	1 July 2014 – 9 June 2018
Dr Alan Hodgson	1 July 2014 – 9 June 2018
Dr David Marsh	1 July 2014 – 9 June 2018
Dr Helen McKenzie	1 July 2014 – 9 June 2018
Dr Sharon Monagle	1 July 2014 – 9 June 2018
Dr Deborah Owies	1 July 2014 – 9 June 2018
Dr Stathis Papaioannou	1 July 2014 – 9 June 2018

Appendix C

Educational Activities 2014/15

President

Date	Organisation / Seminar / Conference	Title of Presentation / Course Session Title
2 August 2014	ANZAPPL Winter Symposium	New Act, New Roles: *The Mental Health Act 2014*
12 November 2014	VMIAC Consumer Workforce Support Day	Overview of the new *Mental Health Act 2014*
16 March 2015	Law Institute of Victoria CPD Intensive	*The Mental Health Act 2014:* Key reform themes and an overview of the first six months of operation
20 April 2015	University of New South Wales	Therapeutic jurisprudence in practice

Deputy President

Date	Organisation / Seminar/ Conference	Title of Presentation / Course Session Title
10 August 2014	Monash Health	ECT Refresher
12 November 2014	Mental Health Legal Centre	Best Practice Advocacy
11 December 2014	ECT Nurse Coordinators	ECT and the *Mental Health Act 2014*
19 February 2015	Law Institute of Victoria Disability Committee	The Mental Health Tribunal and good decision-making
23 February 2015	Monash Health	The Mental Health Tribunal and good decision-making
16 March 2015	Monash Health – Casey Hospital	The Mental Health Tribunal and good decision-making
15 April 2015	Victoria University	The *Mental Health Act 2014* Reforms
15 June 2015	Monash Health – Stepping Stones	The Mental Health Tribunal and good decision-making

Appendix D

Compliance Reports

In 2014/15, the Tribunal developed policies and procedures concerning the *Freedom of Information Act 1982*, the *Protected Disclosure Act 2012* and its records disposal authority under the *Public Records Act 1973.* 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 *Freedom of Information Act 1982* (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 individuals asking for documents about their Tribunal hearings. It should be noted that certain documents may be destroyed or transferred to the Public Records Office in accordance with the *Public Records Act 1973*.

Where possible, the Tribunal provides information administratively without requiring a freedom of information request. This financial year, the Tribunal received five requests for access to documents. In four of those matters, 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. One matter was handled as a formal FOI request.

How to lodge a request

The public is encouraged 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, must clearly identify the documents being requested and be accompanied by the application fee ($26.50 from 1 July 2014). The request should be addressed to:

The FOI Officer
Mental Health Tribunal
Level 30, 570 Bourke Street
Melbourne Vic 3000

Phone: (03) 9032 3200

email: mht@mht.vic.gov.au

The Mental Health 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.foi.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 *Protected Disclosure Act 2012*

The *Protected Disclosure Act 2012* encourages and facilitates disclosures of known or suspected improper conduct of public officers, public bodies and other persons, and disclosures of detrimental action taken in reprisal for a person making a disclosure under the Act.

The 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 provides for the investigation of disclosures that meet the definition of a protected disclosure.

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

During the 2014/15 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 and Human Services or the Independent Broad-based Anti-corruption Commission (IBAC): The Department's contact details are as follows:

Protected Disclosure Coordinator
Department of Health & Human Services
50 Lonsdale Street
Melbourne VIC 3000

Phone: 1300 045 866

Website: www.health.vic.gov.au/whistle-fraud.htm

email: protected.disclosure@dhhs.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:

Level 1, North Tower
459 Collins Street
Melbourne VIC 3000
GPO Box 24234
Melbourne VIC 3001

Telephone: 1300 735 135

Website: www.ibac.vic.gov.au

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

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

Mental Health Tribunal

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